SOUTHEAST RESTAURANTS CORP.

WELFARE BENEFIT PLAN

Summary Plan Description

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SOUTHEAST RESTAURANTS CORP. WELFARE BENEFIT PLAN

Southeast Restaurants Corp. ("Employer") maintains the Southeast Restaurants Corp. Welfare Benefit Plan (the "Plan" and/or "Welfare Benefit Plan") for the exclusive benefit of, and to provide benefits to, its eligible employees, their legal Spouses, and their eligible dependents.

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

(1) General Information

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

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

(i) Southeast Restaurants Corp. Medical Plan ("Medical Plan");

(ii) Southeast Restaurants Corp. Dental Plan ("Dental Plan");

(iii) Southeast Restaurants Corp. Cancer Plan ("Cancer Plan");

(iv) Southeast Restaurants Corp. Vision Plan ("Vision Plan"); and/or

(v) Southeast Restaurants Corp. Hospital GAP Coverage Plan ("Hospital GAP Plan").

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

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

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

(i) Southeast Restaurants Corp. Voluntary Life Plan ("Voluntary Life Plan");

(ii) Southeast Restaurants Corp. Short Term Disability Plan ("Short Term Disability Plan"); and/or

(iii) Southeast Restaurants Corp. Long Term Disability Plan ("Long Term Disability Plan").

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

(d) *Employer Paid Benefit.* The Southeast Restaurants Corp. Group Life Plan ("Group Life Plan") is an Employer Paid Benefit available through this Plan.

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

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

Southeast Restaurants Corp.
1621 Executive Avenue
Myrtle Beach, SC 29577
(843) 448-2646
EIN: 58-2455787

(f) *Plan Administrator.* The Employer is the Plan Administrator. The Plan Administrator is responsible for providing you and other Participants with information regarding your rights and benefits under the Plan. The Plan Administrator must also file various reports, forms, and returns with the Department of Labor ("DOL") and the Internal Revenue Service ("IRS"). The Plan Administrator is vested with full discretionary authority to interpret, construe, and carry out the provisions of the Plan, and to render decisions on the administration of the Plan, including any factual and legal determinations as to whether an individual is eligible to participate in the Plan. The Plan Administrator has the authority to take such corrective action as it might consider to be appropriate in the event that an error in administering the Plan has taken place. For example, if there is a failure to deduct the correct amount of a Participant's election, the Plan Administrator has the authority to deduct an overpayment from future compensation payable to the Participant and/or otherwise recover the amount that is owed.

(g) *Service of Process.* The name of the person designated as the Agent for Service of Legal Process is Rick H. Seagroves, whose address is the same as the Employer's address.

(h) *Spouse.* When the word "Spouse" is used in this SPD, it means a person of the same or opposite sex to whom you are legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which

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

(i) *Plan Year.* The Plan Year is the calendar year.

(2) Participation in the Plan

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

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

(i) *Employee.* You must be an individual employed by the Employer and classified as a Corporate Office Administrator, Area Coach, Restaurant General Manager, Assistant Manager, Shift Manager, or Maintenance; however, notwithstanding this general rule, you are eligible for the Medical Plan (but no other benefits in this Plan) even if you are classified as Delivery Driver, Production, or Server, provided you meet the hours requirement set forth in paragraph (a)(ii) below and are not excluded under paragraph (a)(iii) below;

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

(iii) *Not Excluded from Participation.* You must not be excluded from participation. You are excluded from participation if you are (A) covered under a collective bargaining agreement; (B) classified on the Employer's payroll records as a "leased" employee; (C) classified as a Delivery Driver, Production, and Server (unless you were enrolled on December 31, 2013 and have remained continuously enrolled); however, you may be eligible to participate in the Medical Plan as set forth in paragraph (a)(i) above; or (D) for purposes of participating in this Plan (but not, unless otherwise provided, for purposes of participating on an after-tax basis in any underlying Benefit Package Option), an individual who is, with respect to the Employer, self-employed within the meaning of Section 401(c)(1) of the Code or is treated as a partner under Section 1372 of the Code.

(b) *Plan Entry Date.*

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

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

EXAMPLE #1: You begin working as a full-time employee on March 15. You complete sixty (60) days of employment with the Employer on May 14. You will automatically enter the Plan on the first day of the next month, which is June 1.

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

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

(ii) *All Disability Leave.* Whether treated as unpaid or paid (i.e., taxable or non-taxable compensation) – all disability leave shall be treated as "unpaid leave" for purposes of plan eligibility. However, nothing in this subsection shall preclude you, if you are on FMLA leave from maintaining eligibility during such FMLA leave.

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

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

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

(3) Pre-Tax Benefit Options – Participant Elections

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

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

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

(c) *Failure to make an Election.*

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

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

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

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

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

(A) A change in your marital status;

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

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

(D) A reduction in your hours such that you will no longer average at least thirty (30) hours per week, even though that reduction in hours does not affect your eligibility for benefits under a Group Health Plan. However, in order to make an election change on the basis of a reduction in hours that does not affect Group Health Plan eligibility, you (and any Spouse and/or dependents who are covered through you) must enroll in another group health plan that provides "minimum essential coverage" no later than the first (1st) day of the second (2nd) month following the month in which your coverage under the Group Health Plan was revoked;

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

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

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

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

(ii) *HIPAA Special Enrollment Rights.* Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), group health plans must provide a "special enrollment" period for certain individuals. These individuals include individuals who were eligible for coverage but who did not enroll due to other coverage and individuals who have become dependents through marriage, birth, or adoption.

These individuals also include individuals who become eligible for a state premium assistance subsidy under a group health plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP). Similarly, individuals who lose eligibility for Medicaid or SCHIP coverage have special enrollment rights in the Plan. If you exercise your "special enrollment" rights under HIPAA, you may make an Election change to pay the cost of covering the individuals you enrolled. Unlike with the other Election change events, you have 60 days to enroll an individual if the election change event is a HIPAA special enrollment right related to eligible for a state premium assistance subsidy or a loss of eligibility for Medicaid or SCHIP.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) *Effective Date of Elections.*

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

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

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

(4) After-Tax Benefit Options - Participant Elections

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

(5) Medical Plan

The Employer maintains a Medical Plan that pays benefits pursuant to the terms and conditions of a group contract, with Blue Cross Blue Shield of South Carolina ("BCBS"), P.O. Box 100300, Columbia, SC 29202-3300.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) Dental Plan

The Employer maintains a Dental Plan that pays benefits under an insurance contract with The Guardian Life Insurance Company of America ("Guardian"), 7 Hanover Square, New York, NY 10004.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) Group Life Plan

The Employer maintains a Group Life Plan (which includes accidental death and dismemberment) that pays benefits under an insurance contract with The Guardian Life Insurance Company of America ("Guardian"), 7 Hanover Square, New York, NY 10004.

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

(b) *Eligibility / Plan Entry Date.* The eligibility conditions and the Group Life Plan entry date are the same as those for the Plan, except that you must be enrolled in the Medical Plan to be eligible for this Group Life Plan.

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

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

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

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

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

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

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

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

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

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

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

(8) Voluntary Life Plan

The Employer maintains a Voluntary Life Plan that pays benefits under an insurance contract with The Guardian Life Insurance Company of America ("Guardian"), 7 Hanover Square, New York, NY 10004.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) Short Term Disability Plan

The Employer maintains a Short Term Disability Plan that pays benefits under an insurance contract with The Guardian Life Insurance Company of America ("Guardian"), 7 Hanover Square, New York, NY 10004.

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) The date the Employer terminates the Short Term Disability Plan.

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

(10) Long Term Disability Plan

The Employer maintains a Long Term Disability Plan that pays benefits under an insurance contract with The Guardian Life Insurance Company of America ("Guardian"), 7 Hanover Square, New York, NY 10004.

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

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

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

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

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

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

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

(g) *Claims Procedures.* In the event you have a claim for benefits under the Long Term Disability Plan, you should follow the procedures outlined in the materials prepared by Guardian as applicable. The Plan Administrator, upon your request, will assist

you in making these claims. Guardian has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.

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

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

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

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

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

(v) The date the Employer terminates the Long Term Disability Plan.

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

(11) Cancer Plan

The Employer maintains a Cancer Plan that pays benefits under an insurance contract with The Guardian Life Insurance Company of America ("Guardian"), 7 Hanover Square, New York, NY 10004.

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

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

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

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

(d) *Plan Benefits.* If you elect to participate in the Cancer Plan, you will be insured under a group contract issued by Guardian. This group contract provides you and/or your dependents with life insurance. Guardian has prepared materials which explain the

benefits of the group contract in detail. Guardian will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

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

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

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

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

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

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

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

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

(v) The date the Employer terminates the Cancer Plan.

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

(12) Vision Plan

The Employer maintains a Vision Plan that pays benefits under an insurance contract with The Guardian Life Insurance Company of America ("Guardian"), 7 Hanover Square, New York, NY 10004.

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

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

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

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

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

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

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

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

(h) *Claims Procedures.* In the event you have a claim for benefits under the Vision Plan, you should follow the procedures outlined in the materials prepared by Guardian as applicable. The Plan Administrator, upon your request, will assist you in making these

claims. Guardian has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.

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

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

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

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

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

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

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

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

(13) Hospital GAP Coverage Plan

The Employer maintains a Hospital GAP Plan that pays benefits under an insurance contract with American Fidelity Assurance ("American Fidelity"), P.O. Box 25523, Oklahoma City, OK 73125-0523.

(a) *Type of Plan.* The Hospital GAP Coverage Plan ("Hospital GAP Plan") is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

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

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

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

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

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

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

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

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

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

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

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

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

(v) The date the Employer terminates the Hospital GAP Plan.

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

(14) COBRA Coverage for Group Health Plans

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

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

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

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

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

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

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

(A) Your hours of employment are reduced; or

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

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

(A) Your Spouse dies;

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

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

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

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

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

(A) Your parent-employee dies;

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

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

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

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

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

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

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

(e) *COBRA Notice Procedures.* When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Employer of any of these three qualifying events. **For all other qualifying events, you must notify the Plan Administrator in writing within 60 days after the date on which the qualifying beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event and in accordance with these Notice Procedures. The Plan will not provide you with an Election form to begin or extend COBRA coverage if it does not receive proper notice from you regarding such qualifying events.**

Warning: If your notice is late or if you do not follow these Notice Procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable). If COBRA coverage should have been terminated but was not, due to a lack of notice from a qualified beneficiary, the Employer will immediately terminate coverage and require payment to the Plan of all benefits paid after what should have been the termination date.

(i) *Notices Must Be In Writing And Submitted On Plan Forms.* Any notice that you provide must be in writing and must be submitted on the Plan's required form. (You the may obtain copies of required forms from the Plan Administrator). Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

(ii) *How, When, And Where To Send Notices.* You must mail or hand-deliver your notice to the Plan Administrator, whose address is provided on the first page of this SPD.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the Plan Administrator individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described above in this Section of the SPD.)

(iii) *Information Required For All Notices.* Any notice you provide must include: (A) the name of the Plan; (B) the name and address of the employee who is (or was) covered under the Plan; (C) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (D) the qualifying event and the date it happened; and (E) the certification, signature, name, address, and telephone number of the person providing the notice.

(iv) *Additional Information Required For Notice of Divorce Or Legal Separation.* If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Plan Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

(v) *Additional Information Required For Notice Of Disability.* Any notice of disability must include: (A) the name and address of the disabled qualified beneficiary; (B) the date that the qualified beneficiary became disabled; (C) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (D) the date that the Social Security Administration made its determination; (E) a copy of the Social Security Administration's determination; and (F) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

(vi) *Additional Information Required For Notice Of Second Qualifying Event.* Any notice of a second qualifying event must include: (A) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (B) the second qualifying event and the date that it happened; and (C) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

(vii) *Who May Provide Notices.* The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice of the qualifying event, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

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

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

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

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

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

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

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

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

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

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

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

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

(i) *Extension of Maximum Coverage Period*. If the qualifying event that resulted in your COBRA election was the employee's termination of employment or reduction in hours, the 18-month maximum period may be extended if a qualified beneficiary who has elected COBRA coverage becomes disabled, if a "second qualifying event" occurs, or if the employee became entitled to Medicare in the 18-month period preceding his or her termination of employment or reduction of hours. (These extension opportunities do not apply to a period of COBRA coverage resulting from a covered employee's death, divorce or legal separation, or a dependent child's loss of eligibility.)

(i) *Disability Extension.* If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the

period of COBRA coverage that would be available without the disability extension (generally 18 months). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

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

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

These extensions are available only if you timely notify the Employer in writing of the Social Security Administration's determination of disability and the second qualifying event within the 60-day notice period and the entitlement to Medicare within 30-days of entitlement in accordance with the Plan's Notice Procedures found in Section (e) above.

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

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

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

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

(iv) The employer ceases to provide any group health plan for its employees;

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

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

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

(l) *First Payment.* All COBRA premiums must be paid by check or money order. If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for COBRA coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to Mangrove Employer Services, 1501 S. Church Ave., Tampa, FL 33629. You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise. **If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.**

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

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

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

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

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

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

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

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

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

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

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

(15) USERRA Continuation Rights

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

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

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

Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your Employer's group health plan when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

(16) Group Health Plan Claims Procedures

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

Claims made for benefits under the fully-insured Group Health Plans, and any appeals from the denial of such Claims, shall be processed in accordance with the claims procedures of the insurer. Unless otherwise stated in your applicable insurance policy, before filing any legal action against the Plan, the Employer, the Plan Administrator, or the Claims Administrator, you must first exhaust the administrative remedies summarized in your policy. This means, for example, that, if a claim is denied, you must appeal the denial following the procedures provided in your policy of insurance. If you do not exhaust your administrative remedies, you will not be allowed to file a civil action concerning a claim for benefits under the Plan. Unless otherwise stated in your applicable insurance policy, following the Plan's issuance of a final adverse benefit determination, you will have one hundred eighty (180) days to file a legal action against the Plan, the Employer, the Plan Administrator, or the Claims Administrator. Failure to meet this deadline will result in the forfeiture of any Claim that you may have.

(17) Miscellaneous

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

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

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

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

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

If your coverage ceases while you are on FMLA leave, you will be permitted to reenter the Plan immediately upon your return from FMLA leave on the same basis that you were participating in the Plan prior to your leave, or as otherwise required by the FMLA. If you fail to remit your premium payments within thirty (30) days after the premium payment is due, then the Employer – following any requisite notice mandated by FMLA regulations – may terminate your coverage retroactive to the date the unpaid premium payment was due.

(c) *Return of Premium.* If money is returned in any form by an insurance company that provided or is providing benefits under this Plan, including, but not limited to, a rebate of premiums previously paid or proceeds from demutualization, or rebates resulting from an insufficient "medical loss ratio" (MLR), the Plan Administrator shall have the discretion to apply such amounts to the payment of Plan expenses and/or the reduction of premiums, and/or benefit enhancements. The Plan Administrator shall further have the discretion to allocate such funds in any manner deemed appropriate.

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

(18) Participant's Rights Under ERISA

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

Receive Information About Your Plan and Benefits.

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. DOL and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, but only after first exhausting the Plan's internal claims procedures (i.e., exhausting your administrative remedies) within the time frame set forth in the Plan document. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. DOL, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

(19) Notice of Hospital Rights for Newborns and Mothers

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

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

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

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

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

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

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

(21) Right of Employer to Amend or Terminate

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

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APPENDIX A
SPECIAL ELIGIBILITY RULES UNDER LOOK-BACK MEASUREMENT METHOD

Although the Plan ordinarily requires that an Employee be *regularly scheduled to work at least 30 hours per week* in order to be eligible to participate in the Plan, certain part-time, variable hour, and seasonal workers may be eligible for coverage if they average at least 30 hours per week during the applicable Look-Back Measurement Period. These rules, which were established under regulations adopted pursuant to the Patient Protection and Affordable Care Act ("PPACA"), are extremely complicated and are set forth in detail in the Addendum 1 to the Plan. What follows is simply a general summary of how the Look-Back Measurement Method works. If you have additional questions, please contact the Plan Administrator.

Ongoing Employees

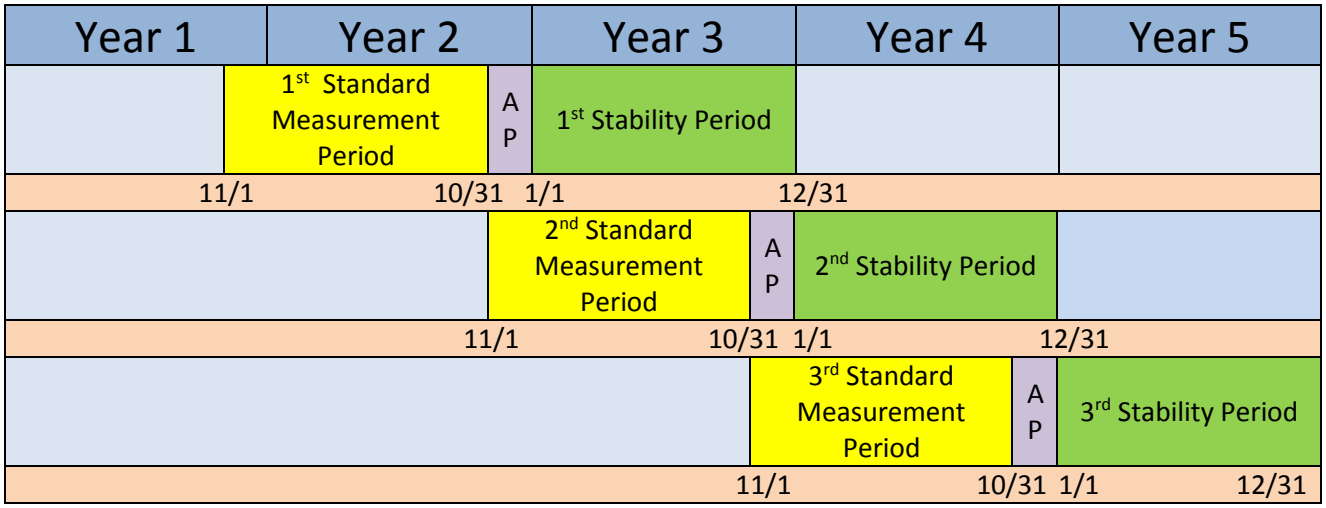
In general, for any Employee who is (i) not already regularly scheduled to work at least 30 hours per week and (ii) not categorically excluded from eligibility for the Plan regardless of hours worked, the Employer will add up the Employee's hours over a specified 12-month period of time (referred to as the "Standard Measurement Period") and determine if the Employee averaged at least 30 hours per week during that 12-month period. If the Employee *did* average at least 30 hours per week during the Standard Measurement Period, then he/she will be considered full-time (and thus will be offered coverage under the Plan) during the 12-month Stability Period that follows, and is associated with, that Standard Measurement Period. This is true regardless of how many hours the Employee actually works during that Stability Period.

If, on the other hand, the Employee *did not* average at least 30 hours per week during the Standard Measurement Period, then he/she will not be considered to be full-time (and thus will not be offered coverage in the Plan) during the 12-month Stability Period that follows the Standard Measurement Period. With some exceptions, this is true regardless of how many hours the Employee actually works during that Stability Period.

In addition, the Employer will be using an "Administrative Period" of approximately 30-60 days as a buffer between the Standard Measurement Period and Stability Period. This Administrative Period will be used by the Employer to count up the Employees' hours and to serve as an open enrollment period, if applicable.

The rules described above apply to all Employees who were employed by the Employer as of the first day of the Standard Measurement Period. These individuals are all referred to as "Ongoing Employees."

Although the Look-Back Measurement Method is complicated, the chart that appears at the top of the next page is designed to provide a visual illustration of what this Look-Back Measurement Method will look like for Ongoing Employees. As you can see from each of the three rows, the Standard Measurement Period and Stability Period will run for the same length of time and same time frame each year. So an individual may be deemed to be a "full-time" employee (and thus offered coverage) during one year's Stability Period (based on his/her hours in the preceding Standard Measurement Period), but then not be deemed a "full-time" employee (and thus not offered coverage) during some other year's Stability Period.



New Employees

A similar, but slightly different rule is used for *new employees*. A "New Employee" is any part-time, variable hour, or seasonal employee who was not employed by the Employer as of the first day of the Standard Measurement Period. A New Employee who, at the time of hire, is expected to average at least 30 hours per week will be treated as full-time immediately and offered coverage no later than the first day following the end of any applicable waiting period. But if the New Employee is a part-time, variable hour, or seasonal employee, the New Employee will *not* be eligible to enter the Plan unless he/she averages 30 hours per week during his/her Initial Measurement Period as described below. Instead, the New Employee's hours will be tracked using measurement and stability periods similar to those used for Ongoing Employees.

Basically, the Employer will start tracking the hours of the New Employee (who is either a part-time, variable hour, or seasonal employee) immediately – or almost immediately – after the New Employee begins employment. This tracking period is known as the "Initial Measurement Period." The Initial Measurement Period will be 12 months, and it will begin on approximately the first day of the first month after the New Employee's start date. If the New Employee *did* average at least 30 hours per week during this Initial Measurement Period, then he/she will be considered full-time (and thus will be offered coverage in the Plan) during the subsequent 12-month Initial Stability Period that follows, and is associated with, that Initial Measurement Period. This is true regardless of how many hours the Employee actually works during that Initial Stability Period.

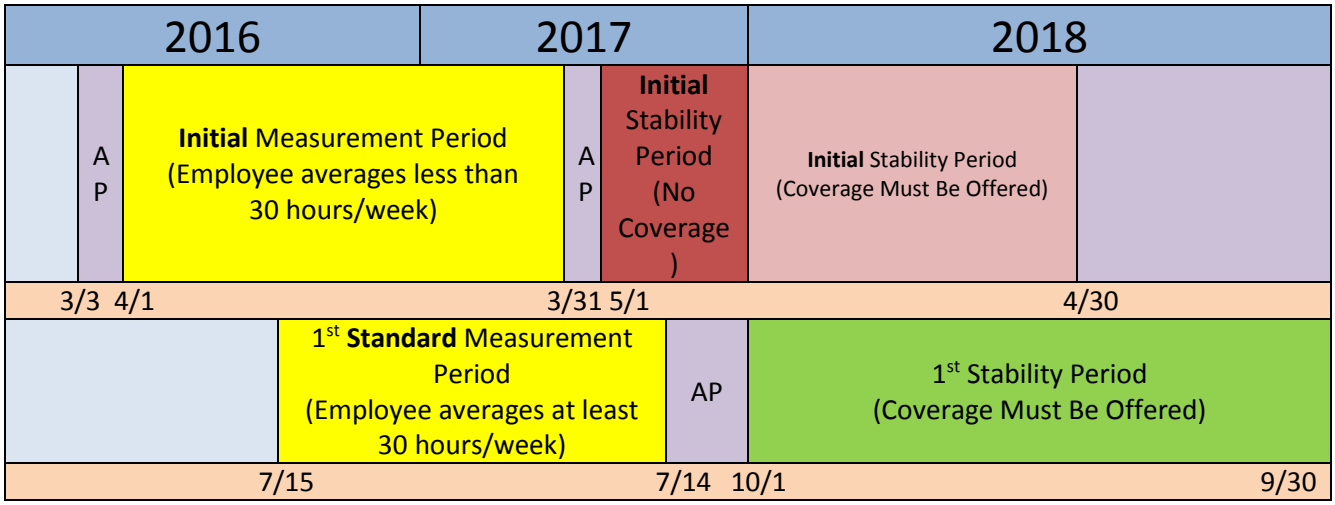
If, on the other hand, the New Employee *did not* average at least 30 hours per week during the Initial Measurement Period, then he/she will not be considered to be full-time (and thus will not be offered coverage in the Plan) during the subsequent 12-month Initial Stability Period that follows the Initial Measurement Period. With some exceptions, this is true regardless of how many hours the Employee actually works during that Initial Stability Period.

At the same time that a New Employee's hours are being tracked in the Initial Measurement Period, they are also being tracked in the Standard Measurement Period that is applicable to Ongoing Employees. In other words, once a New Employee has been employed for an entire Standard Measurement Period, the (now formerly) New Employee must also be tested for full-time status using the Standard Measurement Period applicable to all other Ongoing Employees. In other words, there will be dual, overlapping measurement periods. Moreover, during this transition from New Employee

to Ongoing Employee, the employee must be given the "best of either" treatment. That is, if one test causes the employee to be considered "full-time," while the other test does not, the "full-time" result must be followed.

To see what these rules look like in a visual format, consider the following example, which is detailed on the chart below. The plan is a calendar year plan. A New Employee is hired on March 3, 2016. During this New Employee's Initial Measurement Period (which runs from April 1, 2016 through March 31, 2017), he/she averages less than 30 hours per week. Accordingly, the Employer normally would be able to exclude the New Employee from coverage during the entire Initial Stability Period (which runs from May 1, 2017 through April 30, 2018). But in our example, assume that this employee does average at least 30 hours per week during the Standard Measurement Period that runs from November 1, 2016 through October 31, 2017. As a result, the employee must be offered coverage during the Stability Period that is associated with that Standard Measurement Period. That Stability Period, which overlaps with the plan year, runs from January 1, 2018 through December 31, 2018. So, even though the Initial Stability Period runs through April 30, 2018, the employee must be offered coverage no later than January 1, 2018, which is the beginning of the Stability Period that is associated with the Standard Measurement Period in which the employee averaged at least 30 hours per week.

The following chart provides a visual of the preceding example:



There are special rules that apply to employees who have employment status changes (e.g., from variable hour to full-time) during their Initial Measurement Period. There are also special rules that apply to employees who are terminated and later rehired. A description of those special rules, however, is simply not possible in this very brief summary.

We recognize that these eligibility rules are incredibly complex. There is no easy way to summarize all the intricate rules and exceptions in a brief 2-3 page summary. If you have questions, we encourage you to contact the Plan Administrator.