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GROUP INSURANCE PLAN

Employer provides various types of group insurance benefits to eligible employees. These insurance benefits are provided through a policy with each insurance carrier. Each insurance carrier is to provide you with a booklet or certificate describing the insurance benefits provided by that carrier.

The booklet or certificate will contain the following information:

- The eligibility conditions for any dependent coverage, including eligibility for dependent coverage for children up to age 26 who are related to the Employee by birth, marriage, legal guardianship, or legal adoption. Please note that as of September 23, 2010, dependent coverage is no longer limited by financial dependency, marital status, or enrollment in school.
- A summary of benefits.
- A description of any deductibles, co-insurance, or co-payment amounts.
- A description of any annual or lifetime caps or other limits on benefits. Please note that as of September 23, 2010, group plans may no longer include a lifetime limit on essential health benefits.
- Whether and under what circumstances preventive services are covered.
- Whether and under what circumstances prescription drugs are covered.
- Whether and under what circumstances coverage is provided for medical tests, devices, and procedures.
- Provisions governing the use of network providers (if any). If there is a network, the booklet or certificate will contain a general description of the provider network and you will be entitled to obtain a list of providers in the network from the insurer.
- Whether and under what circumstances coverage is provided for any out-of-network services.
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care.
- Any conditions or limits applicable to obtaining emergency medical care.
- Any provisions requiring preauthorization or utilization as a condition to obtaining a benefit service.
- A summary of the claim procedures.

- A description of the internal appeal and external review procedures for any adverse benefit determinations.

ELIGIBILITY AND PARTICIPATION

Rules regarding eligibility or participation vary between different programs addressed below and according to the status of the Employee. If you have any questions, you are encouraged to contact your Plan Administrator.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Notwithstanding any contrary provision in any group health insurance policy under the Plan, an eligible dependent child may include a child for whom an employee is required to provide coverage pursuant to a qualified medical child support order ("QMCSO"). Participants can obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Administrator.

YOUR RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or the 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).

YOUR RIGHTS UNDER CHIPRA

On February 4, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") was signed into law. The purpose of CHIPRA is to permit states to subsidize premiums for employer-provided, group health insurance coverage for eligible children in an effort to reduce the numbers of uninsured children in the United States. CHIPRA provides for a special enrollment period for qualifying employees and employees' dependents.

Effective April 1, 2009, employees and employees' dependents, who are eligible but not enrolled for coverage under the Plan, are permitted to enroll in the Plan for coverage under the two following scenarios:

1. The employee's or employees' dependents' coverage under Medicaid or CHIP is terminated because of a loss of eligibility; or
2. The employee or employees' dependents become eligible for a subsidy under Medicaid or CHIP.

Under the first scenario, an employee must request special enrollment within sixty (60) days after the loss of coverage. Under the second scenario, the employee must request special enrollment within sixty (60) days of when eligibility is determined.

Please note that Michigan is one of ten states, which do not provide premium assistance as of September 1, 2010. Accordingly, this notice of CHIPRA rights is not required to be sent to employees residing in Michigan. However, if Employer has employees domiciled in a state offering premium assistance or Employee is domiciled in a state offering such assistance, then notice of such rights must be provided. A copy of the CHIPRA notice is attached hereto as Appendix A.

YOUR RIGHTS UNDER THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

Under the Mental Health Parity Act of 1996 (“MHPA”), group health plans may not impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits. The Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) preserves the MHPA protections and adds significant new protections. Although the MHPAEA requires “parity,” or equivalence, with regard to annual and lifetime dollar limits, financial requirements and treatment limitations, the law DOES NOT require large group health plans and their health insurance issuers to include mental health and substance use disorder (“MH/SUD”) benefits in their benefits package. The law’s requirements apply only to large group health plans (more than 50 employees) and their health insurance issuers that already include MH/SUD benefits in their benefits packages.

Below are the key changes made by MHPAEA, which is generally effective for plan years beginning after October 3, 2009:

- If a group health plan includes medical/surgical benefits and mental health benefits, the financial requirements (e.g. deductibles and co-payments) and treatment limitations (e.g. number of visits or days of coverage) that apply to mental health benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;
- If a group health plan includes medical/surgical benefits and substance abuse disorder benefits, the financial requirements and treatment limitations that apply to substance use disorder benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;
- MH/SUD benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits;
- If a group health plan includes medical/surgical benefits and mental health benefits, and the plan provides for out-of-network medical/surgical benefits, it must also provide for out-of-network mental health benefits;
- If a group health plan includes medical/surgical and substance use disorder benefits, and the plan provides for out-of-network medical/surgical benefits, it must also provide for out-of-network substance use disorder benefits;
- Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD, must be disclosed upon request; and

- The MHPA parity requirements under existing law (regarding annual and lifetime dollar limits) continue and are extended to substance use disorder benefits.

There are, however, certain exceptions to the MHPAEA requirements:

- MHPAEA requirements do not apply to small employers who have between 2 and 50 employees;
- MHPAEA DOES NOT require large group health plans and their health insurance issuers to include MH/SUD benefits in their benefits package; and
- A non-federal governmental employer that provides self-funded group health plan coverage to its employees (coverage that is not provided through an insurer) may elect to exempt its plan from the requirements of MHPAEA.

Please note that as of September 23, 2010, group plans may no longer place lifetime benefit limits on essential health benefits.

SOURCES OF CONTRIBUTIONS AND COST OF BENEFITS

Employer makes contributions under the Plan on behalf of the employees who participate in the Plan. Employer applies its contributions under the Plan to purchase insurance coverage. Employees may be required to contribute to the cost of coverage. If employees are required to contribute to the cost of coverage, Employer will notify employees of the required premiums. If the Employer maintains a Section 125 plan, required premiums may be paid on a pre-tax basis.

TERMINATION OF COVERAGE

In order to remain eligible for coverage under the Plan, you must remain an eligible employee actively working for Employer. However, in certain circumstances, you or your dependents may be eligible for COBRA continuation coverage and/or a conversion policy, as explained in the following sections.

NOTICE OF COBRA CONTINUATION COVERAGE

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation 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 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. COBRA continuation coverage is only available for those whose employers employed 20 or more employees. For additional information about

your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

[For retiree plans: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become 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.]

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent children's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Employer in writing.

Notice Requirements

A qualified beneficiary must give the Plan Administrator written notice of (1) a divorce or legal separation, (2) a child losing dependent status under the plan, or (3) a second qualifying event within 60 days after the later of: the date of the qualifying event or the date the qualified beneficiary loses health coverage on account of that qualifying event.

A qualified beneficiary must give the Plan Administrator written notice of a determination of disability or change in disability that has been made by the Social Security Administration within 60 days after the latest of: (1) the date of the Social Security Administration determination; (2) the date on which the qualifying event occurs; (3) the date on which the qualified beneficiary loses coverage; or (4) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice.

If timely notice is received, the Plan Administrator has the responsibility to notify the insurer of the divorce, legal separation, loss of dependent status, or disability determination. If timely notice is not received, continuation coverage will not be available as a result of the divorce, legal separation, or loss of dependent status. The Plan Administrator also has the responsibility to notify the insurer of your death, termination of employment, reduction in hours, or Medicare entitlement.

The Plan Administrator will notify all eligible qualified beneficiaries of their right to elect continuation coverage within 14 days after receiving notice of a qualifying event. If Plan Administrator receives notice of a qualifying event from a participant or qualified beneficiary who is not eligible to receive COBRA, Plan Administrator must provide a notice to the individual explaining why he or she is not entitled to such coverage.

If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify the Plan Administrator in writing within 60 days after the later of: (1) the date the qualified beneficiary loses health coverage on account of the qualifying event; (2) or the date on which the qualified beneficiary is sent notice of his or her eligibility for continuation coverage. If the qualified

beneficiary does not choose continuation coverage during the 60-day period, his or her participation will end as otherwise provided in the group health plan.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. The Plan Administrator must provide a notice for the election of COBRA continuation coverage within 14 days after receiving notice of a qualifying event. The individual then has 60 days to decide whether to elect COBRA continuation coverage. The 60-day election period is measured from the latter of the coverage loss date or the date the COBRA election notice is provided. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouse, and parents may elect COBRA continuation coverage on behalf of their children. After electing to participate in COBRA continuation coverage, the person has 45 days to pay the initial premium.

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). Otherwise, 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.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration 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 maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of 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 Administrator. This extension may be

available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

How Do You File a COBRA Claim for Benefits?

A person claiming COBRA benefits must submit a claim in accordance with the Plan's rules for filing claims. If such claim is denied, then the claimant must be provided notice of the denial in writing within 90 days after the claim is filed. Such notice shall state the reasons for the denial, any additional information needed to support the claim, and procedures for appealing the claim. A claimant shall have at least 60 days to appeal a denial and the claimant must receive a decision on the appeal generally within 60 days after the appeal is filed.

If You Have Questions

Questions concerning your 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.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator 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 Plan Administrator.

Cost

Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost may be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries who elect an additional 11 months of continuation coverage, the cost may be 150% of the cost of identical coverage for similarly situated participants for the additional 11-month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law). The 150% cost amount shall also apply to the disabled qualified beneficiary's dependents, as long as the disabled qualified beneficiary is in the coverage group-receiving COBRA.

The initial premium must be paid within 45 days after the qualified beneficiary elects continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within 45 days after the qualified beneficiary elects continuation coverage. Payment is considered made on the date on which it is sent to the plan.

The American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 ("ARRA"), as amended by the Department of Defense Appropriations Act, 2010, reduces the COBRA premiums in some cases. The premium reduction is available to certain individuals who experience a qualifying event relating to COBRA continuation coverage that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending February 28, 2010. If you qualify for the premium reduction, you are required to pay only 35% of the COBRA premium otherwise due under the Plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts more than 15 months, you will have to pay the full amount to continue your COBRA continuation coverage. If you believe that ARRA may apply to your continued coverage under COBRA, you must immediately contact the Plan Administrator to discuss eligibility.

The Trade Act of 2002

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance ("TAA") and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC"). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage.

The American Recovery and Reinvestment Act of 2009 ("ARRA"), however, made several amendments to the provisions of the Trade Act of 2002. These amendments included an increase in the amount of the credit to 90% of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PGBC recipients and TAA-eligible individuals.

If you are a PGBC recipient or believe that you are TAA-eligible, you must immediately contact the Plan Administrator to discuss possible eligibility and other provisions.

Termination

Generally, COBRA continuation coverage terminates at the end of the initial 18- or 36-month continuation period or at the end of any additional 11- or 18-month continuation period for which the qualified beneficiary is entitled to elect continuation coverage. However, COBRA continuation coverage for a qualified beneficiary may end before the end of the initial or additional continuation period for any of the following reasons:

- **Coverage Terminated**
Employer no longer offers a group health plan to any of its employees;
- **Unpaid Premium**
The premium for continuation coverage is not timely paid;

- **Other Coverage**

The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan. However, this provision does not apply during any time period the other group health plan contains any limitation or exclusion with regard to any pre-existing conditions, other than a limitation or exclusion, which does not apply to the qualified beneficiary or is satisfied by the qualified beneficiary due to HIPAA;

- **Medicare**

The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B); or

- **Cause**

The date on which a qualified beneficiary's coverage is terminated for cause on the same basis that the plan terminates for cause the coverage of similarly-situated nonqualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits).

YOUR RIGHTS UNDER MICHELLE'S LAW

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your dependent's right to continuation coverage, which is a temporary extension of coverage under the Plan, under limited circumstances.

On October 9, 2008, President George W. Bush signed legislation commonly known as "Michelle's Law" (Pub L. 110-381). As a general matter, federal law does not require that group health plans provide coverage to dependents. However, if a group health plan provides coverage to a dependent child based on student status at a postsecondary educational institution, then Michelle's Law may apply. Michelle's Law adds a one-year continuation coverage requirement for ill or injured students enrolled in a postsecondary educational institution.

Under Michelle's Law, an employer's group health plan must continue to provide coverage to a dependent child if the child takes a leave of absence from a postsecondary educational institution, or has a change in enrollment status, that:

- Begins when the student is suffering from a serious injury or illness;
- Is medically necessary (as confirmed in a written communication from the student's treating physician); and
- Causes the child to lose student status for purposes of coverage under the Plan.

A "dependent child" for purposes of Michelle's Law is a child who (1) is a dependent child or a participant or beneficiary under the terms of the Plan, and (2) was enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the medical leave of absence began. The Plan must continue the child's coverage for up to one year after the leave of absence begins or, if earlier, until coverage would have otherwise terminated under the terms of the Plan (e.g. the child ages out of the Plan or the child's parent terminates employment and loses coverage under the Plan). The level of benefits provided to the child during Michelle's Law continuation coverage must be the same as the benefits the child would have received if the child continued as a covered student without regard to Michelle's Law. The premium the Plan charges must also remain the same as if the child had maintained regular student status.

If you believe that continuation coverage under Michelle's Law may apply to your child, then you must immediately provide notice in writing to the Plan Administrator, along with a certification of the child's treating physician indicating that the dependent child is suffering from a serious illness or injury and that the leave of absence or change in enrollment is medically necessary.

Please be advised that the federal government has not yet released regulations regarding the effect of Michelle's Law on COBRA continuation coverage. The federal government is expected to release rules and regulations in 2010.

EXTENSION OF DEPENDENT COVERAGE UNDER PPACA

PPACA generally extended the length of time that an eligible dependent is permitted to remain on the employee's plan until the eligible dependent is 27. An eligible dependent must be an eligible employee's or spouse's

- Son, daughter, stepson, stepdaughter, adopted child or child placed for adoption, foster child or other legally placed child; or
- The biological child of an eligible dependent child (a grandchild) and meets one of the following criteria:
 1. The child's parent will not be older than age 26 on the last day of the Plan year, is unmarried and without a domestic partner, both the child's parent and the child live in the household of the eligible employee; or
 2. The child lives with the eligible employee, and the employee is legally responsible for the welfare of the grandchild. The employee must be able to provide legal documentation of guardianship, conservatorship, or other custody documents.
- The child shall not have attained the age of 27 as of December 31 of the Plan year, unless such child meets all requirements of a child with a disability.

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS

If you or an insured dependent is receiving benefits in connection with a mastectomy and you or your insured dependent, in consultation with the attending physician, elects breast reconstruction, coverage will be provided for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymph edemas.

Please be advised that the above reconstruction benefits are subject to the same provisions as any other benefit provided under the Plan.

CONVERSION PRIVILEGES

When you are no longer eligible under the Plan (either as an active participant or as a qualified beneficiary receiving continuation coverage) you may be eligible to obtain an individual conversion policy for one or more of your insured benefits. The availability of this conversion coverage and the rules concerning your eligibility are set forth in the policy with each insurance carrier. If you have any questions, you are encouraged to contact the Plan Administrator.

ADMINISTRATION

Employer is the Plan Administrator. The Plan Administrator is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan. However, because all benefits under the Plan are fully insured, the insurer has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits, and to otherwise construe and interpret the terms of the policy.

AMENDMENT AND TERMINATION

Although Employer intends to maintain the Plan indefinitely, Employer has the authority to amend or terminate the Plan at any time. However, no amendment or termination can retroactively diminish a participant's right to obtain Plan benefits.

YOUR RIGHTS AS A PLAN PARTICIPANT

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information About the Plan and its Benefits

- Examine, without charge, at the Plan Administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and if 100 or more participants, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, any updated summary plan description and, if 100 or more participants, a copy of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.
- If there are more than 100 participants in the Plan, receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continued Group Health Plan Coverage

Continued 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 on the rules governing your COBRA continuation coverage rights.

Reduction or Elimination of any Exclusionary Periods of Coverage for Pre-existing Conditions Under the 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; 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 any plan pre-existing condition exclusion, which may be up to 12 months (or 18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Participant's Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents from the Plan and do not receive them within 30 days, you may file suit in 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 federal court. The court shall 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 the participant's claim is frivolous.

Review Procedure

If you or a covered individual believe that there has been an adverse benefit determination for any medical claim submitted under the Plan, including rescission, then an internal appeal process is available, and finally, an external review process. These processes shall be set forth in the booklet or certificate provided by the insurance carrier. Plans and insurance carriers currently have until July 1, 2011 to implement the following standards regarding the appeal and review processes. However, such processes must generally comply with the following provisions:

- The Plan or insurance carrier must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim by the Plan or insurance carrier. Please note, however, that there is a special exception if the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.
- In order to provide a full and fair review, the Plan or insurance carrier is required to provide to the claimant, without charge, with any new or additional evidence considered, relied upon, or generated by the Plan or insurance carrier in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale.
- The Plan or insurance carrier must also clarify that any decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual such as a claims adjudicator or medical expert shall not be based upon the likelihood that the individual will support the denial of benefits.

- All notices provided by the Plan or insurance carrier must be provided in a culturally and linguistically appropriate manner.
- Any notice of an adverse benefit determination or a final internal adverse benefit determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- The Plan or insurance carrier must ensure that the reasons or reasons for an adverse benefit determination or an internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's or insurance carrier's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision.
- The Plan or insurance carrier must also provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
- The Plan or insurance carrier must also disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.
- If a Plan or insurance carrier fails to strictly adhere to all of the above requirements, then the claimant shall be deemed to have exhausted the Plan's or insurance carrier's internal claims and appeals process, regardless of whether the Plan or insurance carrier asserts that it has substantially complied, and the claimant may initiate any available external review process or remedies available under ERISA or state law.

Again, the federal government continues to establish regulations regarding the recent changes to federal law. Accordingly, certain requirements may change. If you have any questions, you are encouraged to contact your Plan Administrator.

Assistance With Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., 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 Pension and Welfare Benefits Administration.

APPENDIX A

Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 1, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243

<p align="center">ARIZONA – CHIP</p> <p>Website: http://www.azahcccs.gov/applicants/default.aspx</p> <p>Phone: 1-877-764-5437</p>	
<p align="center">ARKANSAS – CHIP</p> <p>Website: http://www.arkidsfirst.com/</p> <p>Phone: 1-888-474-8275</p>	<p align="center">FLORIDA – Medicaid</p> <p>Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml</p> <p>Phone: 1-866-762-2237</p>
<p align="center">GEORGIA – Medicaid</p> <p>Website: http://dch.georgia.gov/</p> <p>Click on Programs, then Medicaid</p> <p>Phone: 1-800-869-1150</p>	<p align="center">MONTANA – Medicaid</p> <p>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</p> <p>Telephone: 1-800-694-3084</p>
<p align="center">IDAHO – Medicaid and CHIP</p> <p>Medicaid Website: www.accesstohealthinsurance.idaho.gov</p> <p>Medicaid Phone: 1-800-926-2588</p> <p>CHIP Website: www.medicaid.idaho.gov</p> <p>CHIP Phone: 1-800-926-2588</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.dhhs.ne.gov/med/medindex.htm</p> <p>Phone: 1-877-255-3092</p>
<p align="center">INDIANA – Medicaid</p> <p>Website: http://www.in.gov/fssa/2408.htm</p> <p>Phone: 1-877-438-4479</p>	<p align="center">NEVADA – Medicaid and CHIP</p> <p>Medicaid Website: http://dwss.nv.gov/</p> <p>Medicaid Phone: 1-800-992-0900</p>
<p align="center">IOWA – Medicaid</p> <p>Website: www.dhs.state.ia.us/hipp/</p> <p>Phone: 1-888-346-9562</p>	<p>CHIP Website: http://www.nevadacheckup.nv.org/</p> <p>CHIP Phone: 1-877-543-7669</p>

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	NEW YORK – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/index.htm</p> <p>Phone: 573-751-6944</p>	<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: http://www.nc.gov</p> <p>Phone: 919-855-4100</p>
<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/</p> <p>Phone: 1-800-755-2604</p>	<p align="center">UTAH – Medicaid</p> <p>Website: http://health.utah.gov/medicaid/</p> <p>Phone: 1-866-435-7414</p>
<p align="center">OKLAHOMA – Medicaid</p> <p>Website: http://www.insureoklahoma.org</p> <p>Phone: 1-888-365-3742</p>	<p align="center">VERMONT – Medicaid</p> <p>Website: http://ovha.vermont.gov/</p> <p>Telephone: 1-800-250-8427</p>
<p align="center">OREGON – Medicaid and CHIP</p> <p>Medicaid & CHIP Website: http://www.oregonhealthykids.gov</p> <p>Medicaid & CHIP Phone: 1-877-314-5678</p>	<p align="center">VIRGINIA – Medicaid and CHIP</p> <p>Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm</p> <p>Medicaid Phone: 1-800-432-5924</p> <p>CHIP Website: http://www.famis.org/</p> <p>CHIP Phone: 1-866-873-2647</p>
<p align="center">PENNSYLVANIA – Medicaid</p> <p>Website: http://www.dpw.state.pa.us/partnersproviders/medicallasistance/doingbusiness/003670053.htm</p> <p>Phone: 1-800-644-7730</p>	<p align="center">WASHINGTON – Medicaid</p> <p>Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm</p> <p>Phone: 1-877-543-7669</p>
<p align="center">RHODE ISLAND – Medicaid</p> <p>Website: www.dhs.ri.gov</p> <p>Phone: 401-462-5300</p>	<p align="center">WEST VIRGINIA – Medicaid</p> <p>Website: http://www.wvrecovery.com/hipp.htm</p> <p>Phone: 304-342-1604</p>

SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since September 1, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
 Services
 Employee Benefits Security Administration
www.dol.gov/ebsa
 1-866-444-EBSA (3272)
valid.1-877-267-2323, Ext. 61565

U.S. Department of Health and Human
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
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