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**SUMMARY PLAN DESCRIPTION**

**FRANKCRUM FLEXIBLE BENEFITS PLAN**

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**January, 2011**

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**SUMMARY PLAN DESCRIPTION**  
**FRANKCRUM FLEXIBLE BENEFITS PLAN**

**1. INTRODUCTION**

FrankCrum (the "Company") is the sponsor of the FrankCrum Flexible Benefits Plan (the "Plan"). The Plan provides eligible employees of the Company and Adopting Employers with the welfare benefits (the "Benefits") described in Schedule I attached to this summary.

The Plan also has a "cafeteria plan" feature which permits employees who are covered under one or more of the Benefits to pay their portion of the costs of coverage on a pre-tax basis. Finally, the Plan offers two special reimbursement accounts, the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account (together referred to as "Accounts" in this summary), which permit eligible employees to pay for otherwise unreimbursed medical and dependent care expenses on a pre-tax basis. The Benefits and the Accounts provide all of the benefits under the Plan, and together are referred to in this summary as the "Benefits Programs."

This booklet, along with the Certificates of Coverage and separate governing documents (if any) issued by the companies that insure the benefits described in this booklet (the "Insurers"), is the summary plan description for the Plan. Both the Certificates of Coverage and the separate governing documents are incorporated into this summary plan description by reference.

This document is intended to provide an overview of the major features of the Plan. However, this is only a summary of the Plan, and it cannot explain every situation that might arise. The Plan is governed by separate legal documents that are available for your review. If there is a conflict between this summary and the legal documents for the Plan, the legal documents will control.

The Company has the right to amend or terminate the Plan, or any Benefit provided under the Plan (including the right to change the Insurer providing a Benefit) at any time, in its sole discretion. You will be notified of any changes which are made to the Plan that change the information provided in this summary.

In this document, capitalized terms have a special meaning. You should refer to the end of the document for the definitions of any capitalized terms.

## **2. ELIGIBILITY**

Participation in the Plan is limited to "employees." In general, all individuals who work for an Employer will be employees, except that the following individuals are not employees:

- Individuals who are independent contractors;
- Nonresident aliens with no income within the United States; and
- Self-employed individuals.

To be eligible to participate in the Plan, an employee must first either be a "full-time employee" or have been employed continuously by an Employer for three (3) years. Employees who satisfy either of these requirements will commence participation in the Plan as provided below. For purposes of the foregoing, a "full-time employee" is an employee who is either (i) regularly scheduled to work thirty (30) hours or more per week for an Employer, or (ii) is employed by an Employer and is classified by the Employer as exempt from the overtime pay requirements under the federal Fair Labor Standards Act, as amended, or any similar act.

Eligible employees may generally participate in a Benefit listed in Schedule I attached to this summary on the first day of the calendar month that coincides with or next follows the date they satisfied the eligibility requirements. However, if a Benefit imposes other requirements (which may include a longer waiting period), the employee will not be eligible to participate in that Benefit until he or she has also satisfied these other requirements. The eligibility requirements for a particular Benefit and the waiting periods and effective dates of coverage for a Benefit are generally described in the Certificate of Coverage for such Benefit. All employees who are eligible to be covered under one or more Benefits, and who are required to pay all or a portion of the costs of coverage (including any coverage for a spouse or dependent) pay for those costs on a pre-tax basis through the cafeteria plan feature described in Section 6 below.

Eligible employees may participate in the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account as of the first day of the calendar month coinciding with or next following the date as of which they become an eligible employee.

## **3. BENEFITS AND COSTS OF COVERAGE**

The Benefits provided under this Plan are described in detail in the Certificate of Coverage and separate governing documents (if any) for each Benefit. Under any of the health, dental or vision Benefits described in Schedule I attached to this summary, you may be required to obtain services from a

network provider or you may receive services at a lower cost by using a network provider, as described in the separate Certificates of Coverage that you have been provided. A list of participating providers is available to you online.

The Benefits available under the Plan are provided through contracts of insurance with the Insurers in return for premium payments paid to the Insurers. The Employer pays the cost of certain Benefits, while the cost of other Benefits are shared by the Employer and eligible employees or are paid entirely by eligible employees. The specific amounts, if any, that you will be required to pay for any particular Benefit will be provided to you separately. The Employer forwards all contributions that it or eligible employees make for coverage under a Benefit directly to the Insurers as premium payments.

The cost of coverage under a Benefit may change from time to time. The Employer will inform eligible employees of any change in the cost of a Benefit.

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

In accordance with the Women's Health and Cancer Rights Act of 1998, the Plan will cover certain breast reconstructive benefits in connection with a mastectomy. If you choose breast reconstruction in connection with a mastectomy, coverage is available in a manner determined in consultation with you and your Physician for:

- i. Reconstruction of the breast on which the mastectomy was performed
- ii. Surgery and reconstruction of the other breast to produce a symmetrical appearance
- iii. Prosthesis and treatment of physical complications for all stages of mastectomy, including lymphedemas

Such coverage is subject to all the terms of the Plan, including relevant deductibles and coinsurance provisions.

#### **4. ENROLLMENT PROCEDURES**

If you are eligible for and wish to become covered under a Benefit listed in Schedule I to this summary, you must complete any required enrollment forms. The Certificates of Coverage and other governing documents which you have been provided describe the deadlines for completing the enrollment forms. If you do not submit a completed enrollment form on a timely basis, your coverage under a Benefit may be delayed or subject to evidence of insurability requirements. The Plan Administrator will provide you with any necessary forms. The Plan Administrator may also choose to implement procedures for enrolling electronically (for example, through the internet) or telephonically.

Because any portion of the costs of coverage of a Benefit that you are required to pay will be paid on a pre-tax basis under the cafeteria plan feature described in Section 6 below, your enrollment for these benefits will be subject to the special rules described in that paragraph. Also, your enrollment under the Health Care and Dependent Care Flexible Spending Accounts described in Sections 7 and 8 are subject to the special rules in those sections.

#### **5. TERMINATION OF PARTICIPATION UNDER A BENEFIT**

Coverage under a Benefit ends at the times described in the separate Certificates of Coverage or other documents governing the Benefit. In some instances, you may be able to elect to convert your coverage to an individual policy of insurance. Please refer to the applicable Certificate of Coverage or other governing document for more information. Also, if you have coverage under any health, dental or vision Benefits described in Schedule I attached to this summary, you may be eligible to elect COBRA continuation coverage, as described in Section 11 of this summary. You may also be eligible to elect COBRA continuation coverage if your coverage under the Health Care Flexible Spending Account described in Section 7 terminates.

#### **6. CAFETERIA PLAN FEATURE**

##### **A. Introduction**

Any costs of coverage for any Benefit that you are required to pay will be paid as a pre-tax deduction from your pay. Under federal tax laws, such a pre-tax arrangement is known as a “cafeteria plan” feature because it lets you choose between receiving your full salary or choosing from several different Benefits or flexible spending reimbursement accounts according to your individual needs. You pay for your costs of these benefits by entering into a salary reduction agreement with the Employer.

Please note that any amounts you pay on a pre-tax basis under the Plan are exempt from federal income and FICA taxes. In calculating your future Social Security benefits, only your compensation after your pre-tax deductions are excluded will be taken into account, which means that use of the Plan could reduce your ultimate Social Security benefit. You should talk with your personal tax advisor for more information.

This Section 6 describes the Plan's cafeteria plan feature, the requirements applicable to your enrollment in Benefits for which you will pay all or a portion of the costs of coverage, and the rules governing your election (or change in election) to reduce your compensation to make your required payments. The general rules regarding enrollment and elections described in this Section 6 also apply to the Health Care and Dependent Care Flexible Spending Accounts, but special rules for these two reimbursement accounts are described in Sections 7 and 8 below.

## **B. Enrollment for Benefits Programs**

When you first become eligible to participate in the Plan, the Plan Administrator will provide you with a notice regarding your eligibility for coverage under the Benefit Programs. If you want to enroll for coverage under one or more Benefit Programs, you must agree to participate in this Plan and have the Employer deduct your share of the cost of those programs from your pay on a pre-tax basis. In order to participate in the Plan, you must complete the benefit enrollment form and return it to the Benefits Department within 30 days. The Plan Administrator may implement procedures for filing your election electronically (for example, through the internet) or telephonically. If you do not file your enrollment forms within the required time, you will not be permitted to enroll in the Plan until the next regular enrollment period. With certain exceptions described below, your benefit elections will remain in effect for the entire Plan Year.

Before the beginning of each new Plan Year, you will be provided with a new notice and new benefit election form. If you do not return the form within the time described by the Plan Administrator, your prior year's benefit elections will continue in effect for the upcoming year. However, you must return the appropriate benefit election forms if you wish to continue to participate in the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account—those coverages cannot be continued automatically. With certain exceptions described below, your benefit elections will remain in effect for the entire upcoming Plan Year.

## **C. Election Changes**

Generally, you cannot change your election to participate in the Plan, the Benefit Programs you have selected, or the type or amount of coverage under

the selected Benefit Programs during the Plan Year. However, there are important exceptions to this general rule, as follows:

- Change in Status. If you have a “change in status,” you can change your prior election consistent with that change in status. A change in status includes (i) a change in your legal marital status through marriage, death of your spouse, divorce, legal separation, or annulment; (ii) a change in the number of dependents you have for federal income tax purposes due to birth, adoption, placement for adoption, or death; (iii) a change in the employment status of you, your spouse, or any other dependent, such as termination or beginning of employment, a reduction or increase in hours of employment, a strike or lockout, or beginning or end of an unpaid leave of absence; (iv) a dependent of yours satisfying or no longer satisfying the requirements for health insurance coverage due to attainment of age, change in student status, or any similar circumstance as provided in the health plan; and (v) a change in your place of residence or the residence of your spouse or any of your dependents that affects eligibility to participate in a Benefit Program. For (i) any health, dental and vision Benefits described in Schedule I attached to this summary, a new election will be considered consistent with your change in status only if the changes in status caused you (or your spouse or dependent) to gain or lose other health insurance coverage and the new election is consistent with that gain or loss.

For purposes of the foregoing change in status rules, the term "dependent" also includes any child of a Participant who is covered under a Benefit described in Paragraph 1 of Schedule I attached to this summary, or under the Participant's Health Care Flexible Spending Account. For this purpose, a Participant's "child" includes his or her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's child will be an eligible dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Participant or any other person. When the child reaches the applicable limiting age, coverage will end at the end, except as provided under the applicable Benefit.

- Special Enrollment Rights. If you, your spouse, or one of your covered dependents did not enroll for health, dental or vision benefits described in Schedule I attached to this summary because you had other coverage (for example, under another employer's plan), and you, your spouse, or your dependents lose the other coverage, you can make a change in your election to enroll in the health, dental or vision insurance coverage. You may also make an election change if your eligibility for benefits under your state's CHIPRA program changes. The administrator of the group health insurance plan will furnish you with information as to the special enrollment rights that you and your dependents have with regard to health, dental or vision insurance. Note that if the change in coverage is effective retroactively, you will be required to pay the cost of the retroactive coverage.

- Qualified Medical Child Support Orders. If your child or dependent foster child is the subject of a qualified medical child support order that requires he or she be provided with health, dental or vision insurance, your election of such insurance may be changed as needed to comply with the order.
- Medicare or Medicaid. If you or your spouse or dependents become enrolled in Medicare or Medicaid, or lose eligibility under those programs, you can change your health, dental or vision insurance elections consistently.
- Changes in the Cost of Benefit Programs. If the cost of a Benefit Program changes, but the change is not significant, your elected salary reduction amounts will be automatically changed. If the cost of a Benefit Program changes, and the change is significant, you may make a corresponding change to either elect coverage (if the cost of the Benefit Program has decreased) or to revoke coverage and elect a Benefit Program providing similar coverage (if the cost of the Benefit Program has increased). If the cost change relates to the Dependent Care Flexible Spending Account, it must have been imposed by a dependent care provider who is not your relative. You cannot change the amount of coverage under the Health Care Flexible Spending Account for cost changes.
- Reduction in Coverage. If the coverage of you, your spouse or a dependent under a Benefit Program is curtailed, you may revoke your election of that Benefit Program and elect coverage under another Benefit Program providing similar coverage (if the curtailment qualifies as a loss of coverage and no similar coverage is available, you can simply revoke your election of the coverage).
- New or Improved Benefit Programs. If a new Benefit Program becomes available during the Plan Year or coverage under an existing program is significantly improved, you can revoke coverage under a corresponding program and elect coverage under the new or improved program.
- Changes in Other Plans. If your coverage under another company's plan (for example, through your spouse or dependent) is changed and the other plan allows you to change a cafeteria plan election with regard to that coverage, or if the enrollment period for that other plan is different than the enrollment period under this Plan, you can change your elections under this Plan consistent with the change under the other plan.

## **D. Rules for Election Changes**

In order to change your elections under this Plan, you must complete and file a new election form with the Plan Administrator within 30 days of the occurrence of the event that permits an election change. The Plan Administrator may implement procedures for filing this election electronically (for example, through the internet) or telephonically. If you do not file a new election form with the Plan Administrator within the 30-day period, you will not be able to make a change in your elections until the next Plan Year.

If you change the amount of your coverage under the Health Care Flexible Spending Account, expenses incurred prior to the change are payable up to the original amount of coverage, and expenses incurred after the change are payable up to the new amount of coverage.

The Plan Administrator may change or revoke your election(s) of coverage during the Plan Year if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

## **E. Termination of Coverage**

Your coverage for Benefits will end on the date your employment ends (subject to your right to elect COBRA continuation coverage for certain health, dental or vision benefits).

## **F. Reemployment**

If you are reemployed during the same Plan Year less than 31 days after your employment was terminated, your prior elections will be reinstated for the balance of the Plan Year. If you are reemployed in a following Plan Year, or in the same Plan Year but at least 31 days after your termination of employment, you will be permitted to make a new benefits election.

# **7. HEALTH CARE FLEXIBLE SPENDING ACCOUNT**

## **A. Benefits**

Under the Health Care Flexible Spending Account ("HCFSA"), you may elect to purchase up to \$2,500 of medical expense reimbursement benefits. The amount of coverage you elect is withheld from your pay on a pre-tax basis each year in equal portions throughout the year, and can then be used to reimburse you for your uninsured medical expenses on a tax-free basis.

If you elect coverage under the HCFSA, a health care reimbursement Account will be set up in your name to keep a record of the benefits you are

entitled to, as well as the amounts you have paid for such benefits during the Plan Year. This Account is for bookkeeping purposes only, and no actual account is established, nor are any assets set aside. Rather, any reimbursement benefits are paid from the Employer's general assets.

The full amount of the coverage you have elected will be available to reimburse you for your out-of-pocket medical expenses at any time during the Plan Year, so long as you continue to pay the premiums. However, you will not be entitled to receive a refund if your actual health care expenses are less than the annual benefit you have elected. Any amounts remaining in your Account after the deadline for submitting claims has passed will be used to offset the Employer's expenses of administering the HCFSA.

### **B. Submitting Claims for Reimbursement**

If you elect to participate in the HCFSA, you will need to submit a claim to the Plan Administrator on a claim form that will be supplied to you in order to receive reimbursement of your eligible expenses. The Plan Administrator may implement procedures for filing your claim electronically (for example, through the internet) or telephonically. Reimbursement for your eligible expenses will be made as soon as administratively feasible following your submission of a claim for reimbursement but at least monthly. To have your claims processed as soon as possible, please read the claims instructions you have been furnished. Please note that reimbursement of small claims may be suspended until claims above a reasonable minimum are submitted.

If an ineligible expense is paid under the HCFSA or if you receive greater reimbursement than that to which you are entitled, you will be required to return the overpayment to the HCFSA. By electing to participate in the HCFSA, you authorize the Employer to recover any overpayments that you do not repay by offsetting future reimbursements or by withholding any overpayments from your pay.

All claims for reimbursement of expenses incurred during a Plan Year must be submitted no later than 90 days after the end of that Plan Year.

### **C. Eligible Expenses**

Any expense for medical care (as defined in the Internal Revenue Code) for which you have not been reimbursed from insurance, or some other source, can be reimbursed under the HCFSA. Upon request, we will provide you with a list of typical medical care expenses that may be reimbursed through the HCFSA. Please note that it is *not* necessary that you have actually paid an amount due for an eligible medical expense—only that you have *incurred* the expense, and that it is not being paid for or reimbursed from any other source. For purposes of the HCFSA, you are considered to have "incurred" an expense

when the health care services are rendered for which you are seeking reimbursement, and not when you have actually paid the bill.

One exception to the foregoing is that you may not be reimbursed from your HCFSA for the cost of any medicine or drug that is not "prescribed" by a physician or other medical provider, and is also not insulin.

Only expenses incurred during the Plan Year can be reimbursed. You may not be reimbursed for any expenses arising before your election of coverage under the HCFSA becomes effective, or for any expenses incurred after the close of the Plan Year.

## **8. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT**

### **A. Benefits**

Under the Dependent Care Flexible Spending Account ("DCFSA"), you may elect to purchase dependent care reimbursement benefits. The amount of coverage you elect is withheld from your pay on a pre-tax basis in equal portions throughout the year, and can then be used to reimburse you for your work-related dependent care expenses on a tax-free basis.

If you elect coverage under the DCFSA, a dependent care reimbursement Account will be set up in your name to keep a record of the benefits you are entitled to, as well as the amounts you have paid for such benefits during the Plan Year. This Account is for bookkeeping purposes only, and no actual account is established, nor are any assets set aside. Rather, any reimbursement benefits are paid from the Employer's general assets. Only amounts actually credited to your Account will be available for reimbursement of your dependent care expenses. Please note that you will not be entitled to receive a refund if your actual dependent care expenses are less than the annual benefit you have elected. Any amounts credited to your Account after the deadline for submitting claims has passed will be used to offset the Employer's expenses of administering the Plan.

The maximum amount of coverage you can elect for a calendar year is the smallest of the following amounts:

- Your earned income for the calendar year (after all reductions in compensation including the reduction related to dependent care reimbursement coverage), or
- The earned income of your spouse for the calendar year, if you are married (if your spouse is a full time student or is physically or mentally incapable of caring for himself or herself, he or she is treated as having earned income of

not less than \$200 per month if you have one dependent and \$400 per month if you have two or more dependents), or

- \$5,000 (if you are married and certify you will file a joint Federal income tax return for the year), or
- \$2,500 (if you are single or married filing separate returns).

## **B. Submitting Claims for Reimbursement**

When you incur a dependent care expense that is eligible for reimbursement, you must submit a claim to the Plan Administrator on a claim form that will be supplied to you. The Plan Administrator may implement procedures for filing your claim electronically (for example, through the internet) or telephonically. If there are enough credits in your Account, you will be reimbursed for your eligible expenses as soon as administratively feasible but at least monthly. If your claim is for an amount that is more than your current Account balance, the excess part of the claim will be carried over and paid out as your balance becomes adequate. Also, reimbursement of small claims may be suspended until claims above a reasonable minimum are submitted. To have your claims processed as soon as possible, please read the claims instructions you have been furnished.

All claims for reimbursement of expenses incurred during a Plan Year must be submitted no later than 90 days after the end of that Plan Year.

## **C. Eligible Expenses**

You may only be reimbursed for work-related expenses incurred for the care of persons in your family who are under age 13, who you can claim as a dependent on your federal income tax return or for other dependents who are mentally or physically unable to care for themselves. You are encouraged to consult your personal tax advisor or IRS Publication 17 “Your Federal Income Tax” for further guidance as to what is or is not an eligible expense if you have any doubts.

You cannot be reimbursed for any expenses above the available balance in your Account. You also will not be reimbursed for any expenses that arise before your election of coverage under the DCFSA becomes effective, or for any expenses incurred after the close of the Plan Year.

Please note that it is not necessary that you have actually paid an amount due for eligible dependent care expenses—only that you have *incurred* the expense, and that it is not being paid for or reimbursed from any other source.

## **D. Tax Considerations**

You will not normally be taxed on your dependent care reimbursement benefits. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Because you may not claim any other tax benefit for expenses reimbursed under the DCFSA, you should determine whether it is more advantageous for you to participate in the DCFSA or to claim the household and dependent care tax credit for your dependent care expenses.

The household and dependent care credit is a credit against your federal income tax liability equal to a percentage of your annual, eligible work-related dependent care expenses. The amount of the tax credit varies depending on the amount of your expenses, the number of your dependents, and your adjusted gross income. Because the actual determination of the preferable method for treating dependent care expenses depends on a number of factors, you will have to decide which treatment is best.

You will receive a statement by January 31 of each year showing the amount of reimbursements made to you under the DCFSA.

## **9. LEAVES OF ABSENCE**

### **A. Family and Medical Leaves**

If the Employer is subject to the federal Family and Medical Leave Act ("FMLA") and you are absent from work for a family or medical leave covered by the FMLA, you may revoke your election of coverage under any health, dental and vision Benefits described in Schedule I attached to this summary, and reinstate coverage when you return from the FMLA leave.

If you elect to maintain any of the health, dental and vision Benefits described in Schedule I attached to this summary, during your absence and your leave is a paid leave, payroll deductions will continue in accordance with your election. If you wish to maintain your coverage under these programs and your leave is unpaid, you must pay the premiums for the coverage using one of the following methods:

i. Prepayment. Under the prepayment option, you may (at your option) increase your salary reduction in an amount sufficient to cover the premiums that will come due during the FMLA leave during the same Plan Year.

Alternatively you can elect to prepay the premiums that will come due during the leave on an after-tax basis.

ii. Pay-as-you-go. With the pay-as-you-go option, you continue to pay premiums on a regular basis throughout the FMLA leave. If you choose this option, you will have to reimburse the Employer at regular intervals from your after-tax funds for the premiums that come due during the leave. Your coverage will end if you fail to make the payments required under this option.

## **B. Military Leaves**

If you are absent from work for active military duty that is covered by the federal Uniformed Services Employment and Reemployment Rights Act (“USERRA”), your right to continued participation in the Plan will be as follows:

i. If you are absent from work for less than 31 days, your coverage under any health, dental and vision Benefits described in Schedule I attached to this summary will be continued at active employee rates.

ii. If you are absent for more than 30 days, you may elect to continue coverage under (i) any of the health, dental and vision Benefits described in Schedule I attached to this summary, for up to 24 months or the period of your military service, whichever is shorter. You may be required to pay up to 102% of the normal premium for this continued coverage. If you elect not to continue coverage under these programs, your coverage will be reinstated to the extent required under USERRA upon your return to employment.

## **10. CLAIMS PROCEDURES**

### **A. In General**

To obtain benefits from the Insurer of a Benefit, you should follow the claims procedures described in the Certificates of Coverage that you have been provided separately. However, the following claims procedures also apply to any claim for a Benefit Program (including a claim under the Health Care and Dependent Care Flexible Spending Accounts), and take precedence over any conflicting procedures in the Certificates of Coverage.

A Participant or his or her duly authorized representative (“Claimant”) may file a claim for a Benefit, and may appeal the denial of a claim. All claims and appeals should be filed directly with the Insurer. The Insurer will decide claims in a consistent manner with respect to similarly situated Claimants.

## **B. Claims Not Involving Health or Disability Benefits**

If a claim for a Benefit Program is wholly or partially denied, the Insurer will notify the Claimant of its decision in writing. The notice will be written in a manner calculated to be understood by the Claimant and will contain (i) specific reasons for the denial, (ii) specific reference to pertinent Plan provisions, (iii) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and (iv) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA § 502(a) following an adverse benefit determination on review. The notice will be provided within 90 days after the claim is received by the Insurer (or within 180 days, if special circumstances require an extension of time for processing the claim, and if written notice of the extension, the circumstances requiring the extension, and the date a decision is expected to be made, is provided within the initial 90 day period). If the notice is not provided within this period, the claim will be considered denied as of the last day of the period and the Claimant may request a review of the claim.

Within 60 days after the date of a written notice of denial (or, if applicable, within 60 days after the date on which the denial is considered to have occurred) the Claimant may (i) file a written request with the Insurer for a review of the claim, and (ii) submit written comments, records and other information to the Insurer. The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The Insurer will provide for a review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Written notice regarding the decision on review will be provided to the Claimant. The notice will be written in a manner calculated to be understood by the Claimant and will contain (i) specific reasons for the decision, (ii) specific references to pertinent Plan provisions, and (iii) an explanation that the Claimant can have access to or copies of relevant documents upon request and without charge. The decision on review will be made within 60 days after the request for review is received by the Insurer (or within 120 days, if special circumstances require an extension of time for processing the request, such as an election by the Insurer to hold a hearing, and if written notice of the extension, the circumstances requiring the extension, and the date a decision is expected, is given to the Claimant within the initial 60 day period). If the decision on review is not made within this period, the claim will be considered denied.

### **C. Claims Involving Disability Benefits**

If a claim is for a disability benefit, the claim procedure described above applies, except that notice of the initial decision regarding the claim will be provided within 45 days of receipt of the claim. The 45-day period may be extended for an additional 30 days if the extension is necessary due to matters beyond the control of the Insurer, and the Claimant receives notice of the extension prior to the expiration of the initial 45-day period, including an explanation of the circumstances requiring the extension and the date by which the Insurer expects to make a decision. The 30-day extension period can be extended for a second period of 30 days due to matters beyond the control of the Insurer, provided the Claimant again receives notice prior to the expiration of the first extension period in the same manner as for the first extension. Any notice of an extension will explain the standards upon which entitlement to a benefit is based, the unresolved issues that prevent a decision from being made, and any additional information that is needed to resolve those issues. If the Claimant is asked to provide additional information so that the claim can be adjudicated, the Claimant will have 45 days to provide the additional information. In the case of an adverse determination with respect to a claim, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, the Insurer will notify the Claimant that such a rule, guideline, protocol or other similar criterion was relied on, and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon written request.

A Claimant has 180 days following the receipt of an adverse determination involving a disability benefit to request a review of the determination. If a review of the adverse decision is requested, (i) no deference will be given to the initial decision, and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial decision nor a subordinate of that individual, (ii) if the initial decision was based in whole or in part on a medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, (iii) the Insurer will provide to the Claimant the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination, without regard to whether the advice was relied on in making the determination, and (iv) any health care professional engaged for purposes of reviewing the initial decision will be an individual who is neither an individual who was consulted in connection with the initial decision, nor a subordinate of that individual.

The Insurer must notify the Claimant of its decision on review within 45 days after the request for review is received, or within 90 days if special circumstances require an extension of time, the Claimant is given written notice of the extension within the first 45-day period, and the notice describes the special circumstances and indicates the date a decision is expected to be made.

The notice of the decision on appeal will be written in a manner calculated to be understood by the Claimant and will contain (i) specific reasons for the decision, (ii) specific references to pertinent Plan provisions, and (iii) an explanation that the Claimant can have access to or copies of relevant documents upon request and without charge. In the case of an adverse determination on appeal, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, the Insurer will notify the Claimant that such a rule, guideline, protocol or other similar criterion was relied on, and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon written request. In addition, if an adverse decision is based on medical necessity or experimental treatment or a similar exclusion or limit, the Insurer will provide either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. The notice will also contain the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

#### **D. Claims Involving Health Benefits**

If a claim is for a health benefit, the claim procedure described above applies, except that:

i. In the case of a claim involving urgent care, the Insurer shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Insurer shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Insurer shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (i) the Plan's receipt of the specified information, or (ii) the end of the period afforded the Claimant to provide the specified additional information. If the decision regarding the claim is adverse, the notice shall include a description of the expedited review process applicable to the claim.

ii. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments (i) any

reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Insurer shall notify the Claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of the adverse benefit determination before the benefit is reduced or terminated, and (ii) any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Insurer shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

iii. In the case of a claim not described in paragraphs (i) or (ii) above, the Insurer shall notify the Claimant of the Plan's benefit determination:

a. In the case of a pre-service claim, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Insurer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

b. In the case of a post-service claim, within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Insurer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and

the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

If a Claimant fails to follow the Plan's procedures for filing a pre-service claim, the Claimant shall be notified of the failure and of the proper procedures to be followed. The notice shall be provided as soon as possible, but not later than 5 days (24 hours in the case of a failure involving an urgent care claim) following the failure.

In the case of an adverse determination with respect to a claim, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, the Insurer will notify the Claimant that such a rule, guideline, protocol or other similar criterion was relied on, and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon written request. In addition, if an adverse decision is based on medical necessity or experimental treatment or a similar exclusion or limit, the Insurer will provide either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

A Claimant has 180 days following the receipt of an adverse determination involving a health benefit to request a review of the determination. If a review of the adverse decision is requested, (i) no deference will be given to the initial decision, and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial decision nor a subordinate of that individual, (ii) if the initial decision was based in whole or in part on a medical judgment, including whether a treatment, drug or item is experimental or investigational or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted during the initial decision and is not a subordinate of such a person, (iii) the Insurer will provide to the Claimant the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination, without regard to whether the advice was relied on in making the determination, and (iv) any health care professional engaged for purposes of reviewing the initial decision will be an individual who is neither an individual who was consulted in connection with the initial decision, nor a subordinate of that individual. If the claim is an urgent care claim, the Claimant shall have available an expedited appeal process, can submit a request for review orally or in writing, and can submit information regarding the appeal by phone, facsimile or other expeditious method.

The Insurer must notify the Claimant of its decision on review within 72 hours of the date the request was received if the appeal involves an urgent care claim, within 30 days if the appeal involved a pre-service claim, and within 60

days if the appeal involves a post-service claim. The notice of the decision on appeal will be written in a manner calculated to be understood by the Claimant and will contain (i) specific reasons for the decision, (ii) specific references to pertinent Plan provisions, and (iii) an explanation that the Claimant can have access to or copies of relevant documents upon request and without charge. In the case of an adverse determination on appeal, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, the Insurer will notify the Claimant that such a rule, guideline, protocol or other similar criterion was relied on, and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon written request. In addition, if an adverse decision is based on medical necessity or experimental treatment or a similar exclusion or limit, the Insurer will provide either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. The notice will also contain the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

## **11. RIGHTS TO CONTINUE COVERAGE UNDER FEDERAL LAW (COBRA)**

### **A. General**

If you are a Qualified Beneficiary, you have the right to continue your coverage under any health, dental and vision Benefits described in Schedule I attached to this summary, if you lose that coverage due to a Qualifying Event. You may also have rights to continue your coverage under the Health Care Flexible Spending Account. If you are an employee, you are a "Qualified Beneficiary" if you are covered by either program on the day prior to a Qualifying Event that is your termination of employment (for reasons other than gross misconduct) or a reduction in your hours of employment. If you are the spouse or dependent child of an employee, you are a "Qualified Beneficiary" if you are covered by either program on the day prior to a Qualifying Event. A child born to or placed for adoption with an employee during a period of COBRA coverage is also a Qualified Beneficiary. Employees who are nonresident aliens with no U.S.-source income, and the spouse or dependent children of such employees, are not Qualified Beneficiaries.

A "Qualifying Event" means each of the following events, if it causes a Qualified Beneficiary to lose coverage under one of these programs:

- i. The employee's hours of employment are reduced;

- ii. The employee's employment ends for any reason other than gross misconduct (as defined below);
- iii. The death of the employee;
- iv. The employee's entitlement to Medicare benefits;
- v. A divorce or legal separation between the employee and his or her spouse; or
- vi. For a dependent child, the child's ceasing to satisfy the definition of a dependent under the terms of the applicable program.

If you are a Qualified Beneficiary and you lose coverage under a program due to the first four Qualifying Events listed above, you will automatically receive a Qualifying Event notice from the Plan Administrator of your right to elect COBRA continuation coverage. However, if you are a Qualified Beneficiary and you lose coverage under a program due to a divorce or legal separation, or due to a child's loss of dependency status, you must notify the Plan Administrator of the event within 60 days after the Qualifying Event occurs or you will lose your right to elect COBRA continuation coverage.

As indicated previously, an employee's termination of employment for gross misconduct is not considered a Qualifying Event. Gross misconduct means conduct that could have an adverse impact on the business of the Employer, including but not limited to theft, embezzlement, and serious violations of Employer policy that subject an employee to dismissal.

## **B. Electing COBRA Coverage**

If you are a Qualified Beneficiary and you experience a Qualifying Event, you will receive a Qualifying Event notice from the Plan Administrator describing your rights to elect COBRA continuation coverage, as well as an election form you can use to apply for that coverage. The Plan Administrator may implement procedures for filing your COBRA election electronically (for example, through the internet) or telephonically. Remember, if the Qualifying Event is a divorce, legal separation, or a child's loss of dependency status, you must first notify the Plan Administrator of the event before this notice will be sent to you. If you do not receive a Qualifying Event notice and election form within 30 days of your Qualifying Event (or within 14 days of the date you notified the Plan Administrator of a Qualifying Event, if applicable), you should contact the Plan Administrator.

Although each Qualified Beneficiary has an independent right to elect COBRA coverage, the Qualifying Event notice and election form will usually only be sent to the employee and spouse, at the employee's address shown in the records of the Plan. However, if the records of the Plan show that the employee

and spouse live at different locations, or that a dependent child lives at a different location, separate notices will be sent. For this reason, it is very important that you keep the Plan Administrator informed of your current address and the addresses of your spouse and covered dependents. Again, each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA coverage will be provided only if it is elected by a Qualified Beneficiary during the COBRA election period. The COBRA election period begins on the date of the Qualifying Event and ends 60 days after the date a Qualifying Event Notice is sent to the Qualified Beneficiary or, if later, the date the Qualified Beneficiary would otherwise lose coverage as a result of the Qualifying Event. For elections sent by mail, the postmark date is used to determine whether an election was made prior to the end of the COBRA election period.

If elected, COBRA coverage begins on the date coverage would otherwise have been lost. The Plan does not permit you to waive COBRA coverage during the election period and then revoke the waiver before the end of the election period in order to elect coverage as of a date other than the date coverage was initially lost.

Prior to the time a Qualified Beneficiary elects COBRA coverage, his or her coverage under the Plan will be terminated. However, the coverage will be retroactively reinstated to the date coverage was lost following a timely election of COBRA coverage and the timely payment by the Qualified Beneficiary of the first premium payment. This means that, until you elect COBRA coverage, any provider who asks will be told that your coverage has been terminated, but may be retroactively reinstated if you timely elect and pay for COBRA coverage.

### **C. Paying for COBRA Coverage**

Qualified Beneficiaries must pay for each one-month period of COBRA coverage on a monthly basis. A period of COBRA coverage runs from the first day of the month through the end of that month, except that the initial period of coverage runs from the date coverage was lost due to the Qualifying Event, through the end of the month in which the Qualifying Event occurred.

The cost for each one-month period of COBRA coverage depends on the type of coverage that is being continued. The cost will be communicated to you in the Qualifying Event notice sent to you by the Plan Administrator. The cost may change at the beginning of each Plan Year. Any changes will be communicated to you.

The first payment for COBRA coverage must be postmarked or received by the Plan no later than 45 days after the date you elect COBRA coverage. The first payment must include payment for all one-month periods of coverage that have begun between the date coverage was lost and the date the first premium payment is received. If the payment is not postmarked or received within 45 days of the date you elected COBRA coverage, you will lose your right to COBRA coverage.

Payments for subsequent one-month periods are due on the first day of those periods and should be sent to the Plan Administrator. You will have a 30-day grace period to send in these payments, but they must be postmarked or received no later than 30 days after the first day of the coverage period or your COBRA coverage will be terminated retroactively to the first day of that period and cannot be reinstated. Any payment that is less than the full premium payment due will not be accepted unless the balance is paid prior to the end of the normal grace period. In some cases, however, if your payment is not significantly less than the applicable premium, you will have 30 days following the date you are notified of the shortfall to make up the balance.

If payment for a period of COBRA coverage is made after the first day of that period, your coverage will be continued but will be subject to retroactive termination if payment for that period is not received during the grace period. However, any claims incurred prior to payment will not be processed until payment is made. This means that, until you pay for COBRA coverage, any health care provider who asks will be told that your coverage is in force, but may be retroactively terminated if you do not timely pay for COBRA coverage. In addition, you will be required to reimburse the Plan for any claims that are paid if you do not subsequently send in timely payment.

#### **D. Application of Deductibles and Other Plan Limits**

If COBRA coverage begins during the middle of a Plan Year, the Qualified Beneficiary's deductibles for the remainder of the Plan Year will be administered as follows:

- i. Each Qualified Beneficiary who elects COBRA coverage will receive credit for any expenses previously applied during the Plan Year to his or her individual deductible.
- ii. If the Qualified Beneficiary was previously part of a family unit, only those expenses incurred by family members electing COBRA coverage will be credited. If the Qualifying Event results in more than one family unit (for example, due to a divorce), the expenses incurred by the members assigned to a given family unit following the COBRA election shall be credited as of the date coverage begins.

Other Plan limits will be applied consistent with the rules applicable for deductibles.

#### **E. Duration of COBRA Coverage**

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

i. If you or anyone in your family covered under any of the health, dental and vision Benefits described in Schedule I attached to this summary is determined by the Social Security Administration ("SSA") to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60<sup>th</sup> day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the SSA's determination before the end of the 18-month period of COBRA continuation coverage and not later than 60 days after the latest of (i) the date of the disability determination by the SSA, (ii) the date on which a Qualifying Event occurs, or (iii) the date on which you or another Qualified Beneficiary loses (or would lose) coverage under the program as a result of the Qualifying Event. If a Qualified Beneficiary who was previously determined by the SSA to be disabled is subsequently determined by the SSA to be no longer disabled, you must

notify the Plan Administrator of that determination within 30 days of the date you receive the determination from the SSA.

ii. In addition, if your family experiences another Qualifying Event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available only if the second event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second Qualifying Event within 60 days of the event. Only individuals who were Qualified Beneficiaries in connection with the first Qualifying Event and who are still Qualified Beneficiaries at the time of the second Qualifying Event are eligible for this extension.

COBRA coverage will end prior to the 18-, 29- or 36-month period described above under the following circumstances:

- i. the first day of a coverage period for which timely payment is not made;
- ii. the date the Employer ceases to provide any group health plan to any employee;
- iii. the date, after the date a COBRA election is made, upon which the Qualified Beneficiary first becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of the Qualified Beneficiary;
- iv. the date, after the date a COBRA election is made, upon which a Qualified Beneficiary first becomes entitled to Medicare benefits;
- v. the first day of the coverage period that is more than 30 days after the date a Qualified Beneficiary entitled to a disability extension is finally determined to not be disabled; or
- vi. the date coverage is terminated for cause.

If the COBRA coverage of a Qualified Beneficiary terminates early, the Plan Administrator will send a notice regarding the termination of COBRA Coverage to you as soon as practicable.

Special rules apply to continuation of your coverage under the Health Care Flexible Spending Account. If these rules apply to you, you will be notified by the Plan Administrator.

#### **F. How to Notify the Plan Administrator**

You must send written notice of a Qualifying Event that is a divorce, a legal separation, or a child's loss of dependent status, to the Plan Administrator within 60 days of the event. The Plan Administrator may implement procedures for notifying the Plan Administrator electronically (for example, through the internet) or telephonically. Also, if you elect COBRA coverage and you are eligible for an 11-month extension of that coverage due to the disability of a Qualified Beneficiary, or for an 18-month extension of that coverage due to the occurrence of a second Qualifying Event, you must provide written notice of the disability determination or the second Qualifying Event to the Plan Administrator. Notice must be sent by first class mail or other nationally-recognized courier service, by facsimile, or by hand-delivery. Oral notice will not be accepted. Your notice must include your name and the names of other affected family members, the type of Qualifying Event and written documentation of the event that identifies the date on which the event occurred. You should keep a copy, for your records, of any notices you send to the Plan Administrator.

Any notices required to be provided to the Plan Administrator may be provided by the employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of either of them, and will be sufficient for all beneficiaries affected by the same Qualifying Event.

#### **G. If You Have Questions**

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

## **12. QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

The health, dental and vision Benefits described in Schedule I attached to this summary will provide benefits to a child of an eligible employee in accordance with a Qualified Medical Child Support Order ("QMCSO"), as defined in ERISA § 609, as referenced in the Certificates of Coverage. You may obtain a

copy of the Plan's Qualified Medical Child Support Order Procedures, free of charge, upon written request to the Plan Administrator.

### **13. STATEMENT OF ERISA RIGHTS**

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants will be entitled to:

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

ii Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series), if any, and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

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

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

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 benefit or exercising your rights under ERISA.

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

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, 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.

#### 14. GENERAL PLAN INFORMATION

**Plan Name:** FrankCrum Flexible Benefits Plan

**Plan Number:** 501

**Employer  
Identification Number:** 59-2626531

**Plan Year:** January 1 through December 31

**Type of Plan:** Welfare benefit plan, providing health, dental, voluntary life benefits, and certain other eligible benefits that may be adopted by specific Adopting Employers

**Name and Address  
of Employer:** FrankCrum  
100 S. Missouri Ave.  
Clearwater, FL 33756

**Plan Administrator:** FrankCrum  
100 S. Missouri Ave.  
Clearwater, FL 33756  
(800) 393-0815

Please note that the Insurers are the claim fiduciaries for all Benefits under the Plan. The name, address and phone number of the Insurers are described in the Certificates of Coverage.

**Type of Administration:** Self-administered, with certain duties contracted to outside third parties

**Agent for Service of  
Legal Process:** Service of legal process may be made upon the Employer or the Plan Administrator at the address described above

## 15. DEFINITIONS

- A. Account** means the accounts established as a record of an employee's contributions to, and reimbursements under, the Health Care and Dependent Care Flexible Spending Account, if applicable.
- B. Adopting Employer** means an entity who has adopted the Plan with the permission of the Company.
- C. Benefit** means a benefit described in Schedule I attached to this summary.
- D. Benefit Program** means any of the benefits offered under this Plan, including both the Benefits in Schedule I, and the Health Care and Dependent Care Flexible Benefits Accounts.
- E. Certificate of Coverage** means the certificate of coverage that has been prepared by the Insurer to describe the Benefit. The Certificates of Coverage are incorporated into and are an integral part of this summary. The Certificates of Coverage have been provided separately to eligible employees.
- F. COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- G. Company** means FrankCrum 11, Inc., d/b/a FrankCrum.
- H. Code** means the Internal Revenue Code of 1986, as amended.
- I. Dependent Care Flexible Spending Account, or DCFSA,** means the reimbursement Account described in Section 8 of this summary, and which permits eligible employees to be reimbursed on a pre-tax basis for otherwise unreimbursed dependent care expenses.
- J. Employer** means the Company and any Adopting Employer.
- K. ERISA** means the Employee Retirement Income Security Act of 1974, as amended.
- L. FMLA** means the Family and Medical Leave Act, as amended.
- M. Health Care Flexible Spending Account, or HCFSA,** means The reimbursement Account described in Section 7 of this summary, and which permits eligible employees to be reimbursed on a pre-tax basis for otherwise unreimbursed health care expenses.

**N. HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.

**O. Insurer** means an insurance company which has issued an insurance contract through which one or more Benefits are provided. The name, address and phone number of each Insurer providing a benefit is described in the Certificates of Coverage which have been separately provided. The Insurers are responsible for financing all Benefits in exchange for payment of insurance premiums, and are also responsible for processing and deciding all claims for Benefits.

**P. Plan** means the FrankCrum Flexible Benefits Plan.

**Q. Plan Administrator** means the person or persons designated by the Employer to administer the Plan or, if no persons are designated, the Employer itself.

**R. Plan Year** means January 1 through December 31.

**S. Qualified Medical Child Support Order or QMCSO** means the continuation of a health care benefit under ERISA § 609.

**T. USERRA** means the Uniformed Services Employment and Reemployment Act, as amended.

**SCHEDULE I**  
**COVERED BENEFITS**

1. Health Benefits  
Period of Coverage: November 1 through October 31  
Provider of Coverage: Aetna  
Contract Number: USO83923, 657366, 427602, 427697, 427771
  
2. Voluntary Life Benefits  
Period of Coverage: January 1 through December 31  
Provider of Coverage: AFLAC  
Benefits:
  - a. Cancer
  - b. Accident
  - c. Intensive care
  - d. Hospital
  - e. Specific disease
  - f. Vision
  
3. Dental Benefits  
Period of Coverage: November 1 through October 31  
Provider of Coverage: MetLife  
Contract Number: TS 05333771
  
4. Other Benefits Offered by Adopting Employer  
An Adopting Employer may offer any benefits plans that it has adopted for its employees, provided that such benefits plans are eligible to be offered through a cafeteria plan under Code Section 125 and the regulations promulgated thereunder.