NINNESCAH VALLEY HEALTH SYSTEMS, INC.

CAFETERIA PLAN

Summary Plan Description

NINNESCAH VALLEY HEALTH SYSTEMS, INC. CAFETERIA PLAN
SUMMARY PLAN DESCRIPTION
TABLE OF CONTENTS

1. General Information 1
2. Participation in the Plan 3
3. Pre-Tax Benefit Options - Participant Elections 5
4. After-Tax Benefit Option - Participant Elections 10
5. Medical Plan 10
6. Dental Plan 13
7. Health Flexible Spending Account 14
8. Dependent Care Assistance Plan 22
9. Vision Plan 27
10. Group Life Plan 29
11. Voluntary Life Plan 30
12. AFLAC Pre-Tax Plan 31
13. AFLAC After-Tax Plan 33
14. COBRA Coverage for Group Health Plans 35
15. USERRA Continuation Rights 43
16. Group Health Plan Claims Procedures (Not applicable to the Health FSA) 43
17. Miscellaneous 44
18. Participant's Rights Under ERISA 45
19. Notice of Hospital Rights for Newborns and Mothers 46
20. Notice of Rights under the Women's Health and Cancer Rights Act of 1998 47
21. Notice of Opportunity to Enroll Adult Children up to Age 26 47
22. No Lifetime Limit under the Medical Plan 47

23. Patient Protection Notice 48

24. Right of Employer to Amend or Terminate 48

COBRA Notice Procedures A-1

SUMMARY PLAN DESCRIPTION
NINNESCAH VALLEY HEALTH SYSTEMS, INC. CAFETERIA PLAN

Kingman Community Hospital ("Employer") maintains the Ninnescah Valley Health Systems, Inc. Cafeteria Plan ("Plan") for the exclusive benefit of, and to provide benefits to, its Eligible Employees, their legal Spouses, and their eligible dependents.

This Summary Plan Description ("SPD") describes the basic features of the Plan, how the Plan operates, and the benefits that can be purchased through the Plan. This SPD is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant. It is not a part of the official plan documents. ***If there is a conflict between the plan documents and this SPD, the plan documents will control.***

(1) General Information

(a) *Type of Plan.* The Plan is a cafeteria plan. The Employer has assigned number 501 as the Plan Number for the Plan.

(b) *Pre-Tax Benefits.* Participants in the Plan may reduce their salary on a pre-tax basis to pay for the cost of benefits provided by one or more of the following plans maintained by the Employer:

(i) Ninnescah Valley Health Systems, Inc. Medical Plan ("Medical Plan");

(ii) Ninnescah Valley Health Systems, Inc. Dental Plan ("Dental Plan");

(iii) Ninnescah Valley Health Systems, Inc. Health Flexible Spending Account ("Health FSA");

(iv) Ninnescah Valley Health Systems, Inc. Dependent Care Assistance Plan ("DCAP");

(v) Ninnescah Valley Health Systems, Inc. Vision Plan ("Vision Plan"); and/or

(vi) Ninnescah Valley Health Systems, Inc. AFLAC Pre-Tax Plan ("AFLAC Pre-Tax Plan").

Each of the above Pre-Tax Benefits is governed by a plan document. Please refer to such document for information regarding specific terms and conditions associated with each plan. This SPD serves as the summary plan description for each of these Pre-Tax Benefits. A summary of each of these plans is provided later in this SPD.

(c) *Taxation of Pre-Tax Benefits.* The amount by which your salary is reduced to purchase benefits, and any benefits paid to you under these pre-tax plans, will not be included in your taxable income for federal income tax purposes and is not subject to FICA taxes.

(d) *After-Tax Benefits.* Participants in the Plan may reduce their salary on an after-tax basis to pay for the cost of benefits provided by one or more of the following plans maintained by the Employer:

(i) Ninnescah Valley Health Systems, Inc. Voluntary Life Plan ("Voluntary Life Plan"); and/or

(ii) Ninnescah Valley Health Systems, Inc. AFLAC After-Tax Plan ("AFLAC After-Tax Plan").

This SPD serves as the summary plan description for each of these plans. A summary of each of these plans is provided later in this SPD.

(e) *Employer-Paid Benefits.* The Ninnescah Valley Health Systems, Inc. Group Life Plan ("Group Life Plan") is an Employer-Paid Benefit available through this Plan.

This SPD serves as the summary plan description for this plan. A summary of this plan is provided later in this SPD.

(f) *Employer.* The name, address, telephone number, and federal tax identification number of the Employer are:

KINGMAN COMMUNITY HOSPITAL
750 WEST D AVENUE
P.O. BOX 376
KINGMAN, KS 67068
(620) 532-3147
EIN: 48-0761700

(g) *Plan Administrator/Service of Process.* The Employer is the Plan Administrator. The Plan Administrator is responsible for providing you and other Participants with information regarding your rights and benefits under the Plan. The Plan Administrator must also file various reports, forms, and returns with the Department of Labor ("DOL") and the Internal Revenue Service ("IRS"). The Plan Administrator is vested with full discretionary authority to interpret, construe, and carry out the provisions of the Plan, and to render decisions on the administration of the Plan, including any factual and legal determinations as to whether an individual is eligible to be enrolled in and/or receive any benefit under the terms of this Plan. The name of the person designated as the Agent for Service of Legal Process is Ed Riley, whose address is the same as the Employer's address. Service of Legal Process may also be made upon a Plan trustee or the Plan Administrator.

(h) *Spouse.* Spouse means a person of the same or opposite sex to whom you are legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which you currently reside. A common law marriage shall be considered to be a legal marriage if the common law marriage was validly entered into in

a state that recognizes common law marriage. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of a legal marriage (including the existence of a common law marriage). An individual will not be considered a "Spouse" for purposes of this Plan if (i) his/her marriage to you has been terminated by a court having jurisdiction over you or the individual or (ii) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.

(i) *Dependent.* Dependent means, for purposes of the Health FSA only, the following:

(i) *Children Through Age Twenty-Six (26).* Your natural child, lawfully adopted child (including a child placed with you for adoption but for whom the adoption is not yet final), stepchild, or other child for whom you have obtained legal guardianship pursuant to a court order, until the end of the year which such child attains age twenty-six (26) (or until such child attains age eighteen (18) in the case of a legal guardianship). Children placed with you for adoption and children who are the subject of a Qualified Medical Child Support Order will also be considered Dependents.

(ii) Disabled Children Above Age 26. Your natural child, lawfully adopted child (including a child placed with you for adoption but for whom the adoption is not yet final), stepchild, or other child for whom you have obtained legal guardianship pursuant to a court order, who is unmarried and incapable of self-sustaining employment by reason of mental retardation or physical disability and for whom you are the major source of financial support, from the end of the calendar year in which the child attains age 26.

(iii) Non-Children Dependents. Any of your relatives who reside in your home, are claimed by you as a tax dependent, and meet the definition of a tax dependent under Code § 152.

(j) *Plan Year.* The Plan Year is the twelve (12) month period beginning every August 1 and ending the subsequent July 31.

(2) Participation in the Plan

You will automatically become a Participant in the Plan on your plan entry date if you satisfy the eligibility conditions for the Plan. Once you become a Participant, you will continue to be a Participant until the eligibility conditions are no longer met. These requirements are explained in more detail below.

(a) *Eligibility Conditions.* To be eligible to participate in the Plan (i.e., to be an "Eligible Employee"), the following conditions must be met:

(i) *Employee.* You must be an individual employed by the Employer;

(ii) *Regularly Scheduled Hours per Week.* Your regularly scheduled workweek must ordinarily equal or exceed thirty (30) hours per week. For purposes of the Plan, this is considered to be "full-time"; and

(iii) *Not Excluded from Participation.* You must not be excluded from participation. You are excluded from participation if you are (A) covered under a collective bargaining agreement; (B) classified on the Employer's payroll records as a "leased" employee; or (C) for purposes of participating in this Plan (but not, unless otherwise provided, for purposes of participating on an after-tax basis in any underlying Benefit Package Option), an individual who is, with respect to the Employer, self-employed within the meaning of Section 401(c)(1) of the Code or is treated as a partner under Section 1372 of the Code.

(b) *Plan Entry Date.*

(i) *General Rule.* If you are an Eligible Employee, you will become a Participant on the first day of the month following sixty (60) days of continuous, active employment as an Eligible Employee.

If you enter the Plan pursuant to this Section (2) of this SPD, you are a Participant without regard to whether you elect to reduce your Compensation in order to purchase benefits under one (1) or more of the Pre-Tax Benefits and/or After-Tax Benefits.

EXAMPLE #1: You are hired as a full-time employee on March 15. You complete sixty (60) days of employment with the Employer on May 14. You will be eligible to participate in the Plan on June 1. If you wish to participate in the Plan, you must make an Election to do so within thirty (30) days of June 1, (that is, by July 1).

If you do not return a completed Election form, or if your completed Election form is received after July 1, you will not be able to enter the Plan until the first day of the next Plan Year unless you experience an "Election change event".

(c) *Termination of Participation.* Once you become a Participant, you will continue to be a Participant as long as each of the eligibility conditions is met. If one or more of these conditions is not met, you will cease to be a Participant, unless a special rule applies. The special rules that might apply are summarized below.

(i) *Special Rule for Leaves of Absence.* If the number of hours that you are regularly scheduled to work each week falls below the minimum number required for you to participate in the Plan, you may still continue to participate in the Plan if you are on (A) a paid leave approved by the Employer; (B) unpaid leave under the Family and Medical Leave Act ("FMLA") if the FMLA is applicable to the Employer; or (C) unpaid leave through the end of the month,

(ii) *Special Rule for Military Service.* If you enter active service in the armed forces of any country, you will not be eligible to participate in the Plan unless your service is temporary active service of two (2) weeks or less.

(iii) *Special Rule for Certain Pre-Tax Benefits.* If you are participating in a Pre-Tax Benefit and your employment is terminated before the end of a pay period or the end of the month, your participation in the Plan may continue through the end of the pay period and/or the month (depending on the underlying Pre-Tax Benefit).

EXAMPLE: You participate in the Medical Plan. You are paid on the first (1st) and fifteenth (15th) of each month. You terminate employment on July 5. You will remain an Eligible Employee in the Plan for purposes of participating in the Medical Plan on a pre-tax basis through the end of the month.

(3) Pre-Tax Benefit Options – Participant Elections

To purchase benefits on a pre-tax basis through the Plan, you must elect to do so by completing and returning a salary reduction agreement to the Plan Administrator. This is known as an "Election." Once you have made an Election, you will not be able to change that Election until the next Plan Year, unless an exception applies. These rules are discussed in more detail below.

(a) *How to make an Election.* To make an Election, you must complete a salary reduction agreement and return the completed salary reduction agreement to the Plan Administrator. If you are changing an Election in the middle of a Plan Year, you may also be required to complete and return an Election change form. The Plan Administrator may require the salary reduction agreement or the Election change form to be completed and submitted in electronic form through the use of the Internet, an Intranet, a telephone system, or such other system as the Plan Administrator may prescribe.

(b) *When to make an Election.* An Election for the next Plan Year must be made during the Annual Enrollment Period for that Plan Year. The Annual Enrollment Period will be announced by the Plan Administrator each year. An Election change during the middle of a Plan Year must be made no later than thirty (30) days after the event that allows an Election change to be made, except that an Election change made in connection with certain HIPAA special enrollment rights may be made within sixty (60) days after the event as further described in (3)(d)(ii) below. If you are a new Participant in the Plan, an Election must be made no later than thirty (30) days after the date you entered the Plan.

(c) *Failure to make an Election.*

(i) *Failure to Make an Initial Election.* If you have never made an Election, you will not be able to purchase any benefits through the Plan on a pre-tax basis.

(ii) *Failure to Change Existing Election.* Once you have made an Election, a failure to complete a new salary reduction agreement for a subsequent Plan Year will be treated as a decision on your part to retain your existing Elections for the new

Plan Year. However, if you have elected to put money into the Health FSA or DCAP, your Election for those plans will be reduced to zero dollars for any subsequent Plan Years.

(d) *Election Changes.* An Election may not be changed in the middle of a Plan Year unless you qualify for one of the exceptions listed below. All Election changes must be approved by the Plan Administrator. In approving or denying an Election change, the Plan Administrator may rely on the terms of the Plan, IRS regulations, and informal guidance from the IRS.

You may change an Election in the middle of a Plan Year in the following circumstances (and subject to the other rules of the Plan):

(i) *Change in Status.* If there is a "change in status" and the Election change is consistent with the "change in status," then the following events may constitute a "change in status":

(A) A change in your marital status;

(B) A change in the number of your dependents;

(C) A change in the employment status of yourself, your Spouse, or your dependent. This may include starting a new job, leaving an old job, taking an unpaid leave of absence, or returning from an unpaid leave of absence. It may also include a change in the number of hours that you, your Spouse, or your dependent are regularly scheduled to work, but only if the change in hours affects your eligibility for benefits under the Plan, or any of the other Benefit Plans, or your Spouse's or dependent's eligibility under a benefit plan of their employer;

(D) One of your dependents satisfies, or ceases to satisfy, the eligibility requirements for a dependent under a Benefit Plan;

(E) A change in residence for yourself, your Spouse, or your dependent if it affects that person's eligibility for benefits; and/or

(F) You enroll in a Qualified Health Plan through an Exchange/Health Insurance Marketplace (the "Marketplace") established pursuant to the Patient Protection & Affordable Care Act by virtue of having become eligible for a special enrollment period in the Marketplace or by having enrolled during the Marketplace's annual open enrollment period. However, in order to make an Election change on this basis, you (and any Spouse and/or dependents who are covered through you) must enroll in the Qualified Health Plan and have such coverage take effect no later than the day immediately following the day that your coverage under the Medical Plan is terminated.

Whether an Election change is consistent with the "change in status" will be determined by the Plan Administrator in accordance with IRS regulations and prevailing IRS guidance.

(ii) *HIPAA Special Enrollment Rights.* Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), group health plans must provide a "special enrollment" period for certain individuals. These individuals include individuals who were eligible for coverage but who did not enroll due to other coverage and individuals who have become dependents through marriage, birth, or adoption. These individuals also include individuals who become eligible for a state premium assistance subsidy under a Group Health Plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP). Similarly, individuals who lose eligibility for Medicaid or SCHIP coverage have special enrollment rights in the Plan. If you exercise your "special enrollment" rights under HIPAA, you may make an Election change to pay the cost of covering the individuals you enrolled. Unlike with the other Election change events, you have sixty (60) days to enroll an individual if the Election change event is a HIPAA special enrollment right related to eligibility for a state premium assistance subsidy or a loss of eligibility for Medicaid or SCHIP.

(iii) *Change in Coverage of Your Spouse or Dependent.* If there is a change in the coverage of your Spouse or your dependent and that coverage is obtained through the cafeteria plan of another employer, you may make a "corresponding" Election change. For this exception to apply, one (1) of the following conditions must be met: (A) The plan year of the other employer's cafeteria plan is different than the Plan Year of the Plan; or (B) the cafeteria plan of the other employer permits only those Election changes that are authorized under IRS regulations. The Plan Administrator will decide in its discretion and in accordance with prevailing IRS guidance whether a requested change is on account of, and corresponds with, the change made under the plan of the other employer.

EXAMPLE: You have elected to provide medical coverage for your family under the Employer's Medical Plan. Your Spouse is employed by a different employer. During open enrollment for the cafeteria plan of that employer, your Spouse elects "family coverage" under the medical plan of that employer. The plan year of that employer is different than the Plan Year of your Employer. Under this exception, you may discontinue your Election to pay for family coverage on a pre-tax basis through this Plan.

(iv) *Loss of Governmental/Educational Institution Group Health Coverage.* If you, your Spouse, or your dependent loses group health coverage and the coverage was sponsored by a governmental or educational institution, you may make an Election change to add coverage for the persons who are losing coverage. For purposes of this provision, group health coverage sponsored by a governmental or educational institution includes a state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act, a medical care program of an

Indian Tribal government or a tribal organization, a state health benefits risk pool, or a foreign government health plan.

(v) *"Significant" Curtailment in Coverage.*

(A) *Without Loss of Coverage.* If coverage under a plan is "significantly curtailed," but not lost, you may change your Election to elect coverage under another benefit option that provides similar coverage. Coverage under a plan is "significantly curtailed" only if there is an overall reduction in the coverage provided to participants in the plan.

(B) *With Loss of Coverage.* If coverage under a plan is "significantly curtailed" and that curtailment constitutes a "loss of coverage" for you, your Spouse, or your dependent, you may change your Election to elect coverage under another benefit option that provides similar coverage. If no similar benefit option is available, you may elect to drop coverage. For purposes of this provision, a "loss of coverage" means a complete loss of coverage under the benefit option. This includes the elimination of a benefit option, the loss of coverage under an option due to an individual reaching an overall lifetime or annual coverage limit, a substantial decrease in the medical care providers available under the option, or a reduction in the benefits for a specific type of medical condition or treatment for which you, your Spouse, or your dependent is currently receiving treatment.

(C) *Determinations to be Made by the Plan Administrator.* The Plan Administrator will decide in its discretion, and in accordance with prevailing IRS guidance, whether a curtailment is "significant," whether a curtailment represents a "loss of coverage" with respect to a particular individual, and whether a substitute benefit option provides "similar coverage."

(vi) *Addition or Improvement of a Benefit Option.* If a benefit option is added in the middle of a Plan Year or if coverage under an existing benefit option is significantly improved, you may make an Election change to add that option.

(vii) *FMLA Leave.* If you take a leave of absence under the FMLA, you may change your Election for coverage under a Group Health Plan. You may also be able to change your Election under the "change in status" exception discussed above.

(viii) *To Comply with a Judgment, Decree, or Order.* If you are required to provide medical coverage for a dependent child pursuant to a judgment, decree, or order, you may change your Election to pay for the increased cost of the coverage. If you are already providing coverage and a judgment, decree, or order requires someone else to provide coverage, you may change your Election to reflect the decreased cost of coverage. *However*, before you are allowed to drop coverage, you may be required to provide proof that other coverage for the child is actually being provided.

(ix) *Entitlement to Medicare/Medicaid.* If you, your Spouse, or your dependent becomes entitled to Medicare or Medicaid, you may change your Election to reflect the decreased cost of coverage under the Employer's Group Health Plan. If you, your Spouse, or your dependent loses your/their entitlement to Medicare or Medicaid, you may increase your Election to reflect the increased cost of coverage under the Employer's Group Health Plan.

(x) *Significant Change in Cost of Coverage.* If your share of the premium for coverage under a benefit option increases by a significant amount, you may increase your Election to reflect the increased cost or you may elect to be covered under another benefit option (if any) providing similar coverage. If similar coverage is not available, you may drop your coverage all together.

If your share of the premium for coverage under a benefit option decreases by a significant amount, you may decrease your Election by a corresponding amount or, if you are not currently enrolled in that benefit option, you may elect to become covered under that benefit option.

Whether there has been a "significant" change in cost and whether another benefit option provides "similar coverage" will be decided by the Plan Administrator in its discretion and in accordance with prevailing IRS guidance.

(e) *Effective Date of Elections.*

(i) *Election Made During Annual Enrollment Period.* An Election made during the Annual Enrollment Period will be given effect as of the first day of the next Plan Year.

(ii) *Election Made in the Middle of a Plan Year.* An Election made in the middle of a Plan Year will be given effect as of the earliest administratively practicable date after a completed Election change form and salary reduction agreement are received by the Plan Administrator. This includes both Election changes and the initial Elections made by new Participants. Under IRS regulations, Elections cannot be given retroactive effect. For example, although you can use pre-tax dollars to pay for future coverage, you cannot use pre-tax dollars to pay for coverage that has already been provided. The only exception to this prohibition is for newborn children and newly adopted dependents who are enrolled in a Group Health Plan pursuant to HIPAA "special enrollment" rights. Coverage that is retroactive to the date of their birth or adoption may be paid for on a pre-tax basis.

(f) *Special Rule for Former Participants Rehired Within Thirty (30) Days of Termination.* If you are rehired within thirty (30) days after the date on which your employment was terminated, you will be reinstated in the Plan with the same Elections you had before your employment was terminated unless (i) you would be permitted to make an Election change for some reason other than the change in your employment with the Employer or (ii) the Plan Year ended on or after the date your employment was terminated, but before the date you were rehired.

(g) *Special Rule for Health FSAs.* You may *not* change your Election under the Health Flexible Spending Account ("Health FSA") in the middle of a Plan Year except as follows:

(i) You may begin to participate in the Health FSA if you are eligible, provided you are permitted to make an Election change under the rules summarized in Section (3)(d) above;

(ii) You may increase your Election as long as you do not exceed the maximum Election amount permitted under the Health FSA and provided you are permitted to make an Election change under the rules summarized in Section (3)(d) above; or

(iii) You may decrease your Election, provided you are permitted to make an Election change under the rules summarized in Section (3)(d) above; however, you may not reduce your Election amount below the total amount you have already been reimbursed.

EXAMPLE: During the Annual Enrollment Period, you make an Election of $1,200 for your Health FSA for the Plan Year. To pay for this benefit, your salary is reduced by $100 per month. Suppose that after three (3) months, you have contributed a total of $300 into your Health FSA, you have been reimbursed $400, and you experience a qualifying Election change event. You may change your Election for the Plan Year to any amount equal to or greater than $400.

Continuing with the above example, suppose you change your Election amount to $600 instead of $1,200. Because you have already been reimbursed $400, only $200 will be available to you for reimbursement through the end of the Plan Year.

Except as set forth above, an Election with respect to the Health FSA may not be changed during the Plan Year once it has been made.

(4) After-Tax Benefit Option - Participant Elections

You may make and/or change your Elections with respect to an After-Tax Benefit at any time in accordance with the rules and procedures established by the Plan Administrator. Any such Election change will take effect on the earliest administratively practicable date after the request to change an after-tax Election is received by the Plan Administrator.

(5) Medical Plan

The Employer maintains a Medical Plan that pays benefits pursuant to the terms and conditions of a group contract with Blue Cross Blue Shield of Kansas ("BCBS"), 1133 SW Topeka Boulevard, Topeka, Kansas 66629-0001.

(a) *Type of Plan.* The Medical Plan is a group health plan. The Medical Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Dates.* The eligibility conditions and the Medical Plan entry dates are the same as those for the Plan.

(c) *Enrollment in the Plan.* **To become a Participant in the Medical Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Medical Plan entry date. **If you do not elect to participate in the Medical Plan, you will not receive any benefits under the Medical Plan.**

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Medical Plan until the next open enrollment period and your enrollment will not take effect until the anniversary date of the BCBS group contract. The same rule applies if you fail to enroll your dependents (including your Spouse) when you are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA "Special Enrollment" rights.

(ii) *HIPAA "Special Enrollment" Rights.* If you are declining enrollment in the Medical Plan for yourself or your dependents because of other health insurance coverage and that other coverage is subsequently lost, you may be able to enroll yourself and/or your dependents in the Medical Plan if you request enrollment within thirty (30) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption. Finally, if you become eligible for a state premium assistance subsidy under a Group Health Plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP), you may be able to enroll yourself and/or your dependents in the Medical Plan if you request enrollment within sixty (60) days after you or your dependents become eligible for such assistance. Similarly, if you lose eligibility for Medicaid or SCHIP coverage, you have special enrollment rights in the Plan, provided you request enrollment within sixty (60) days after you or your dependents lose eligibility for Medicaid or SCHIP coverage.

(d) *Plan Benefits.* If you elect to participate in the Medical Plan, benefits will be provided by the Employer pursuant to the terms and conditions of the group contract between the Employer and BCBS. This Medical Plan provides you and/or your dependents with comprehensive medical coverage. BCBS has prepared materials which explain the benefits under this Medical Plan in detail. If you have not received these materials from BCBS, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* BCBS is solely obligated to pay for medical benefits provided under the BCBS group contract. The Employer makes no promise, and will have no obligation, to provide or pay for any benefits under the group contract.

(f) *Premiums.* The monthly premiums for insurance coverage under the Medical Plan are determined by BCBS and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on a pre-tax basis through the Plan.

(g) *Medical Treatment.* The Medical Plan does not provide medical treatment or give medical advice. **It is your responsibility, in consultation with the physicians of your choice, to get appropriate medical treatment.** The fact that some expense may not be eligible for reimbursement by the Medical Plan does not mean that you or your dependents should not have that treatment.

(h) *Claims Procedures.* In the event you have a claim for benefits under the Medical Plan, you should follow the procedures outlined in the materials prepared by BCBS, as applicable. The Plan Administrator, upon your request, will assist you in making these claims. BCBS has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the applicable group contract.

(i) *Explanation of Benefits.* You will receive an explanation of benefits (EOB) under the Medical Plan at your primary residence (as provided to the Claims Administrator, i.e., the insurance company for fully insured plans or third-party administrator for self-funded plans). If your covered Spouse or dependent does not wish for an EOB to be provided at this address, he/she will need to contact the Claims Administrator and provide an alternate address.

(j) *Termination of Coverage.* Your participation in the Medical Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the insurance group contract – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the insurance group contract – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the Medical Plan.

Your coverage for benefits under the Medical Plan ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD.

(6) Dental Plan

The Employer maintains a Dental Plan that pays benefits under a group contract with Delta Dental of Kansas, Inc. ("Delta Dental"), P.O. Box 789769, Wichita, KS 67278.

(a) *Type of Plan.* The Dental Plan is a group health plan. The Dental Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Dates.* The eligibility conditions and the Dental Plan entry dates are the same as those for the Plan.

(c) *Enrollment in the Plan.* **To become a Participant in the Dental Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Dental Plan entry date. **If you do not elect to participate in the Dental Plan, you will not receive any benefits under the Dental Plan.**

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Dental Plan until the next open enrollment period and your enrollment will not take effect until the anniversary date of the Delta Dental group contract. The same rule applies if you fail to enroll your dependents (including your Spouse) when you are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA "Special Enrollment" rights.

(d) *Plan Benefits.* If you elect to participate in the Dental Plan, benefits will be provided by the Employer pursuant to the terms and conditions of a group contract between the Employer and Delta Dental. This Dental Plan provides you and/or your dependents with comprehensive dental coverage. Delta Dental has prepared materials which explain the benefits under this Dental Plan in detail. If you have not received these materials from Delta Dental, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* Delta Dental is solely obligated to pay for the benefits provided under the Delta Dental group contract. The Employer makes no promise and will have no obligation to provide or pay for benefits under the group contract.

(f) *Premiums.* The monthly premiums for insurance coverage under the Dental Plan are determined by Delta Dental and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on a pre-tax basis through the Plan.

(g) *Dental Treatment.* The Dental Plan does not provide dental treatment or give dental advice. **It is your responsibility, in consultation with the dentists of your choice, to get appropriate dental treatment.** The fact that some expense may not be eligible for reimbursement by the Dental Plan does not mean that you or your dependents should not have that treatment.

(h) *Claims Procedures.* In the event you have a claim for benefits under the Dental Plan, you should follow the procedures outlined in the materials prepared by Delta Dental, as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Delta Dental has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.

(i) *Explanation of Benefits.* You will receive an explanation of benefits (EOB) under the Dental Plan at your primary residence (as provided to the Claims Administrator, i.e., the insurance company for fully insured plans or third-party administrator for self-funded plans). If your covered Spouse or dependent does not wish for an EOB to be provided at this address, he/she will need to contact the claims administrator and provide an alternate address.

(j) *Termination of Coverage.* Your participation in the Dental Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the insurance group contract – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the insurance group contract – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the Dental Plan.

Your coverage for benefits under the Dental Plan ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD.

(7) Health Flexible Spending Account

The Employer maintains a Health FSA that pays benefits out of the Employer's general assets.

(a) *Type of Plan.* The Health FSA is a self-funded group health plan. The Health FSA is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the Health FSA entry date are the same as those for the Plan.

(c) *Election to Participate in the Plan.* To become a Participant in the Health FSA, you must complete and return the form or forms provided by the Plan Administrator. **If you do**

not elect to participate in the Health FSA, the Employer will not provide you with any benefits under the Health FSA.

(i) *Failure to Enroll When First Eligible.* As a general rule, if you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Health FSA until the next Annual Enrollment Period, in which case your enrollment will not take effect until the first day of the next Plan Year. However, if you experience an event that would allow an Election change under the terms of the Plan (see Section (3)(d) of this SPD), you may enroll in the Health FSA in the middle of the Plan Year.

(ii) *Election Changes Once Enrolled in the Health FSA.* Once you elect to participate in the Health FSA, you will be permitted to change your Election after the beginning of the Plan Year if you experience an event that would allow an Election change under the terms of the Plan (see Section (3)(d) of this SPD). In general, you may begin participation or increase your Election amount for the remainder of the Plan Year. You are also permitted to decrease your Election amount provided, however, that the Election amount is not less than the amount you have already been reimbursed.

To determine the amount that you may be reimbursed for the remainder of the Plan Year, you should subtract the amount you have already been reimbursed from the new Election amount.

EXAMPLE: During the Annual Enrollment Period, you elect $1,200 for the Plan Year. You make monthly contributions of $100 per month for six (6) months (totaling $600) and you are reimbursed $900 during that 6-month period. Suppose you experience an Election change event which would permit you to change your Election for the remaining six (6) months of the Plan Year. You then request to *decrease* your election to $600. You will not be permitted to make this change in your Election amount. This is because your total reimbursements to date (i.e., $900) is greater than the new Election amount (i.e., $600). You could, however, decrease your Election to $1,000 for the remainder of the Plan Year. This is because your new Election amount is greater than the amount you have already been reimbursed (i.e., $900). In the remaining six (6) months of the year, you will be able to receive $100 in future reimbursements.

(d) *Special Rules Relating to FMLA Leave.* If you are a Participant in the Health FSA and you are taking or returning from FMLA leave, the following special rules apply to your participation in the Health FSA:

(i) *Taking FMLA Leave.* You may continue to participate in the Health FSA after you begin your FMLA leave by continuing to pay the applicable premium while you are on leave or by making such other arrangements for the payment of the applicable premiums as may be permitted under the Plan (see Section (17)(b) of this SPD). You may also choose to discontinue your participation in the Health FSA once you begin your FMLA leave.

(ii) *Returning From FMLA Leave.* If you discontinued your participation in the Health FSA when you began your FMLA leave, you may choose to participate again once you return to work from your FMLA leave. If you want to resume your participation at the same coverage level that was in effect before your FMLA leave, you will be required to pay the premiums that would have been due while you were on FMLA leave. If you do not want to make up the missed premiums, you may instead choose to resume coverage at a reduced level. In this event, the amount of coverage that you elected will be reduced by the percentage of the Plan Year that you were on FMLA leave. For example, if you had elected $1,200 for the Plan Year and were on FMLA for two months, your annual Election would be reduced to $1,000 under this alternative.

(e) *Effective Date of Election.* If you elect to participate in the Health FSA, your Election will take effect and you will become a Participant as follows:

(i) *Election Made During Annual Enrollment Period.* If you elect to participate during the Annual Enrollment Period for the Plan, your Election will take effect on the first day of the next Plan Year. In other words, you will become a Participant as of the first day of the next Plan Year.

(ii) *Election Made by A Newly Eligible Employee.* If you elect to participate within thirty (30) days after you first become eligible to participate in this Health FSA, your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE: You begin working as a full-time employee on March 15. You complete sixty (60) days of employment with the Employer on May 14. You will be eligible to participate in the Health FSA on June 1. If you wish to participate in the Health FSA, you must make an Election to do so within thirty (30) days of June 1, (that is, by July 1).

If you do not return a completed Election form, or if your completed Election form is received after July 1 you will not be able to enter the Health FSA until the first day of the next Plan Year unless you experience an "Election change event" (see below).

(iii) *Election Made Following an Election Change Event.* If you elect to participate within thirty (30) days after an event that would allow you to make an Election change under the Plan (see Section (3)(d) of this SPD), your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE: During the Annual Enrollment Period, you did not elect to participate in the Plan. On March 15, your child is born. This is a "change in status" which allows you to make an Election change under the Plan. You may elect to participate in the Plan if you do so within thirty (30) days after March 15, (that is, by April 14). If you do not elect to enter the Health FSA within thirty (30) days after this "change in status," you will not have a second opportunity to enter the Health FSA until the first day of the next Plan Year unless you experience a second Election change event.

(f) *Plan Benefits.* If you elect to participate in the Health FSA, you must elect the amount by which you want the Employer to reduce your salary for the Plan Year. To determine how much you should reduce your salary for medical reimbursement benefits, you should estimate the amount of medical and dental expenses you expect to have for the Plan Year in which your health or dental insurance will not cover. When you incur uninsured medical or dental expenses, the Plan Administrator will reimburse you for those expenses. The amount of salary you reduce for these medical or dental expenses is not subject to income tax or FICA.

EXAMPLE: You elect to reduce your salary by $1,200 for the Plan Year. Therefore, $1,200 is your maximum reimbursement for uninsured medical expenses incurred for that Plan Year.

If you do not incur uninsured medical expenses for the Plan Year equal to the maximum reimbursement amount, you will lose the unused portion.

EXAMPLE: Assume you elect to reduce your salary by $1,200 for medical expenses, but incur only $1,000 of uninsured expenses for the Plan Year. As required by IRS regulations, you will forfeit the remaining $200. This example illustrates the importance of carefully estimating your uninsured medical expenses for the Plan Year.

If the Employer determines after the claims Run-Out Period and after processing all pending claims that the total premiums paid by all participants in the Health FSA exceed the total reimbursements paid out, the Plan will have a surplus. Such surplus will be used to offset reasonable administrative costs. Any surplus remaining after such costs are paid will be used to reduce the required premiums in the following Plan Year. If you are a participant in the Health FSA on the date of the first payroll following the date on which the amount of surplus has been determined, you will receive a reduction in the cost of your premium, known as a "premium holiday."

If the Health FSA is terminated by the Employer before or at the end of the Plan Year, then the Employer will determine whether or not there is a surplus. There is a surplus if the total contributions from all Participants exceed the total Health FSA reimbursements. This determination will not be made until after the claims Run-Out Period and after all pending claims have been processed. The Employer will use the surplus, if any, to offset reasonable administrative costs. Any surplus remaining after reasonable administrative costs have been paid shall be distributed to all individuals who were participating in the

Health FSA on the date of the Plan's termination. The amount of remaining surplus will be divided by the number of participants entitled to the distribution in order to determine each person's share. In no case will the surplus be allocated to you based directly or indirectly on your claims experience or on the amount of your annual election.

(g) *Maximum Benefit Amount.* Under the Health FSA, if you or your dependents incur a "qualified medical expense" for which you submit a timely claim for reimbursement, you will receive a reimbursement for the portion of that expense that is not covered by medical or dental insurance; however, your reimbursements may not exceed the maximum reimbursement amount.

(i) *Maximum Reimbursement Amount – General Rule.* The maximum reimbursement amount for a Plan Year may not exceed the total amount that you have elected to contribute to the Health FSA for that Plan Year.

(ii) *Limits on Contributions to a Health FSA.* The amount that you elect to contribute to the Health FSA for a Plan Year may not exceed the dollar limit that is established each year by the Employer. That dollar limit, in turn, may not exceed the dollar limit established by Congress in the Code, as adjusted by the IRS for periodic cost-of-living increases. The dollar limit established by the Employer will be communicated in the enrollment materials for the Health FSA. The Plan Administrator will also provide information about this dollar limit upon request.

(iii) *Maximum Reimbursement Amount – Run-Out Periods.* A claim that is incurred during the previous Plan Year and which is submitted for reimbursement during the Plan's Run-Out Period will count against the maximum reimbursement amount for the previous Plan Year and not the Plan Year during which reimbursement is made.

(iv) *Order of Reimbursement.* Reimbursements during the Run-Out Period for current-year claims will be made from current-year amounts in order to maximize the potential Carryover Amount, unless you specifically request otherwise and the Plan Administrator permits such alternative reimbursement ordering.

(h) *Qualified Medical Expenses.* The "qualified medical expenses" for which you (or your Spouse or Dependent) are entitled to reimbursement under the Health FSA are generally those medical expenses that are tax deductible under Section 213(d) of the Internal Revenue Code and for which you have not otherwise been reimbursed through insurance or any other means. Typical expenses include, but are not limited to:

(i) Deductibles and copayment amounts you pay under your medical or dental or vision care coverage;

(ii) Medical, dental and/or vision care expenses in excess of usual, reasonable and customary rates; and

(iii) Any other Code § 213(d) medical, dental, or vision expenses not reimbursed by insurance; provided, however, over-the-counter drugs or medicine (other than insulin) that are not purchased pursuant to a prescription are not eligible for reimbursement as "qualified medical expenses."

The Health FSA does not reimburse for amounts paid to obtain other health insurance coverage. The Health FSA will only reimburse you for qualified medical expenses incurred while you are a Participant in the Health FSA. Under IRS rules, a qualified medical expense is generally considered to be "incurred" when the treatment is provided and not when you are billed for the treatment or when the treatment is paid for.

Typical expenses not eligible for reimbursement by the Health FSA include, but are not limited to:

(i) Those reimbursed through any other policy or plan, including Medicare or other federal programs;

(ii) Those incurred before you enroll in the Health FSA;

(iii) Those incurred in any year other than the year for which Health FSA contributions are made;

(iv) Those claimed as a deduction or credit for federal income tax purposes; and

(v) Those the IRS would not allow as deductions for federal income tax purposes, except for certain over-the-counter drugs.

(i) *Run-Out Period.* "Run-Out Period" means the period that begins at the close of the Plan Year and ends on the October 29 immediately following the close of the Plan Year. Eligible expenses must be submitted for reimbursement before the end of the Run-Out Period.

(j) *Electronic Payment Card.* The Employer permits the use of an electronic payment card, such as a debit card, to pay for Qualified Medical Expenses. The electronic payment card may only be used at merchants and service providers which are authorized by the Employer.

(k) *How to Submit a Claim.*

(i) *Claims Forms.* Except as provided in (ii) below, in the event you have a claim for benefits under the Health FSA, you must submit a claim using the claims form that will be provided to you by the Plan Administrator and following the instructions on that form. The Claims Administrator may require you to provide such information as may reasonably be required to process the claims, including, but not limited to, the following:

(A) The amount, date incurred and nature of each expense;

(B) The name of the person, organization or entity with whom the expense was incurred;

(C) The name of the person for whom the expense was incurred;

(D) The amount (if any) recovered under any insurance arrangement or other plan, with respect to the expense; and

(E) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

(ii) *Electronic Payment Card.* If the Employer permits the use of an electronic payment card, such as a debit card, you may be able to access your Health FSA through the use of such card, provided that the claim is properly adjudicated. If your funds are accessible by an electronic payment card, you must comply with the substantiation procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. Under those procedures, some payments with your electronic payment card may be automatically substantiated by this Health FSA; other payments may require further substantiation by you to the Health FSA. Please note that, if you present your electronic payment card as payment for a medical expense and it is denied at the point-of-sale (i.e., when the service or item is provided), that denial of payment will *not* constitute an initial claim denial under these procedures.

(l) *Claims Administrator.* BMI is acting on behalf of the Employer in a ministerial and administrative capacity. The Employer retains full discretionary authority to make all determinations regarding the administration and payment of benefit claims.

(m) *Timing of Claims.* You may submit your claim for benefits under the Health FSA during the Plan Year in which the expenses are incurred or within the Run-Out Period following the close of the Plan Year. You must submit your claim for reimbursement for the Plan Year in which you terminated your participation no later than thirty (30) days after the date of your termination, no later than ninety (90) days after the date the Employer terminates the Health FSA or the October 29 next following the end of the Plan Year, respectively. For example, if you terminate employment with the Employer on July 1 of a particular Plan Year, you must submit your claim for reimbursement no later than July 31 of that Plan Year to receive reimbursement for expenses covered by the Plan which you incurred prior to that July 1.

(n) *Time Frame for Deciding Claims.* If any claim for benefits under this Health FSA is denied, in whole or in part, then the Claims Administrator will promptly furnish you, within thirty (30) days of receipt of the claim, written notice:

(i) Setting forth the reason for the denial;

(ii) Making reference to pertinent Health FSA provisions upon which the denial is based;

(iii) Describing any additional material or information which is necessary and why;

(iv) Referencing any internal rule, guideline, or protocol, or similar criterion relied upon in making the adverse determination (if applicable); and

(v) Explaining the claim review procedure set forth herein, including applicable time limits and a statement of your right to bring a civil action under ERISA § 502(a) following an adverse determination upon review.

(o) *Extension of Time Frame for Deciding Claims.* The Claims Administrator may seek one extension of up to fifteen (15) days in order to make the benefit determination. The extension must be sought due to matters beyond the control of the Plan. You will be notified of the extension prior to the expiration of the initial 30-day period. If the extension is due to your failure to submit information necessary to decide the claim, the notice of extension shall specifically describe the required information and give you at least forty-five (45) days from receipt of the notice to provide the specified information. The period for making the benefit determination shall be tolled from the time the notification of extension is sent until the date on which you respond to the request for information.

(p) *Appealing a Claim Denial.* If your claim is denied, in whole or in part, you have one hundred eighty (180) days to submit an appeal. You may, upon request and free of charge, examine all pertinent documents and may submit issues and comments in writing.

(q) *Time Frame for Deciding Appeal.* The Plan Administrator shall render a decision on review no later than sixty (60) days after receipt of your request for review unless special circumstances require an extension of time (not to exceed sixty (60) days from the date of the initial 60-day period). You will be furnished with written notice of any such extension.

(r) *Decision on Appeal.* In conducting the review, no deference will be given to the initial adverse determination and a plan fiduciary, other than the one who originally decided the claim (or the person's subordinate), will make the determination upon appeal. The decision on review shall be in writing. If the claim is once again denied, in whole or in part, then the notification shall (i) state the reason for the decision, (ii) refer to the Health FSA provisions upon which it is based, (iii) state your right to receive (upon request and free of charge) reasonable access to, and copies of, all relevant information, (iv) describe any voluntary appeals procedures, and (v) state your right to bring an action under ERISA § 502(a).

(s) *Payment of Claims.* Approved claims will be paid directly to you. No claims will be paid to the provider of any services. Prior to making any payment of benefits under the Health FSA, Benefit Management, Inc. ("BMI") (or the Plan Administrator) may require

you to provide such information and complete appropriate documents or forms necessary for the proper administration of the Plan. BMI and/or the Plan Administrator may rely upon all such information furnished to it, including your current mailing address. Furthermore, BMI (or the Plan Administrator), prior to making payments under the Plan, may require you to file all appropriate claims and requests for payment from any other plan or plans maintained by the Employer, including requests for payment with any insurance carrier which has the responsibility for making any benefit payments under any plans maintained by the Employer.

(t) *Termination of Coverage.* Your participation in the Health FSA ends on whichever of the following dates occurs first:

(i) The date that you terminate your employment with the Employer;

(ii) The date in which your election to participate expires;

(iii) The end of a period in which you last paid a required contribution; or

(iv) The date the Employer terminates the Health FSA.

Your coverage for benefits under the Health FSA ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD. You will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds in your Health FSA as of the date of your termination from employment. Any claim submitted following your termination must be submitted in paper form.

(8) Dependent Care Assistance Plan

The Employer maintains a DCAP that pays benefits out of the Employer's general assets.

(a) *Type of Plan.* The DCAP is a Code Section 129 dependent care assistance plan. The DCAP is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the plan entry date are the same as those for the Plan.

(c) *Election to Participate in the Plan.* To become a Participant in the DCAP, you must complete and return the form or forms provided by the Plan Administrator. **If you do not elect to participate in the DCAP, the Employer will not provide you with any benefits under the DCAP.**

(d) *Effective Date of Election.* If you elect to participate in the DCAP, your Election will take effect and you will become a Participant as follows:

(i) *Election Made During Annual Enrollment Period.* If you elect to participate during the Annual Enrollment Period for the Plan, your Election will take effect on the first day of the next Plan Year. In other words, you will become a participant as of the first day of the next plan year.

(ii) *Election Made by A Newly Eligible Employee.* If you elect to participate within thirty (30) days after you first become eligible to participate in this DCAP, your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE: You begin working as a full-time employee on March 15. You complete sixty (60) days of employment with the Employer on May 14. You will be eligible to participate in the DCAP on June 1. If you wish to participate in the DCAP, you must make an Election to do so within thirty (30) days of June 1, (that is, by July 1).

If you do not return a completed Election form, or if your completed Election form is received after July 1, you will not be able to enter the DCAP until the first day of the next Plan Year unless you experience an "Election change event" (see below).

(e) *Election Made Following an Election Change Event.* If you elect to participate within thirty (30) days after an event that would allow you to make an Election change under the Plan (see Section (3)(d) of this SPD), your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE: During the Annual Enrollment Period, you did not elect to participate in the Plan. On March 15, your Spouse begins a full-time job. This is a "change in status" which allows you to make an Election change under the Plan. You may elect to participate in the Plan if you do so within thirty (30) days after March 15, (that is, by April 14). If you do not elect to enter the DCAP within thirty (30) days after this "change in status," you will not have a second opportunity to enter the DCAP until the first day of the next Plan Year unless you experience a second Election change event.

(f) *Plan Benefits.* If you elect to participate in the DCAP, you must elect the amount by which you want the Employer to reduce your salary for the Plan Year. Under the DCAP, the maximum amount of reimbursement you may receive for a Plan Year is limited to the actual amount of your salary reduction for the Plan Year.

(g) *Maximum Benefit Amount.* The benefits you receive under this DCAP may not exceed the maximum amount specified in the Internal Revenue Code. The maximum amount specified in the Internal Revenue Code is $5,000 (or $2,500 if you are a married person filing a separate return) *per calendar year* or, if less, your "earned income limitation." The

maximum benefit amount *per Plan Year* is also $5,000 (or $2,500 if you are a married person filing a separate return) or, if less, your "earned income limitation." The "earned income limitation" is your earned income, if you are not married. If you are married, the earned income limitation is the lesser of your earned income or your Spouse's earned income.

(h) *IRS "Use It or Lose It" Requirement.* You should carefully evaluate the amount of your salary reduction for dependent care expenses. ***If your dependent care expenses are less than the amount by which you have reduced your salary for the Plan Year, you will forfeit the excess amount.*** This is an IRS requirement.

(i) *Election Changes.* Once you make an Election to participate in this DCAP, that Election may not be changed in the middle of the Plan Year, either as to your participation in the Plan or as to the dollar amount you elected, unless an Election change is permitted under the terms of the Plan (see Section (3)(d) of this SPD).

(j) *Federal Income Tax Considerations.* You may be able to claim a Dependent Care Tax Credit on your federal income tax return for your dependent care expenses. The availability of this credit depends on the number of dependents you have and your gross income. More information about the federal Dependent Care Tax Credit may be found in IRS Publication No. 503. ***You may not claim a credit on your federal income tax return for any dependent care expenses for which you have been reimbursed by the DCAP.*** In many cases, you may save more money by receiving tax-free reimbursements under the Plan than by claiming the tax credit. ***Consult your own tax advisor if you are in doubt as to whether to obtain reimbursements under the Plan or to take the tax credit.***

(k) *Qualified Dependent Care Expenses.* A dependent care expense is an amount paid by you for the care of a qualified dependent, including related household services, which enables you to be gainfully employed. The "qualified" dependent care expenses for which you are entitled to reimbursement under the DCAP are generally those dependent care expenses that are permitted under Section 129 of the Internal Revenue Code.

(i) *Qualified Dependent.* A qualified dependent is:

(A) Your child (as defined in Internal Revenue Code § 152) who is under age thirteen (13) and is your "qualifying child" as defined in Code § 152(a)(1); or

(B) Your tax dependent as defined in Code § 152, but determined without regard to Code § 152(b)(1), (b)(2), and (d)(1)(B), who:

(1) Is physically or mentally incapable of caring for himself/herself; and

(2) Is living with you for more than one-half of the calendar year.

(C) Your Spouse who is physically or mentally incapable of self-care and who is living with you for more than one-half of the calendar year.

If you are divorced or separated and have a child whom you do not claim as a dependent for federal income tax purposes, the child must be in your custody for at least six (6) months out of the year to be a qualified dependent.

(ii) *Types of Expenses Eligible For Reimbursement.* The following expenses are eligible for reimbursement:

(A) Payments for the care of a qualified dependent in your home. This includes care provided by a babysitter, nurse, or housekeeper in your home, as long as part of their service benefits the qualified dependent.

(B) Payments for the care of a qualified dependent outside your home. If such expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six (6) individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations. If such expenses are incurred for services performed outside your home for an individual described in (k)(i)(B) above, then such individual must be living with you at least eight (8) hours a day.

(C) Pre-school care, before- and after-school care, and day camp during school vacation.

(iii) *Types of Expenses Not Eligible For Reimbursement.* The following expenses are not eligible for reimbursement:

(A) Expenses paid through another policy or plan providing dependent care benefits to you or your Spouse.

(B) Amounts paid to your child who is age eighteen (18) or younger for babysitting or care of a qualified dependent.

(C) Expenses paid to a person whom you or your Spouse are entitled to claim as a dependent for federal income tax purposes.

(D) Expenses incurred prior to becoming a Participant in the DCAP.

(E) Education expenses for a child in kindergarten or any higher grade.

(F) Overnight care at a convalescent nursing home for a dependent Spouse or relative.

(G) Overnight camp.

(H) Expenses for lessons, tutoring, or certain types of transportation expenses.

(I) Forfeited deposits, but may include application fees, agency fees, and deposits if you are required to pay the expenses to obtain dependent care.

(l) *Run-Out Period.* "Run-Out Period" means the period that begins at the close of the Plan Year and ends on the October 29 immediately following the close of the Plan Year. Eligible expenses must be submitted for reimbursement before the end of the Run-Out Period.

(m) *Claims Procedures.* In the event you have a claim for benefits under the DCAP, you should submit a claim using the claim form that will be provided to you by the Claims Administrator and follow the instructions on that form.

(i) *Claims Administrator.* The Employer has designated BMI to act as the Claims Administrator for the DCAP. As the Claims Administrator, BMI shall have the sole authority to grant or deny any claims for benefits under the Plan. If the Claims Administrator denies a claim, it will state its denial in writing and will deliver or mail to the Participant a notice of denial of benefits, setting forth the specific reasons for the denial. In addition, the Claims Administrator will give any Participant whose claim for benefits has been denied a reasonable opportunity for a review of the decision denying the claim.

(ii) *When to Submit a Claim.* You may submit your claim for benefits under the DCAP during the Plan Year in which the expenses are incurred or within the Run-Out Period following the close of the Plan Year. You must submit your claim for reimbursement for the Plan Year in which you terminated your participation no later than thirty (30) days after the date of your termination, no later than ninety (90) days after the date the Employer terminates the DCAP or the October 29 next following the end of the Plan Year, respectively. For example, if you terminate employment with the Employer on July 1 of a particular Plan Year, you must submit your claim for reimbursement no later than July 31 of that Plan Year to receive reimbursement for expenses covered by the Plan which you incurred prior to that July 1.

(v) *Claims Decisions and the Right to Appeal.* Within a reasonable time, not exceeding ninety (90) days (unless the Claims Administrator notifies you of an extension of up to ninety (90) days), the Claims Administrator will inform you of its decision to approve or deny your claim. If the Claims Administrator denies your claim, in whole or in part, you may have a right to appeal the decision.

(vi) *Payment of Claims.* Approved claims will be paid directly to you. No claims will be paid to the provider of any services.

(vii) *Information Regarding Claims.* Prior to making any payment of benefits under the DCAP, the Claims Administrator may require you to provide such information

and complete appropriate documents or forms necessary for the proper administration of the Plan. The Claims Administrator may rely upon all such information furnished to it, including your current mailing address.

(n) *Termination of Coverage.* Your participation in the DCAP ends on whichever of the following dates occurs first:

(i) The date that you terminate your employment with the Employer;

(ii) The date in which your election to participate expires;

(iii) The end of a period in which you last paid a required contribution; or

(iv) The date the Employer terminates the DCAP.

(9) Vision Plan

The Employer maintains a Vision Plan that pays benefits under a group contract with Vision Care Direct, 2178 South 900 East #7, Salt Lake City, UT 84106.

(a) *Type of Plan.* The Vision Plan is a group health plan. The Vision Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Dates.* The eligibility conditions and the Vision Plan entry dates are the same as those for the Plan.

(c) *Enrollment in the Plan.* **To become a Participant in the Vision Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Vision Plan entry date. **If you do not elect to participate in the Vision Plan, you will not receive any benefits under the Vision Plan.**

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Vision Plan until the next open enrollment period and your enrollment will not take effect until the anniversary date of the Vision Care Direct group contract. The same rule applies if you fail to enroll your dependents (including your Spouse) when you are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA "Special Enrollment" rights.

(d) *Plan Benefits.* If you elect to participate in the Vision Plan, benefits will be provided by the Employer pursuant to the terms and conditions of a group contract between the Employer and Vision Care Direct. This Vision Plan provides you and/or your dependents with comprehensive vision coverage. Vision Care Direct has prepared materials which explain the benefits under this Vision Plan in detail. If you have not received these materials from Vision Care Direct, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* Vision Care Direct is solely obligated to pay for the benefits provided under the Vision Care Direct group contract. The Employer makes no promise and will have no obligation to provide or pay for benefits under the group contract.

(f) *Premiums.* The monthly premiums for insurance coverage under the Vision Plan are determined by Vision Care Direct and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on a pre-tax basis through the Plan.

(g) *Vision Treatment.* The Vision Plan does not provide vision treatment or give vision advice. **It is your responsibility, in consultation with the doctor of your choice, to get appropriate vision treatment.** The fact that some expense may not be eligible for reimbursement by the Vision Plan does not mean that you or your dependents should not have that treatment.

(h) *Claims Procedures.* In the event you have a claim for benefits under the Vision Plan, you should follow the procedures outlined in the materials prepared by Vision Care Direct, as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Vision Care Direct has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.

(i) *Explanation of Benefits.* You will receive an explanation of benefits (EOB) under the Vision Plan at your primary residence (as provided to the Claims Administrator, i.e., the insurance company for fully insured plans or third-party administrator for self-funded plans). If your covered Spouse or dependent does not wish for an EOB to be provided at this address, he/she will need to contact the claims administrator and provide an alternate address.

(j) *Termination of Coverage.* Your participation in the Vision Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the insurance group contract – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the insurance group contract – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the Vision Plan.

Your coverage for benefits under the Vision Plan ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD.

(10) Group Life Plan

The Employer maintains a Group Life Plan that pays benefits under an insurance contract with Advance Insurance Company ("Advance"), 2930 S.W. Woodside Drive, Suite A, Topeka, Kansas 66614-5326.

(a) *Type of Plan.* The Group Life Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator. The Group Life Plan is an Employer-Paid Benefit under the Plan.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the Group Life Plan entry date are the same as those for the Plan.

(c) *Enrollment in the Plan.* **To become a Participant in the Group Life Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Group Life Plan entry date.

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you may be required to pass medical underwriting before you may enroll in the Group Life Plan.

(d) *Plan Benefits.* You will be insured under a group contract issued by Advance. This group contract provides you with life insurance. Advance has prepared materials which explain the benefits of the group contract in detail. Advance will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* Advance is solely obligated to pay for the benefits provided under the Advance group contract. The Employer makes no promise, and will have no obligation, to provide or pay for benefits under the group contract.

(f) *Premiums.* The monthly premiums for insurance coverage under the Group Life Plan are determined by Advance and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will pay one hundred percent (100%) of the monthly premium cost.

(g) *Claims Procedures.* In the event you have a claim for benefits under the Group Life Plan, you should follow the procedures outlined in the materials prepared by Advance, as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Advance has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.

(h) *Termination of Coverage.* Your participation in the Group Life Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage - as specified by the insurance group contract - following your termination of employment with the Employer;

(ii) The last effective date of coverage - as specified by the insurance group contract - following the date on which you cease to be an Eligible Employee; or

(iii) The day the Employer terminates the Group Life Plan.

Your coverage for benefits under the Group Life Plan ends with the termination of your participation. However, you may be eligible for a conversion contract offered by Advance. Please refer to the group contract for further details.

(11) Voluntary Life Plan

The Employer maintains a Voluntary Life Plan that pays benefits under an insurance contract with Advance Insurance Company ("Advance"), 2930 S.W. Woodside Drive, Suite A, Topeka, Kansas 66614-5326.

(a) *Type of Plan.* The Voluntary Life Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the Voluntary Life Plan entry date are the same as those for the Plan.

(c) *Enrollment in the Plan.* **To become a Participant in the Voluntary Life Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Voluntary Life Plan entry date. **If you do not elect to participate in the Voluntary Life Plan, you will not receive any benefits under the Voluntary Life Plan.**

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you may be required to pass medical underwriting before you may enroll in the Voluntary Life Plan.

(d) *Plan Benefits.* If you elect to participate in the Voluntary Life Plan, you will be insured under a group contract issued by Advance. This group contract provides you with life insurance. Advance has prepared materials which explain the benefits of the group contract in detail. Advance will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* Advance is solely obligated to pay for the benefits provided under the Advance group contract. The Employer makes no promise, and will have no obligation, to provide or pay for benefits under the group contract.

(f) *Premiums.* The monthly premiums for insurance coverage under the Voluntary Life Plan are determined by Advance and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums must be paid on an after-tax basis through the Plan.

(g) *Claims Procedures.* In the event you have a claim for benefits under the Voluntary Life Plan, you should follow the procedures outlined in the materials prepared by Advance, as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Advance has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.

(h) *Termination of Coverage.* Your participation in the Voluntary Life Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the insurance group contract – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the insurance group contract – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the Voluntary Life Plan.

Your coverage for benefits under the Voluntary Life Plan ends with the termination of your participation. However, you may be eligible for a conversion contract offered by Advance. Please refer to the group contract for further details.

(12) AFLAC Pre-Tax Plan

The Employer maintains the AFLAC Pre-Tax Plan that permits Participants to elect to receive benefits under an insurance contract issued by American Family Life Assurance of Columbus ("AFLAC"), 1932 Wynnton Road, Columbus, Georgia 31999.

(a) *Type of Plan.* The AFLAC Pre-Tax Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions are the same as those for the Plan. The entry date for the AFLAC Pre-Tax Plan is the August 1 following 60 days of employment as an Eligible Employee.

(c) *Enrollment in the Plan.* **To become a Participant in the AFLAC Pre-Tax Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your AFLAC Pre-Tax Plan entry date. **If you do not elect to participate in the AFLAC Pre-Tax Plan, you will not receive any benefits under the AFLAC Pre-Tax Plan.**

(d) *Plan Benefits.* If you elect to participate in the AFLAC Pre-Tax Plan, you will be able to select from the following policies, whether they be individual policies of insurance or group contracts, which are issued by AFLAC:

(i) Accident Plan; and/or

(ii) Hospital Indemnity Plan.

You will be insured under either individual contracts or group contracts issued by AFLAC. The contracts provide you (and your dependents, if family coverage is selected) with various types of insurance. AFLAC has prepared materials which explain the benefits of each individual policy or group contract, as applicable, in detail. AFLAC will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this Summary Plan Description.

(e) *Obligation to Pay Benefits.* AFLAC is solely obligated to pay for the benefits provided under the AFLAC Pre-Tax Plan. The Employer makes no promise, and will have no obligation, to provide or pay for benefits under the AFLAC Pre-Tax Plan.

(f) *Premiums.* The monthly premiums for insurance coverage under the various individual policies or group contracts, as applicable, listed in (d) above are determined by AFLAC and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. You are required to pay one hundred percent (100%) of the monthly premium cost. Premiums may be paid on a pre-tax basis through the Plan.

(g) *Claims Procedures.* In the event you have a claim for benefits under the AFLAC Pre-Tax Plan, you should follow the procedures outlined in the materials prepared by AFLAC as applicable. The Plan Administrator, upon your request, will assist you in making these claims. AFLAC has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the individual policy of insurance or group contract, as applicable.

(h) *Termination of Coverage.* Your participation in the AFLAC Pre-Tax Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage - as specified by the applicable insurance policy - following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the applicable insurance policy – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the AFLAC Pre-Tax Plan.

Your coverage for benefits under the AFLAC Pre-Tax Plan ends with the termination of your participation. However, if you are covered under an individual insurance policy, you may be able to remain covered under the individual insurance policy outside this Plan. Similarly, if you are covered under a group contract, you may be able to remain covered under an *individual* insurance policy outside this Plan. Please refer to the individual policies or the group contract, as applicable, for further details.

(13) AFLAC After-Tax Plan

The Employer maintains the AFLAC After-Tax Plan that permits Participants to elect to receive benefits under an insurance contract issued by American Family Life Assurance of Columbus ("AFLAC"), 1932 Wynnton Road, Columbus, Georgia 31999.

(a) *Type of Plan.* The AFLAC After-Tax Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

Eligibility/Plan Entry Date. The eligibility conditions are the same as those for the Plan. The entry date for the AFLAC After-Tax Plan is the August 1 following 60 days of employment as an Eligible Employee.

(b) *Enrollment in the Plan.* **To become a Participant in the AFLAC After-Tax Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your AFLAC After-Tax Plan entry date. **If you do not elect to participate in the AFLAC After-Tax Plan, you will not receive any benefits under the AFLAC After-Tax Plan.**

(c) *Plan Benefits.* If you elect to participate in the AFLAC After-Tax Plan, you will be able to select from the following policies, whether they be individual policies of insurance or group contracts, which are issued by AFLAC:

(i) Short Term Disability Plan; and/or

(ii) Critical Illness Plan.

You will be insured under individual policies or group contracts issued by AFLAC. The contracts provide you (and/or your dependents, if family coverage or riders are available and chosen) with one or more of the above types of insurance. AFLAC has prepared materials which explain the benefits of the contracts in detail. AFLAC will provide these materials to you. If you do not receive a copy of these materials, you

should request a copy from the Plan Administrator. These materials are an additional part of this Summary Plan Description.

(d) *Obligation to Pay Benefits.* AFLAC is solely obligated to pay for the benefits provided under the AFLAC individual policies of insurance or the group contracts of insurance, as applicable. The Employer makes no promise, and will have no obligation, to provide or pay for benefits under the policy.

(e) *Premiums.* The monthly premiums for insurance coverage under the AFLAC After-Tax Plan are determined by AFLAC and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. You are required to pay one hundred percent (100%) of the monthly premium cost on an after-tax basis.

(f) *Claims Procedures.* In the event you have a claim for benefits under the AFLAC After-Tax Plan, you should follow the procedures outlined in the materials prepared by AFLAC as applicable. The Plan Administrator, upon your request, will assist you in making these claims. AFLAC has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the individual insurance policy or the group contract, as applicable.

(g) *Termination of Coverage.* Your participation in the AFLAC After-Tax Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the applicable insurance policy – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the applicable insurance policy – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the AFLAC After-Tax Plan.

Your coverage for benefits under the AFLAC After-Tax Plan ends with the termination of your participation. However, if you are covered under an individual insurance policy, you may be able to remain covered under the individual insurance policy outside this Plan. Similarly, if you are covered under a group contract, you may be able to remain covered under an *individual* insurance policy outside this Plan. Please refer to the individual policies or the group contract, as applicable, for further details.

(14) COBRA Coverage for Group Health Plans

Special Note: This Section only applies if your Employer is required to offer COBRA continuation coverage. Generally, your Employer is required to offer COBRA continuation coverage unless the "small employer" exception to COBRA applies. This exception is based on the number of employees that your Employer employed during the previous calendar year. Generally, if such number is *less than twenty (20)*, then your Employer is *not* subject to COBRA and you should disregard this Section. **In the event, however, that your Employer has twenty (20) or more employees as determined under COBRA**, this Section will apply to an employee covered under a Group Health Plan sponsored by the Employer and to such employee's covered Spouse and/or covered dependents. **If COBRA applies, you should read this Section carefully.**

COBRA coverage is a temporary extension of coverage under Group Health Plans, under certain circumstances, when coverage would otherwise end. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Group Health Plans when group health coverage would otherwise be lost. **This section generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The group health components of the Plan in which you may be enrolled are the Medical Plan, the Dental Plan, the Vision Plan and the Health FSA. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the Group Health Plan benefits offered under the Plan and not to any other benefits offered under the Plan. The Plan provides no greater COBRA rights than what COBRA requires and nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

(a) *Qualified Beneficiary.* After a qualifying event (described below) occurs, and any required notice of that event is properly provided to the Plan Administrator, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your dependent children may become qualified beneficiaries and may be entitled to elect COBRA if coverage under a Group Health Plan is lost because of the qualifying event. (Certain newborns, newly-adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

(b) *Continuation Coverage.* Continuation coverage is the same coverage that the Group Health Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Group Health Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

(c) *Qualifying Events.* COBRA continuation coverage is a continuation of group health coverage when coverage would otherwise end because of an event known as a "qualifying event." Specific qualifying events with respect to each type of qualified beneficiary are as follows:

(i) *Employee.* If you are an employee, you will become a qualified beneficiary if you lose (or will lose) your group health coverage under the Plan because either one of the following qualifying events happens:

(A) Your hours of employment are reduced; or

(B) Your employment ends for any reason other than for gross misconduct.

(ii) *Spouse.* If you are the covered Spouse of an employee, you will become a qualified beneficiary if you lose your group health coverage under the Plan because any of the following qualifying events happens:

(A) Your Spouse dies;

(B) Your Spouse's hours of employment are reduced;

(C) Your Spouse's employment ends for any reason other than for gross misconduct;

(D) Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(E) You become divorced or legally separated from your Spouse. If your Spouse (the employee) reduces or eliminates coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

(iii) *Dependents.* If you are the covered dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

(A) Your parent-employee dies;

(B) Your parent-employee's hours of employment are reduced;

(C) Your parent-employee's employment ends for any reason other than for gross misconduct;

(D) Your parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

(E) Your parents become divorced or legally separated; or

(F) You stop being eligible for coverage under the plan as a "dependent child."

In addition to the above qualifying events, filing a proceeding in bankruptcy under Title 11 of the United States Code can sometimes be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's Spouse, surviving Spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

(d) *FMLA Leave.* If you take FMLA leave and do not return to work at the end of the leave, you (and your Spouse and dependent children, if any) will be entitled to elect COBRA if you, your Spouse, and dependent children, if any, (i) were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave), and (ii) will lose Plan coverage within eighteen (18) months because of your failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Group Health Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.

(e) *Special Rule for Health FSAs.* COBRA coverage under a Health FSA will be offered only to qualified beneficiaries who have underspent accounts. A qualified beneficiary has an underspent account if he/she has been reimbursed less money than he/she has contributed.

(i) *COBRA Coverage.* COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year, and COBRA coverage will terminate at the end of the Plan Year.

(ii) *Qualified Beneficiaries.* Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. Each beneficiary, however, has separate election rights, and each could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, you should contact the Plan Administrator for more information.

(f) *Notice Procedures.* When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Employer of any of these three

qualifying events. **For all other qualifying events, you must notify the Plan Administrator in writing within sixty (60) days after the date on which the qualifying beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event and in accordance with the procedures outlined in Appendix A to this SPD.**

(i) *Forms.* The notice procedures outlined in Appendix A may require that specific forms be used by you in providing proper notice of certain qualifying events to the Plan. The Plan will not provide you with an Election form to begin or extend COBRA coverage if it does not receive proper notice from you regarding the qualifying events listed in Appendix A.

(ii) *Failure to Follow Procedures.* **If the procedures outlined in Appendix A are not followed or if notice is not provided in writing to the Plan Administrator during the 60-day notice period, any Spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.**

(g) *Electing COBRA Coverage.* Once the Plan Administrator receives *timely* notice that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect continuation coverage. For example, the covered employee's Spouse may elect COBRA even if the employee does not. COBRA may be elected for one (1), several, or for all dependent children who are qualified beneficiaries. Covered employees and Spouses (if the Spouse of a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. For each qualified beneficiary who timely elects COBRA coverage, COBRA coverage will begin on the date that Plan coverage would otherwise have been lost.

(h) *60-Day Election Period.* A qualified beneficiary must elect coverage in writing within sixty (60) days of losing coverage under the Plan (or, if later, within sixty (60) days of being provided a COBRA election notice), using the Plan's Election form and following the procedures specified on the Election form. (A copy of the Plan's Election form may be obtained from the Plan Administrator.) The Election form must be mailed or hand delivered to the address indicated at the beginning of this SPD and as indicated on the Plan's Election form. If you mail your Election, it must be postmarked no later than the last day of the 60-day Election period. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail and faxed communications.

(i) *Failure to Return Election Form.* **If you or your covered Spouse or covered dependent children do not elect continuation coverage within the 60-day election period, you will lose your right to elect continuation coverage.**

(ii) *Rejection of COBRA Rights.* If a qualified beneficiary rejects COBRA before the due date, he/she may change his/her mind as long as a completed Election form is furnished before the due date.

(iii) *Elections Under More Than One Group Health Plan.* Qualified beneficiaries may be enrolled in one or more group health benefits under the Plan at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he/she may elect COBRA under any or all of the group health benefits under the Plan, and in which he/she was covered on the day before the qualifying event.

(i) *Length of COBRA Coverage.* The COBRA coverage periods described below are *maximum* coverage periods for each type of qualified event. COBRA coverage can end before the end of the maximum coverage periods for several reasons outlined in Subsection (k) below.

(i) *Employee's Termination of Employment.* COBRA continuation coverage may last for up to eighteen (18) months for the former employee, the Spouse, and any dependents who are qualified beneficiaries. The 18-month period for the Spouse and/or dependent child may be extended if a qualified beneficiary is disabled or if there is a "second qualifying event" as described in Subsection (j) below.

(ii) *Employee's Reduction of Hours.* COBRA continuation coverage may last for up to eighteen (18) months for the employee, Spouse, and any dependents who are qualified beneficiaries. The 18-month period for the Spouse and/or dependent child may be extended if a qualified beneficiary is disabled or if there is a "second qualifying event" as described in Subsection (j) below.

(iii) *Death of Employee.* COBRA continuation coverage may last for up to thirty-six (36) months for the Spouse and any dependents who are qualified beneficiaries.

(iv) *Employee Entitlement to Medicare.* COBRA continuation coverage may last for up to thirty-six (36) months for the Spouse and any dependents who are qualified beneficiaries.

(v) *Divorce or Legal Separation.* COBRA continuation coverage may last for up to thirty-six (36) months for the Spouse and any dependents who are qualified beneficiaries.

(vi) *Loss of Dependent Status.* COBRA continuation coverage may last for up to thirty-six (36) months for the dependent who is a qualified beneficiary.

(vii) *Special Rule for Health FSAs.* Regardless of which of the above qualifying events occurs, COBRA coverage under the Health FSA may not be continued beyond the end of the Plan Year in which the qualifying event occurred.

(j) *Extension of Maximum Coverage Period (Not applicable to Health FSA).* If the qualifying event that resulted in your COBRA election was the employee's termination of employment or reduction in hours, the 18-month maximum period may be extended if a qualified beneficiary who has elected COBRA coverage becomes disabled, if a "second qualifying event" occurs, or if the employee became entitled to Medicare in the 18-

month period preceding his/her termination of employment or reduction of hours. (These extension opportunities do not apply to a period of COBRA coverage resulting from a covered employee's death, divorce or legal separation, or a dependent child's loss of eligibility.)

(i) *Disability Extension.* If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional eleven (11) months of COBRA coverage, for a total maximum of twenty-nine (29) months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours. The disability must have started at some time before the sixty-first (61st) day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally eighteen (18) months). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

(ii) *Extension Due to a Second Qualifying Event.* An extension of coverage will be available to Spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the eighteen (18) months (or, in the case of a disability, the twenty-nine (29) months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is thirty-six (36) months. Such second qualifying events include the death of a covered employee, divorce, or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan if the first qualifying event had not occurred.

(iii) *Medicare Extension for Spouse and Dependents.* If a qualifying event that is a termination of employment or reduction of hours occurs within eighteen (18) months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the Spouse and dependent children will end three years from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be eighteen (18) months).

These extensions in subparagraphs (i) through (iii) above are available only if you timely notify the Employer in writing of the Social Security Administration's determination of disability and the second qualifying event within the 60-day notice period and the entitlement to Medicare within thirty (30) days of entitlement in accordance with the Plan's notice procedures found in Appendix A.

(iv) *Special Rule for Health FSAs.* Regardless of which of the above qualifying events occurs, COBRA coverage under the Health FSA will not be extended and will only continue until the end of the Plan Year in which the initial qualifying event occurred.

(k) *Termination of COBRA Coverage before End of Maximum Period.* Continuation coverage will be terminated before the end of the maximum period if:

(i) Any required premium is not paid before the end of the grace period;

(ii) After electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan;

(iii) After electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);

(iv) The employer ceases to provide any Group Health Plan for its employees;

(v) During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or

(vi) Coverage would have been terminated under the same circumstances for a Participant or beneficiary not receiving continuation coverage, for example, if a Participant or beneficiary engages in fraudulent activities against the Plan.

(l) *Cost of COBRA Coverage.* Each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed one hundred two percent (102%) (or, in the case of an extension of continuation coverage due to a disability, one hundred fifty percent (150%)) of the cost to the Group Health Plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

(m) *First Payment.* All COBRA premiums must be paid by check or money order. If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election form. However, you must make your first payment for COBRA coverage within forty-five (45) days after the date of your Election. (This is the date the Election notice is post-marked, if mailed, or the date your Election form is received by the individual at the address specified for delivery of the Election form, if hand-delivered.) Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the address indicated on the Election notice. You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise. **If you do not make your first payment for continuation coverage within that forty-five (45) days, you will lose all continuation coverage rights under the Plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment.

EXAMPLE: You terminate employment on September 30 and lose coverage on September 30. You elect COBRA on November 15. Your initial payment equals the premiums for October and November and is due on or before December 30, which is the forty-fifth (45th) day after the date of your COBRA election. You are responsible for making sure that the amount of your first payment is correct. You may contact the Employer to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

(n) *Monthly Payments for COBRA Coverage.* After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month, for each qualified beneficiary, will be disclosed in the Election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage.

EXAMPLE: You terminate employment on September 30 and lose coverage on September 30. You elect COBRA on October 15. Your initial payment is due on or before November 29 and should equal the premium for October. You will be required to make monthly premiums, starting with the month of November, by the first of each month. This means that the premium for November is due by the first of November.

(o) *Grace Periods.* Although periodic payments are due on the first day of each month of COBRA coverage, you will be given a grace period of thirty (30) days to make each monthly payment. Your COBRA coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a monthly payment later than its due date but during its grace period, your coverage under the Plan may be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that payment/month, you will lose all rights to COBRA coverage under the Plan.

(p) *Children Born to or Placed for Adoption.* A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself/herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

(q) *Alternate Recipients Under QMCSOs.* A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order ("QMCSO") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

(r) *Address Changes.* In order to protect your family's rights, you should keep the Employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer.

(s) *Questions.* Questions concerning your Plan or your COBRA rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, HIPAA and other laws affecting group health plans, contact the nearest regional or district office of the U.S. DOL's Employee Benefits Security Administration ("EBSA") or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through this website.)

(15) USERRA Continuation Rights

If you are absent from employment as a result of military service, you will have the right to elect continuation coverage for a period of up to twenty-four (24) months if such coverage would otherwise be lost as a result of such military service. Your right to continue coverage is subject to the following:

(a) *Payment of Premium.* You must pay the applicable premium for any USERRA continuation coverage. For a leave of absence for less than thirty-one (31) days, you may not be required to pay more than you would have paid had you not been on leave. For a leave of absence of more than thirty (30) days, you must pay the entire cost of coverage plus an additional two percent (2%).

(b) *Failure to Apply for Reemployment.* Following completion of your military service, your right to continue coverage under USERRA will end if you do not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

(16) Group Health Plan Claims Procedures (Not applicable to the Health FSA)

Payment by the Claims Administrator is based on data furnished by you. In order to collect benefits under the Plan, you must first provide the Claims Administrator with information about your claim for benefits.

Claims made for benefits under the fully-insured Group Health Plans (other than the Health FSA), and any appeals from the denial of such Claims, shall be processed in accordance with the claims procedures of the insurer. Unless otherwise stated in your applicable insurance policy, before filing any legal action against the Plan, the Employer, the Plan Administrator, or the Claims Administrator, you must first exhaust the administrative remedies summarized in your

policy. This means, for example, that, if a claim is denied, you must appeal the denial following the procedures provided in your policy of insurance. If you do not exhaust your administrative remedies, you will not be allowed to file a civil action concerning a claim for benefits under the Plan. Unless otherwise stated in your applicable insurance policy, following the Plan's issuance of a final adverse benefit determination, you will have one hundred eighty (180) days to file a legal action against the Plan, the Employer, the Plan Administrator, or the Claims Administrator. Failure to meet this deadline will result in the forfeiture of any Claim that you may have.

(17) Miscellaneous

(a) *Qualified Medical Child Support Orders.* Participants in a Group Health Plan and their beneficiaries may obtain from the Plan Administrator, without charge, a copy of the plan's procedures governing the determination of whether an order is a "qualified medical child support order" ("QMCSO").

(b) *Family and Medical Leave Act.* If you take an unpaid leave under the FMLA, the Employer will, to the extent required by the FMLA, continue to maintain your benefits under a Group Health Plan on the same terms and conditions as though you were still an active Employee.

If you choose to continue your coverage while you are on a FMLA leave, the Employer will continue to pay its share (if any) of the premiums. You will be required, if you choose to continue your coverage, to pay your share of the premiums in one or more of the following ways:

(i) You may pay your share of the premiums with after-tax dollars while you are on FMLA leave (or with pre-tax dollars to the extent you receive Compensation from the Employer during your leave).

(ii) You may be given the option to pre-pay all or a portion of your share of the premium for the expected duration of your FMLA leave on a pre-tax salary reduction basis out of your pre-leave Compensation by making a special Election to that effect prior to the date such Compensation would normally be made available to you. You may not, however, use pre-tax dollars during the current Plan Year to fund coverage that will be provided during a subsequent Plan Year.

(iii) You may pay your share of the premium pursuant to such other arrangement as may be agreed upon between you and the Plan Administrator.

If your coverage ceases while you are on FMLA leave, you will be permitted to reenter the Plan immediately upon your return from FMLA leave on the same basis that you were participating in the Plan prior to your leave, or as otherwise required by the FMLA.

(c) *Return of Premium.* If money is returned in any form by an insurance company that provided or is providing benefits under the Plan, including, but not limited to, a rebate

of premiums previously paid, proceeds from demutualization, or rebates resulting from an insufficient "medical loss ratio" (MLR), the Plan Administrator shall have the discretion to apply such amounts to the payment of Plan expenses, the reduction of premiums, and/or benefit enhancements. The Plan Administrator shall further have the discretion to allocate such funds in any manner deemed appropriate.

(d) *Returns of Benefit Payments Made in Error.* The Plan shall have the right to reimbursement from you, your covered dependents, or assignees for any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to benefit payments to which you, your covered dependents, or assignees were not entitled.

(18) Participant's Rights Under ERISA

As a Participant in the Plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). You have ERISA rights with respect to all benefits provided through the Plan except for the DCAP. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. DOL 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 SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report, if applicable. If, and to the extent, the plan is required to file an annual financial report with the government, the Plan Administrator is required by law to furnish each participant with a copy of a summary annual report. If the plan is not required by law to file an annual financial report, no summary annual report is required.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse, or dependents if there is a loss of coverage under a Group Health Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation rights.

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

If your claim for a 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 a copy of plan documents or the latest annual report from the Plan 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 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, but only after first exhausting the Plan's internal claims procedures (i.e., exhausting your administrative remedies) within the time frame set forth in the Plan document. 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. DOL, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest 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, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

(19) Notice of Hospital Rights for Newborns and Mothers

HIPAA requires this SPD to include the following explanation of your rights under the Health Insurance Portability and Accountability Act of 1996. Please note that this statement is made to you by the federal government. Therefore, the Employer and the Plan Administrator are not responsible for the accuracy or completeness of the explanation, and some of the provisions may not apply to the Plan.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a caesarean 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 forty eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

(20) Notice of Rights under the Women's Health and Cancer Rights Act of 1998

The Employer is required by federal law to provide the following notice:

If a group medical plan provides medical and surgical benefits for mastectomies, that plan must also provide coverage for the following, if they are agreed upon by a participant or beneficiary who is receiving benefits in connection with a mastectomy and that person's attending physician:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prostheses and physical complications of mastectomies, including lymph edemas.

This coverage must be the same as for any other benefit under the plan and is subject to the plan's annual deductibles and co-payment requirements.

(21) Notice of Opportunity to Enroll Adult Children up to Age 26

Effective August 1, 2011, under the Patient Protection and Affordable Care Act of 2010, your children generally can be covered under the Medical Plan until they attain age twenty-six (26), regardless of their student or marital status and regardless of whether your home is their principal place of abode or whether you support them. Thus, children whose coverage under the Medical Plan ended, who were denied coverage, or who were not eligible for coverage because the availability of dependent coverage of children under the Plan ended before attainment of age twenty-six (26), may be eligible for coverage under the Plan beginning August 1, 2011.

(22) No Lifetime Limit under the Medical Plan

Effective August 1, 2011, the lifetime limit on the dollar value of benefits under the Medical Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the Medical Plan are eligible to enroll in the Medical Plan. For more information, contact the Plan Administrator at the address provided at the beginning of this SPD.

(23) Patient Protection Notice

To the extent that the Medical Plan requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the Medical Plan's network of providers and who is available to accept you or your family members. If the Medical Plan requires the designation of a primary care provider and you do not designate one yourself, the Medical Plan will designate one for you until you make the designation yourself. In addition, if you have children covered under the Medical Plan, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator at the address at the beginning of this SPD or the insurance carrier referred to in the Medical Plan section of this SPD.

Finally, please note that you do not need prior authorization from the Medical Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or adhering to certain procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator at the address at the beginning of this SPD or the insurance carrier referred to in the Medical Plan section of this SPD.

(24) Right of Employer to Amend or Terminate

The Employer may at any time amend or terminate the Plan, including any of the plans that are summarized in this SPD, by a written instrument signed by the Chief Executive Officer of the Employer, as provided for in each of the respective plan documents. Any amendment to any plan will be added to the Plan in writing and communicated to Participants.

* * * * * * * * * * * * * * * *

APPENDIX A
COBRA NOTICE PROCEDURES

As an individual covered by the Plan, your right to begin COBRA coverage or to extend or maintain current COBRA coverage is affected by the events listed in the first column of the table below. If you wish to qualify for COBRA continuation coverage, you must provide the Plan with notice of the occurrence of any one of these events in accordance with the procedures outlined in this table. Any required forms may be obtained from the Plan Administrator. Once completed, the various kinds of notices described below must be mailed or hand-delivered to the following address:

Human Resources Officer
Kingman Community Hospital
750 West D Avenue
P.O. Box 376
Kingman, KS 67068

Notice must be in writing. Oral notice, including notice by telephone is not acceptable. Electronic (including e-mailed or faxed) notices are also not acceptable. If mailed, notice must be postmarked no later than the deadline date. If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline date.

If COBRA coverage should have been terminated but was not, due to a lack of notice from a qualified beneficiary, the Employer will immediately terminate coverage and require payment to the Plan of all benefits paid after what should have been the termination date.

The following terms have been abbreviated: QE = Qualifying Event QB = Qualified Beneficiary SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES[1]	WHO MAY PROVIDE NOTICE
DIVORCE OR LEGAL SEPARATION[2]	Notice must be provided 60 days after the date on which covered spouse would lose coverage under the terms of the Plan as a result of the divorce or legal separation.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) Name/address of all QBs who lost coverage due to the QE; (4) The QE; (5) A copy of the divorce or legal separation decree; (6) Date of the QE; and (7) Signature, name and contact information of individual sending the notice.	If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:[3] (1) Notice is mailed/hand-delivered to the address specified at the beginning of this Appendix; (2) Notice deadline is met; (3) From the written notice provided, the Employer can tell that the notice relates to the Plan; and (4) From the written notice provided, the Employer is able to identify the covered employee and QB(s), the QE, and the date on which it occurred.	(1) Covered Employee; (2) Formerly Covered Employee; (3) A QB with respect to the QE; or (4) Representative acting on behalf of the covered (or formerly covered) employee or the QB. A notice provided by any of the above listed individuals will satisfy any responsibility to provide notice on behalf of all QBs who lost coverage due to the QE described in the notice.

[1] In addition to the conditions listed in this column, for each qualifying event, the notice must also be supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements within 15 business days after a written or oral request from Employer for more information.

[2] *Anticipation of Divorce or Legal Separation.* If your coverage is reduced or eliminated and a divorce or legal separation later occurs, you may be able to receive COBRA coverage if you can show that your coverage was reduced or eliminated in anticipation of the divorce or legal separation. You must notify the Employer of this within 60 days of the divorce or legal separation in accordance with these procedures. You must also provide evidence satisfactory to the Employer that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

[3] If any one of the conditions is not met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

QE = Qualifying Event QB = Qualified Beneficiary SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES[1]	WHO MAY PROVIDE NOTICE
LOSS OF DEPENDENT STATUS UNDER THE PLAN	Notice must be provided 60 days after the date on which the covered dependent child would lose coverage under the terms of the Plan due to the loss of dependent status.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) Name/address of all QBs who lost coverage due to QE; (4) Statement of the QE; (5) Date of the QE; (6) If requested, documentation satisfactory to Employer of the date of the QE (e.g., a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution);[4] and (7) Signature, name and contact information of individual sending the notice.	Same as above.	Same as above.
DISABILITY	Notice must be provided 60 days after the latest of (1) the date of the SSA's disability determination; and (2) the date on which the QB would lose coverage under the terms of the Plan as a result of the termination of employment or reduction in hours. Your notice must also be provided within 18 months after the QEs of termination of employment and reduction of hours.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered under the Plan; (3) The initial QE that started COBRA coverage (i.e., termination of employment or reduction in hours); (4) Name/address of all QBs who lost coverage due to the initial QE and who are receiving COBRA coverage at the time of the notice; (5) Name/address of disabled QB; (6) Date of the QE; (7) Date SSA made its determination of disability; (8) Statement as to whether or not SSA has subsequently determined that QB is no longer disabled; and (9) Signature, name and contact information of individual sending the notice. Notice must include a copy of SSA's determination of disability.	If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:[5] (1) Notice is mailed/hand-delivered to address specified at the beginning of this Appendix; (2) Notice deadline is met; (3) From the written notice provided, Employer can tell that the notice relates to the Plan and the QB's disability; and (4) From the written notice provided, Employer is able to identify the covered employee, the QB(s), the QE, and the date on which the covered employee's termination of employment or reduction in hours occurred.	Same as above. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all QBs who may be entitled to an extension of the maximum COBRA coverage period due to the disability reported in the notice.

[4] This will allow the Employer to determine that you gave timely notice of the QE and were consequently entitled to elect COBRA. If you do not provide satisfactory evidence within 15 business days after a written or oral request from Employer that the child ceased to be a dependent on the date specified in your notice of QE, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have started.

[5] If any one of the above conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

QE = Qualifying Event QB = Qualified Beneficiary SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES[1]	WHO MAY PROVIDE NOTICE
SECOND QUALIFYING EVENT - DIVORCE OR LEGAL SEPARATION	Notice must be provided 60 days after the date on which covered spouse would lose coverage under the terms of the Plan as a result of the divorce or legal separation if it had occurred while the QB was still actively covered under the Plan.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) The initial QE that started your COBRA coverage (i.e., termination of employment or reduction of hours); (4) Name/address of all QBs who lost coverage due to above stated QE and who are receiving COBRA at the time of the notice; (5) The second QE (i.e., divorce or legal separation); (6) Date of the second QE; (7) A copy of the decree of divorce or legal separation; and (8) Signature, name and contact information of individual sending the notice.	If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:[6] (1) Notice is mailed/hand-delivered to address specified at the beginning of this Appendix; (2) Notice deadline is met; (3) From the written notice provided, the Employer can tell that the notice relates to the Plan; and (4) From the written notice provided, the Employer is able to identify the covered employee and QB(s), the first QE, the date on which the first QE occurred, the second QE, and the date on which the second QE occurred.	(1) Covered Employee (2) Formerly Covered Employee (3) A QB who lost coverage due to the covered employee's termination or reduction of hours and who is still receiving COBRA coverage (4) Representative acting on behalf of the covered (or formerly covered) employee or the QB A notice provided by any of the above listed individuals will satisfy any responsibility to provide notice on behalf of all QBs who lost coverage due to the QE described in the notice.
SECOND QUALIFYING EVENT - LOSS OF DEPENDENT STATUS	Notice must be provided 60 days after the date on which covered dependent child would lose coverage under the terms of the Plan as a result of the second QE if the event had occurred while the QB was still actively covered under the Plan.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) The initial QE that started your COBRA coverage (i.e., termination of employment or reduction of hours); (4) Name/address of all QBs who lost coverage due to above stated QE and who are receiving COBRA at the time of the notice; (5) The second QE; (6) Date of the second QE; (7) If requested, documentation that is satisfactory to Employer (e.g., a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution) of the date of the QE;[7] and (8) Signature, name and contact information of individual sending the notice.	If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:[8] (1) Notice is mailed/hand-delivered to address specified at the beginning of this Appendix; (2) Notice deadline is met; (3) From the written notice provided, the Employer can tell that the notice relates to the Plan; and (4) From the written notice provided, the Employer is able to identify the covered employee and QB(s), the first QE, the date on which the first QE occurred, the second QE, and the date on which the second QE occurred.	Same as divorce (or legal separation) when it is a *second* QE.

[6] If any one of the above conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

[7] This will allow the Employer to determine that you gave timely notice of the second QE and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from Employer that the child ceased to be a dependent on the date specified in your notice, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage *would* have ended without an extension due to loss of dependent status.

[8] If any one of the above conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

QE = Qualifying Event QB = Qualified Beneficiary SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES[1]	WHO MAY PROVIDE NOTICE
SECOND QUALIFYING EVENT - DEATH OF EMPLOYEE OR FORMERLY COVERED EMPLOYEE	Notice must be provided 60 days after the date on which covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the death of the covered employee or formerly covered employee if the death had occurred while the QB was still actively covered under the Plan.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) The initial QE that started your COBRA coverage (i.e., termination of employment or reduction of hours); (4) Name/address of all QBs who lost coverage due to above stated QE and who are receiving COBRA at the time of the notice; (5) The second QE; (6) Date of the second QE; (7) If requested, documentation of the date of the death that is satisfactory to Employer (e.g., a death certificate or published obituary);[9] and (8) Signature, name and contact information of individual sending the notice.	If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:[10] (1) Notice is mailed/hand-delivered to address specified at the beginning of this Appendix; (2) Notice deadline is met; (3) From the written notice provided, the Employer can tell that the notice relates to the Plan; and (4) From the written notice provided, the Employer is able to identify the covered employee and QB(s), the first QE, the date on which the first QE occurred, the second QE, and the date on which the second QE occurred.	Same as divorce (or legal separation) when it is a *second* QE.
OTHER COVERAGE	Notice that a QB has become covered after electing COBRA under other group health plan, coverage must be provided 30 days after the other coverage becomes effective.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) Name/address of all QBs, specifying the one who obtained other coverage; (4) The QE that started your COBRA coverage; (5) Date of the QE; (6) The date the other coverage became effective;* (7) Evidence of the effective date of the other coverage (e.g., copy of insurance card or application for coverage); and (8) Signature, name and contact information of individual sending the notice.	If a QB first becomes covered by other group health plan coverage after electing COBRA, that QB's COBRA coverage will terminate (retroactively if applicable) as described in the COBRA Continuation Coverage section of the SPD.	Same as divorce (or legal separation) when it is an initial QE.

[9] This will allow the Employer to determine that you gave timely notice of the second QE and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from Employer that the death was the date specified in your notice of QE, the COBRA coverage of all QBs receiving an extension of COBRA as a result of the covered employee's death may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to the covered employee's death.

[10] If any one of the above conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

QE = Qualifying Event QB = Qualified Beneficiary SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES[1]	WHO MAY PROVIDE NOTICE
MEDICARE ENTITLEMENT	Notice that a QB has become entitled, after electing COBRA, to Medicare Part A, Part B or both, must be provided 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) Name/address of all QBs, specifying the one who became entitled to Medicare; (4) The QE that started your COBRA coverage; (5) Date of that QE and the date that Medicare entitlement occurred; (6) A copy of the Medicare card showing the date of Medicare entitlement; and (7) Signature, name and contact information of individual sending the notice.	If a QB first becomes entitled to Medicare Part A, Part B, or both after electing COBRA, that QB's COBRA coverage will terminate (retroactively if applicable) as described in the COBRA Continuation Coverage section of the SPD.	Same as divorce (or legal separation) when it is an initial QE.
CESSATION OF DISABILITY	Notice that a disabled QB whose disability resulted in an extended COBRA coverage period is no longer disabled (as determined by the SSA) must be provided 30 days after the other coverage becomes effective or, if later, 30 days after the date of the SSA's determination.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) Name/address of all QBs, specifying who was the disabled QB; (4) State the QE that started your COBRA coverage; (5) Date of the QE; (6) Date of the SSA's determination that QB is no longer disabled; (7) A copy of SSA determination; and (8) Signature, name and contact information of individual sending the notice.	If a disabled QB is determined by SSA to be no longer disabled, COBRA coverage for all QBs whose COBRA coverage is extended due to the disability will terminate (retroactively if applicable) as described in the COBRA Continuation Coverage section of the SPD.	Same as divorce (or legal separation) when it is an initial QE.

APPENDIX A
MEDICAL PLAN

This Appendix A contains the terms and conditions specific to the Ninnescah Valley Health Systems, Inc. Medical Plan that may be elected under Section 4.01 of the Plan. Unless otherwise altered by the terms of this Appendix A, the terms and conditions of the Plan are incorporated into, and made applicable to, this Medical Plan.

Section A1.01 Eligibility/Plan Entry Dates. The eligibility conditions and the Medical Plan entry dates are the same as those for the Plan.

Section A1.02 Medical Benefits. Benefits under this Plan are identical to those described in, and shall be paid pursuant to the terms of, the Group Contract (" Blue Cross Blue Shield of Kansas Group Contract") between Blue Cross Blue Shield of Kansas ("BCBS") and the Employer (Group No. 09286). The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by BCBS. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Medical Plan shall be determined from the BCBS Group Contract. The Participant shall bear fully any and all risk of BCBS's insolvency.

Section A1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the BCBS Group Contract. Under the terms of the Group Contract, BCBS may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on a pre-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant. If money is returned in any form by BCBS, including but not limited to a rebate or proceeds from demutualization, the Plan Administrator shall apply such amounts to the payment of Plan expenses and/or the reduction of premiums.

Section A1.04 Election to Participate. A Participant who desires to receive medical insurance coverage under this Medical Plan must elect to participate in this Medical Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive medical coverage under this Medical Plan, the Employer will not provide him/her with any medical coverage.

Section A1.05 Payment of Premium. A Participant who has elected to participate in this Medical Plan may pay the applicable premium on a pre-tax basis by entering into a salary reduction agreement pursuant to the terms and provisions of the Plan. Except for those Participants who are (a) exercising their right to continuation coverage pursuant to Section A1.06 below, (b) exercising their right to continue coverage during a qualifying unpaid leave pursuant to Section 3.03, or (c) eligible pursuant to Section 2.12(b), all premiums must be paid through pre-tax salary reductions.

Section A1.06 Continuation of Coverage. An individual who will lose coverage under this Medical Plan may have the right to continue coverage under this Medical Plan as described in Article VIII.

Section A1.07 Children Subject to a QMCSO. Children who are the subject of a Qualified Medical Child Support Order ("QMCSO") shall become "alternate recipients" of benefits under this Medical Plan in accordance with Section 609 of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan Administrator shall establish reasonable procedures to determine the qualified status of a medical child support order. Upon receiving a medical child support order, the Plan Administrator shall promptly notify in writing all involved parties of its receipt and shall inform such parties of the Plan's procedures for determining if the order is a QMCSO. Within a reasonable period of time, the Plan Administrator shall determine the qualified status of the order and notify all parties of its decision. Notwithstanding anything to the contrary in the document for this Medical Plan, this Medical Plan shall provide coverage for "alternate recipients" in accordance with the terms of a properly issued and properly recognized QMCSO and the requirements of ERISA and applicable DOL regulations.

Section A1.08 Claims Administration. BCBS will act as Claims Administrator with respect to any claim for benefits under this Medical Plan. BCBS has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

Section A1.09 Termination of Participation. A Participant ceases to be a Participant as of the earliest of the following:

(a) The last effective date of coverage - as specified by the insurance Group Contract - following the Participant's termination of employment with the Employer;

(b) The date on which the Participant's election to participate expires;

(c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;

(d) The last effective date of coverage - as specified by the insurance Group Contract - following the date on which the Participant ceases to be an Eligible Employee; or

(e) The date on which this Medical Plan terminates.

Notwithstanding anything in this Section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Medical Plan if and to the extent such individual elects continuation of benefits under the rules in Section A1.06.

Section A1.10 Character of Benefits Provided. This Medical Plan does not provide medical treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Group Contract. The fact that a particular medical service may not be eligible for reimbursement under this Medical Plan does not mean that a Participant or other person who is covered under this Medical Plan should not receive that service.

[The remainder of this page is intentionally left blank.]