Excel Partners, Inc.
Preventive Services Minimum Essential Coverage (MEC) Employee Benefit Plan

Summary Plan Description

January 1, 2017

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Oferta de Asistencia en Espanol

Esta Resumen del Plan Descripción (Summary Plan Description) contiene un resumen en Inglés de sus derechos y beneficios del plan bajo Servicios de Prevención de Cobertura Mínima Esencial (MEC) Grupo Plan de Beneficios de Salud. Si tiene dificultad para entender cualquier parte de esta descripción resumida del plan, póngase en contacto con PAI, el administrador del plan al 1-866-798-0803 para obtener ayuda.

Introduction

Excel Partners, Inc. (the "Employer") maintains the Preventive Services Minimum Essential Coverage (MEC) Employee Benefit Plan ("the Plan") for the exclusive benefit of its eligible employees and their eligible dependents. Benefits under the Plan. The Employer has retained the services of Planned Administrators, Incorporated ("PAI"). PAI is a third party administrator responsible for processing preventive care claims and for providing third party administrative services in connection with the operation of the Plan.

Plan benefits, including information about eligibility, are summarized in the plan document, Member Payment Summary, and Provider & Facility Directory issued by PAI, copies of which are available from your Human Resources Department, free of charge. These documents together with this document constitute the Summary Plan Description required by the federal law known as the Employee Retirement Income and Security Act ("ERISA"). Capitalized terms not otherwise defined in this document are defined in the plan document. No overall life-time or annual maximum dollar amounts apply to this Plan. This Plan imposes reasonable Medical Management provisions and preventive care coverage limitations as outlined within the plan document

The Plan is not intended to, and does not, either directly or indirectly constitute any form of employment contract or other employment arrangement between you and Employer.

Specific Plan Information

Plan Name:	Preventive Services Minimum Essential Coverage (MEC) Employee Benefit Plan
Type of Plan:	Group Health Plan
Plan Year:	January 1 to December 31
Plan Number:	510
Employer / Plan Sponsor:	Excel Partners, Inc.

Sources of Plan Contributions

Plan Funding:	This Plan is self-funded. Plan contributions for employee and dependent coverage are made by the Employer and employee.
Type of Administration:	Third-party administration.
Plan Sponsor's Employer Identification Number:	06-1420255
Plan Administrator:	Excel Partners, Inc.

	1177 Summer Street Stamford, CT 06905
Services Provided by Third party Administrator (TPA):	PAI performs the following third party administrative services with respect to this benefit of the Plan: collection of premiums and payment of claims.
Named Fiduciary:	Excel Partners, Inc. 1177 Summer Street Stamford, CT 06905 203-978-6200
Agent for Service of	Excel Partners, Inc. 1177 Summer Street Stamford, CT 06905
Legal Process:	
Important Disclaimer:	This summary plan description (**SPD**) only summarizes the provisions of the formal Plan document and does not attempt to cover all of the details contained in the Plan document. The operation of the Plan and the benefits to which you (or your beneficiaries) may be entitled will be governed solely by the terms of the official Plan document. To the extent that any of the information contained in this SPD or any information you receive orally is inconsistent with the official Plan document, the provisions set forth in the Plan document will govern in all cases. If you wish to review the Plan document, please refer to the section of this SPD entitled "**YOUR RIGHTS**" which discusses your ability to review the Plan Document.

Eligibility

You can elect to have Medical Plan coverage for yourself, you and your Eligible Dependent or you can elect the Waived Coverage Option.

You may participate in the Plan if:

- You are an active, full-time salaried or hourly employee who works for the Employer (please review the plan document to determine if there are any other categories of active employees eligible to enroll for coverage);

- You properly enroll yourself (and, where applicable, Eligible Dependent(s)) within the timeframes outlined within the plan document; and
- You pay any required premium within the timeframe outlined within the plan document.

All employees actively at work are eligible to enroll after completion of the waiting period. The eligibility waiting period is 0 days.

An "Eligible Dependent" is defined as:

- All children from newborn to age 26, without regard to their student or marital status or whether they are your financial dependents, as required under the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA). No spouse of a married adult child or the children of a married adult child may be covered. Coverage terminates at the end of the month in which an eligible child's 26th birthday occurs, absent proof of handicap or disability. The term "children" includes your natural and adopted children (including legal guardianship) and/or stepchildren to age 26.

The Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children. Also eligible is any child covered under a Qualified Medical Child Support Order (QMCSO) as defined by applicable law and determined by your Employer under its QMCSO procedures, a copy of which is available from your Human Resources Department, free of charge.

If you and your spouse work for the Company, each of you can elect the coverage option and category you want. However, you cannot be covered as a spouse if you are covered as an employee. Only one parent may cover an eligible child.

Anyone found falsifying his/her child status will be subject to disciplinary action up to and including termination of benefits.

Enrollment

If eligible for coverage, you must complete an application form to enroll in the Plan and PAI (available from your Human Resources Department) or otherwise comply with your Employer's enrollment procedures. Coverage and any required contributions for coverage will stay in effect until December 31st of the Benefit year in which you start work, unless you have a qualified event status change that allows you to change your Medical Plan coverage category (please reference the plan document for more details regarding if there are other scenarios for you to implement changes to your coverage). Your elections will apply to you, a spouse and any eligible children you enroll in your coverage.

ID Cards

You will be issued an ID Card after you enroll with PAI. Please carry your Card with you and present it each time you receive care.

If you lose your ID Card, you can request a new one by calling PAI at 1-866-798-0803.

Annual Open Enrollment

Annual open enrollment takes place each year (please reference the plan document for details of when to enroll and your coverage start date). Elections made during annual open enrollment will be in effect for the next benefit year. This is the Plan coverage period. The coverage categories for the Plan are: employee only or employee plus eligible dependent(s). You may also choose the "waived coverage" option. You will not be able to change your coverage until the next annual open enrollment, unless you have a qualified event status change that allows you to change your medical coverage.

Special Situations, Extension of Coverage

Certain IRS-defined changes in status permit you to make benefit changes during the year that normally can only be made during the annual Open Enrollment period. If you experience an IRS-defined change in status, you have 30 days from the IRS-defined change in status date to make any eligible changes. Change(s) must be consistent with the IRS-defined change in status.

For example, you may be allowed to make changes to your benefits if you:

- Get married or register a domestic partner
- Get divorced
- Have or adopt a child
- Experience a death
- Have a dependent who loses or gains eligibility
- Change in employment status—that is, you or your spouse/domestic partner begin or end employment, an unpaid leave of absence, or family medical leave
- Experience a significant change in medical coverage or cost for you or your spouse/domestic partner

When Coverage Begins and Ends

Coverage Start Dates

If employed continuously during the above referenced waiting period, coverage will commence:

- For Directly Paid or Employer Collected Monthly Premiums: The first day of the month.
- For Payroll Deduction Premiums: The first day of the following pay-period for which a payroll deduction is taken.

Coverage End Dates

Coverage will terminate if your employment with the Employer terminates, if your hours drop below the required eligibility threshold, or you no longer meet the eligibility requirements. Coverage may also terminate

if your employer cancels the benefit plan, you fail to pay your share of the premium, or if you submit false claims, etc. (See the Plan document for more information.) Coverage for dependents stops when your coverage stops. Their coverage will also stop for other reasons specified in the Plan documents.

Plan Amendment, Modification, and Termination.

The Plan Sponsor intends to continue the Plan indefinitely, but reserves the right to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason, by action of the Plan Sponsor in its sole and absolute discretion. However, no amendment, modification or termination may deprive you of any benefit to which you have become entitled, except that an amendment to comply with the requirements of the Internal Revenue Code or other federal or state law may be made at any time with retroactive effect. Plan benefits will typically change from year-to-year and you should examine the SPD provided to you each year to determine the benefits of the Plan.

Circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture, or suspension of any benefits are described in the separate Plan documents.

Family and Medical Leave Act (FMLA)

If the Family Medical Leave Act (FLMA) applies to your Employer and you qualify for an approved family or medical leave of absence (as defined in the FMLA), eligibility may continue for the duration of the leave if required contributions are paid toward the cost of the coverage. Your Employer has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 31days of the due date established by your Employer will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, your Employer has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA.

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence, coverage for you and your eligible dependents will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible under the plan. Any waiting period for pre-existing conditions or other waiting periods will not apply.

If you do not return to work at the end of an FMLA leave, you may be entitled to elect COBRA Continuation Coverage, even if you were not covered under the Plan during the leave. Coverage continued under this provision is in addition to coverage described below under the section entitled "Continuation Coverage (COBRA)."

The Plan intends to comply with all existing FMLA regulations. If for some reason the information presented differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

Summary of Plan Benefits

The Plan provides eligible employees and their eligible dependents with health and welfare benefits through an employer sponsored health and welfare benefit plan.

The Plan provides a self insured health and welfare benefits plan in accordance with the applicable requirements of federal laws, such as Employee Retirement Income Security Act (ERISA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability Accountability Act (HIPAA), Newborns' and and Mental Health Parity Act (MHPA).

Prescription Drug Coverage

No prescription drugs are covered, except as specifically outlined within the Schedule of Benefits.

Generally

- **Services that are not Preventive Services as defined by the Patient Protection and Affordable Care Act ("PPACA") will not be covered by the Plan.** That means things such as emergency medical care will **not** be covered by the Plan.

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What is Covered?

The following is a brief summary of the medical and prescription drug coverage. For more detailed information, refer to the Plan documents or contact PAI. **Services that are not Preventive Services as defined by the Patient Protection and Affordable Care Act ("PPACA") will not be covered by the Plan.**

Coinsurance:	PPO:	Non-PPO:
Coinsurance Amounts:	The below listings of Preventive Services are paid at 100% if performed by participating PPO Providers. Participant pays 0%.	The below listings of Preventive Services are subject to usual and customary fee limitations and paid at 40% if performed by a non-participating PPO Provider. Participant pays 60% unlimited; with no out of pocket maximum applicable.

Adult Covered Wellness and Preventive Benefit List		
The Adult Covered Wellness and Preventive Benefits, limited to the following list of services, are covered as follows:		
PPO:		**Non-PPO:**
Plan Pays 100% of Covered Preventive Services		**Plan Pays 40% of Covered Preventive Services**
Annual Wellness Exam	An adult annual wellness visit with a primary care physician	
Abdominal Aortic Aneurysm	One-time screening, referral during the course of a preventive physical examination, for abdominal aortic aneurysm by ultrasound in men ages 65-74 years who have ever smoked.	
Alcohol Misuse	Annual Screening and four (4) brief behavioral counseling intervention sessions per year within primary care setting to reduce alcohol misuse	
Aspirin for the Prevention of Cardiovascular Disease	For men age 45-79 years and women age 55-79 years, when prescribed by a physician and when benefits for prevention of cardiovascular disease outweigh potential harms	
Blood Pressure Screening	Annual blood pressure screening for adults as a standard component of the Annual Adult Wellness exam	
Cholesterol Screening for Lipid Disorders	One (1) Screening every five (5) years for asymptomatic adult men age 35 years and older and for adult women age 45 years and older	
Colorectal Cancer Screening	One (1) Screening every five (5) years for adults ages 50to 75 years (thru 74 years)	
Depression Screening	Screening for depression	
Screening for Diabetes	Two (2) screenings annually for adults with high blood pressure	
Healthy Diet Counseling	Healthy diet counseling for adults at higher risk for chronic disease, including three (3) hours annually of one-on-one intensive behavioral dietary counseling	
HIV Screening	Annual HIV screening for adults. Screening can be performed up to three (3) times annually for anyone pregnant or at increased risk	
Immunizations	Adult Immunizations. Details provided within the Preventive Service Benefits section of this document	
Obesity Screening and Counseling	Screening and Counseling for all adults	
Sexually Transmitted Infection (STI)	Prevention Counseling for adults at higher risk	
Tobacco Use Screen & Cessation Intervention	Screening for adults and two (2) attempts (up to 8 counseling sessions) per year of cessation interventions for tobacco users	
Syphilis Screening	One (1) annual screening for all adults at higher risk	
Fall Prevention, Older Adults	Vitamin D supplementation, exercise and physical therapy services, adults 65 years and older	
Hepatitis C Screening	One (1) time screening for HCV infection to adults at high risk and born between 1945 and 1965.	
Skin Cancer Prevention	Young adults to age 24 years with fair skin counseling about reducing their risk for skin cancer.	

Women's Covered Wellness and Preventive Benefit List	
The Women's Covered Wellness and Preventive Benefits, limited to the following list of services, are covered as follows:	
PPO:	**Non-PPO:**
Plan Pays 100% of Covered Preventive Services	**Plan Pays 40% of Covered Preventive Services**
Detailed List of Women's Covered Wellness and Preventive Benefits:	
Anemia Screening	Screening on a routine basis for pregnant women
Bacteriuria	One screening per pregnancy, with urine culture for urinary tract or other infection for all pregnant women at 12-16 weeks' gestation or at the first prenatal visit, if later
BRCA Risk Assessment, Genetic Counseling and Testing	Counseling about genetic testing for asymptomatic women, at higher risk
Breast Cancer Screening	Screenings include clinical exam and mammography every 1-2 years for women over 40
Breast Cancer Chemoprevention	Counseling for women at higher risk
Breastfeeding Primary Care Interventions	Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies for pregnant and nursing women
Cervical Cancer Screening	Cervical cancer screening for women: -PAP smear annually for women twenty one to sixty five years of age (21to 65, through 64); and/or -Co-test (cytology PAP smear/HPV testing) every five (5) years for women thirty to sixty five (30to 65, through 64) years of age.
Chlamydia Infection Screening	One (1) annual screening for women
Contraceptive Services	Contraceptive methods approved by the Food and Drug Administration (FDA) including oral and device birth control, sterilization procedures, patient education and counseling. Excludes abortifacient drugs and male sterilization
Intimate Partner Violence and Elderly Abuse Screening	Screening for all women and counseling for women who screen positive
Folic Acid Supplementation	Supplements to prevent birth defects for women who may become pregnant
Gestational Diabetes Screening	Screening for gestational diabetes mellitus for women on or after 24 weeks pregnant and those at high risk of developing gestational diabetes
Gonorrhea Screening	Screening for all women at higher risk
Hepatitis B Screening	Screening for pregnant women at their first prenatal visit
Human Immunodeficiency Virus (HIV) Screening	Screening and counseling for sexually active women
Human Papillomavirus (HPV) DNA Test	High risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
Osteoporosis Screening	One (1) screening every two (2) years for women sixty (60) years of age and older at high risk
Rh Incompatibility Screening	Screening for all pregnant women and follow-up testing for women at higher risk
Tobacco Use Screening and Interventions	Screening and interventions for all women and expanded counseling for pregnant tobacco users
Sexually Transmitted Infections (STI) Counseling	Counseling for sexually active women
Syphilis Screening	Screening for all pregnant women or other women at increased risk
Well-woman Visits	One (1) annual well- woman visit to obtain recommended preventive services for women under 65. Additional visits are covered to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors

Children's Covered Wellness and Preventive Benefit List	
The Children's Covered Wellness and Preventive Benefits , limited to the following list of services, are covered as follows:	
PPO:	**Non-PPO:**
Plan Pays 100% of Covered Preventive Services	**Plan Pays 40% of Covered Preventive Services**
Detailed List of Children's Covered Wellness and Preventive Benefits:	
Alcohol and Drug Use Screening	Annual Assessment for adolescents age 11 years and older
Autism Screening	Limited to two (2) Screenings for children at 18 and 24 months
Psychosocial/Behavioral Assessment	Five (5) Assessments including screening and surveillance for all children during well child visits up to age twenty one (21) years
Blood Pressure Screening	Screening for children during well child visits
Cervical Dysplasia Screening	Screening annually for sexually active females
Congenital Hypothyroidism Screening	Screening for newborns
Depression Screening	Screening for adolescents twelve (12) years and older
Developmental Screening	Screening for children under age 3 and surveillance throughout childhood.
Dyslipidemia Screening	Screening for children at higher risk of lipid disorders: Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years and 15 to 17 years.
Fluoride Chemoprevention Supplement	Supplements for Children without fluoride in their water source
Gonorrhea Prevention Medication	Preventive medication for the eyes of all newborns
Hearing Screening	Screening for all newborns and annually for age 4 years, 5 years, 6 years, 8 years and 8 years
Height, Weight and Body Mass Index Measurements	Measurements for children: Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years and 15 to 17 years
Hematocrit or Hemoglobin Screening	Screening for children
Hemoglobinopathies Screening	Sickle Cell screening for newborns
HIV Screening	Screening for adolescents at higher risk
Immunizations	Vaccines for children from birth to age 18. Recommended ages and recommended populations vary. Diphtheria, Tetanus, Pertussis Haemophilus Influenzae Type B Hepatitis A / Hepatitis B Human Papillomavirus / Inactivated Poliovirus Influenza (Flu Shot) / Measles, Mumps, Rubella Meningococcal / Pneumococcal Rotavirus / Varicella
Iron Supplement	Supplements for children ages 6 to 12 months at risk for anemia when prescribed by a physician
Lead Screening	Screening for children at risk for exposure
Medical History	For all children throughout development: Ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
Obesity Screening and Counseling	Screening and Counseling age six (6) years and older
Oral Health Assessment	Risk assessment for young children: Ages 0 to 11 months, 1 to 4 years, 5 to 10 years
Phenylketonuria (PKU) Screening	Screening for this genetic disorder in newborns
Sexually Transmitted Infection (STI) Screening and Counseling	Prevention counseling and screening for adolescents at higher risk
Tuberculin Testing	Tuberculosis testing for children
Vision Screening	Screening for all children
Skin Cancer Prevention	Children and adolescents ages 10 to 18 years with fair skin counseling about reducing their risk for skin cancer.

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them.

The Plan Administrator establishes this Group Health Plan and the applicable Benefits, rights and privileges that pertain to participating employees ("Employees") as well as eligible Dependents of such Employees. The benefits are provided through a fund established by the Plan Sponsor ("Plan of Benefits").

Third Party Administrative Services Only

PAI provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Group Health Plan is a self -funded health P
assumes all financial risk and obligation with respect to claims.

Clerical Errors

Clerical errors by PAI or the Plan Sponsor will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

Claims and Appeals

PAI is responsible for evaluating all benefit claims under the Plan. PAI will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. If your claim is denied, you may appeal to PAI for a review of the denied claim and PAI will decide your appeal in accordance with its reasonable procedures, as required by ERISA. See the plan document for complete details regarding PAI's claims and appeals procedures.

CLAIMS FILING PROCEDURES

A health plan benefits claim is a request for a Plan benefit or benefits, made by a covered employee/dependent or their representative that complies with the Plan's reasonable procedure for making benefit claims. A claim for benefits includes a request for a coverage determination, for pre-authorization or approval of a Plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

1. Written notice of receipt of services on which a claim is based must be furnished to PAI, at its address listed in this booklet, within twenty (20) days of the beginning of services, or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Participant can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, PAI will furnish or cause a claim form to be furnished to you, the Participant. If the claim form is not furnished within fifteen (15) days after PAI receives the notice, the Participant will be deemed to have complied with the requirements of this Plan of Benefits as to proof of loss. The Participant must submit written proof

covering the character and extent of the services within this Plan of Benefits' time fixed for filing proof of loss.

2. For Benefits not provided by a Participating Provider, the Participant is responsible for filing claims with PAI. When filing the claims, the Participant will need the following:
   A. A claim form for each Participant. Participants can get claim forms from PAI at the telephone number indicated on the Identification Card or via the website, www.paisc.com.
   B. Itemized bills from the Provider(s). These bills should contain all the following:
      i. Provider's name and address;
      ii. Participant's name, date of birth and Identification Card number; and
      iii. Date the service took place, description of illness or injury, the diagnosis, as well as a description and cost of each service.
   C. Participants must complete each claim form and attach the itemized bill(s) to it. If a Participant has other insurance that already paid on the claim(s), the Participant also should attach a copy of the other Plan's Explanation of Benefits notice.
   D. Participants should make copies of all claim forms and itemized bills for the Participant's records, since they will not be returned. Claims should be mailed to PAI's address listed on the claim form.

3. PAI must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Participant shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than twelve (12) months following the date services were received.

4. Receipt of a claim by PAI will be deemed written proof of loss and will serve as written authorization from the Participant to PAI to obtain any medical or financial records and documents useful to the Plan of Benefits. The Plan of Benefits, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to PAI in support of a Participant's claim will be deemed to be acting as the agent of the Participant. If the Participant desires to appoint an Authorized Representative in connection with such Participant's claims, the Participant should contact PAI for an Authorized Representative form.

5. Claims for preventive services are processed as Post-Service Claims. The Group Health Plan will make a determination of your claim within the following time period:
   A. Post-Service Claim
      i. A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.
      ii. An extension of fifteen (15) days may be necessary if PAI (on behalf of the Group Health Plan) determines that, for reasons beyond the control of PAI, an extension is necessary. If an extension is necessary, PAI will notify the Participant within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date PAI expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Participant will have at least forty-five (45) days to provide the required information. If PAI does not receive the required information within the forty-five (45) day time period, the claim will be denied. PAI will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If PAI receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first-level appeal. Reference the Claims Filing and Appeal Procedures section, B. Appeal Procedures for an Adverse Benefit Determination, for details regarding the appeals process.

6. Notice of Determination
   A. If the Participant's claim is filed properly, and the claim is in part or wholly denied, the Participant will receive notice of an Adverse Benefit Determination. This notice will:
      i. State the specific reason(s) for the Adverse Benefit Determination;
      ii. Reference the specific Plan of Benefits provisions on which the determination is based;
      iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;
      iv. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;
      v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,
      vi. If the reason for denial is based on a lack of Medical Necessity, or Experimental or Investigational services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).
   B. The Participant will also receive a notice if the claim is approved.

APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

1. The Participant has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:
   A. An appeal must be in writing; and,
   B. An appeal must be sent (via U.S. mail or FAX) at the address or FAX number below:
      Planned Administrators, Inc.
      Attention: Appeals
      P.O. Box 6927
      Columbia, SC 29260
      FAX 1-803-870-8012
   C. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,
   D. An appeal must include the Participant's name, address, identification number and any other information, documentation or materials that support the Participant's appeal.

2. The Participant may submit written comments, documents, or other information in support of the appeal, and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. If the appealed claim involves an exercise of medical judgment, the Plan Sponsor will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

4. The final decision on the appeal will be made within the time period specified below:
   a. Post-Service Claim
      PAI (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal.

5. Notice of Final Internal Appeals Determination
   A. If a Participant's appeal is denied in whole or in part, the Participant will receive notice of an Adverse Benefit Determination.

i. State specific reason(s) for the Adverse Benefit Determination;
ii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;
iii. State that the Participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;
iv. Disclose and provide any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination
v. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, or Experimental or Investigational services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
vi. Include a statement regarding the Participant's right to request an external review; and
vii. Include a statement regarding the Participant's right to bring an action under section 502(a) of ERISA.

B. The Participant will also receive a notice if the claim on appeal is approved.

6. The Plan Sponsor may retain PAI to assist the Plan Sponsor in making the determination on appeal. Regardless of its assistance, PAI is acting only in an advisory capacity and is not acting in a fiduciary capacity. The Plan Sponsor at all times retains the right to make the final determination.

EXTERNAL REVIEW PROCEDURES

The Plan gives you the opportunity to seek review of certain claim denials by an independent external review organization. If you disagree with PAI's or the Plan's final determination on internal appeal, you can seek review within four months of the decision. Your claim is eligible for external review if either:

- PAI, the Plan, or its designee does not strictly adhere to all claim determination and appeal requirements under federal law (other than minor violations); or

- You have exhausted the standard levels of appeal and your appeal relates to (1) medical judgment or (2) a rescission, which is a retroactive cancellation or discontinuance of coverage.

Claims based on (1) legal or contractual disputes or (2) issues regarding your eligibility, are not eligible for external review.

Plan Administration and Interpretation

The Plan Administrator has the exclusive right, power and authority, in its sole and absolute discretion, to administer and interpret the Plan and other Plan documents. The Plan Administrator has all powers reasonably necessary to carry out its responsibilities under the Plan including (but not limited to) the sole and absolute discretionary authority to:

- Administer the Plan according to its terms and to interpret Plan policies and procedures;
- Resolve and clarify inconsistencies, ambiguities and omissions in the Plan document and among and between the Plan document and other related documents;
- Take all actions and make all decisions regarding questions of coverage, eligibility and entitlement to benefits, and benefit amounts; and
- Process and approve or deny all claims for benefits.

The decision of the Plan Administrator on any disputes arising under the Plan, including (but not limited to) questions of construction, interpretation and administration shall be final, conclusive and binding on all persons having an interest in or under the Plan. Any determination made by the Plan Administrator shall be given deference in the event the determination is subject to judicial review and shall be overturned by a court of law only if it is arbitrary and capricious.

Other Materials

The Member Payment Summary, and the Provider & Facility Directory issued by PAI are part of the Summary Plan Description. Please refer to these materials for other important provisions regarding your participation in the Plan.

The Plan Administrator will furnish the following documentation without charge as a separate document:

- Upon request, a description of the Plan's procedures for Qualified Medical Child Support Orders;
- Upon request, provider lists/directories for the applicable health provider networks utilized by the Plan; and
- Automatically, claims procedures for medical and disability benefits to the extent such procedures change prior to the next revision of this SPD.

Your Rights Under The Employee Retirement Income Security Act (ERISA)

As a participant in the Plan (which is a type of employee welfare plan called a "group health plan") you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all group health 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, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the 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 Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

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 Plan. The people who operate the 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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 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 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. If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are

successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. However, no legal action may be commenced or maintained against the Plan prior to your exhaustion of the Plan's claims procedures.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

Restriction on Venue

Any claim that you may have relating to or arising under the Plan may only be brought in the US District Court for the Spartanburg Division of South Carolina. No other court is a proper venue for your claim. The US District Court for South Carolina will have personal jurisdiction over you and any other participant or beneficiary named in the action.

Required Notices

COBRA Continuation Coverage

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." The following are qualifying events (please also refer to the plan document for additional information regarding COBRA coverage):

- Termination of your employment for any reason except gross misconduct. Coverage may continue for you and/or your eligible dependents;
- A reduction in your hours. Coverage may continue for you and/or your eligible dependents;
- Your death. Coverage may continue for your eligible dependents;
- Your divorce or legal separation. Coverage may continue for your eligible dependents;
- Your becoming entitled to Medicare. Coverage may continue for your eligible dependents; and
- Your covered dependent child's ceasing to be a dependent child under the Plan. Coverage may continue for that dependent.

Note: To choose this continuation coverage, an individual must be covered under the Plan on the day before the qualifying event. In addition, your newborn child or child placed for adoption with you during a period of continuation coverage will remain eligible for continuation coverage for the remaining period of coverage even if you and/or your spouse terminate continuation coverage following the child's birth or placement for adoption.

Notification Requirements

Under the law, you or the applicable dependent has the responsibility to inform the Plan Administrator, in writing, within 60 days of a divorce or legal separation or of a child losing dependent status under the Plan. Failure to provide this written notification within 60 days will result in the loss of continuation coverage rights.

Your Employer has the responsibility to notify the Plan Administrator of your death, termination of employment, reduction in hours, or entitlement to Medicare within 30 days of the qualifying event.

Subject to the Plan Administrator being informed in a timely manner of the qualifying events described in the above paragraphs, the Plan will promptly notify you and other qualifying individual(s) of their continuation coverage rights. You and any applicable dependents must elect continuation coverage within 60 days after Plan coverage would otherwise end, or, if later, within 60 days of the notice of continuation coverage rights. Failure to elect continuation coverage within this 60-day period will result in loss of continuation coverage rights.

Trade Act of 2002

If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, they you will be provided with an additional 60 day enrollment period, with continuation coverage beginning on the date of such TAA approval

Notice of Unavailability of Continuation Coverage

If the Plan Administrator receives a notice of a qualifying event from you or your dependent and determines that the individual (you or your dependent) is not entitled to continuation coverage, the Plan Administrator will provide to the individual an explanation as to why the individual is not entitled to continuation coverage. This notice will be provided within the same time frame that the Plan Administrator would have provided the notice of right to elect continuation coverage.

Maximum Period of Continuation Coverage

The maximum period of continuation coverage is 36 months from the date of the qualifying event, unless the qualifying event is your termination of employment or reduction in hours. In that case, the maximum period of continuation coverage is generally 18 months from the date of the qualifying event. For more information regarding continuation of coverage, please access the plan document.

However, if a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-disabled eligible dependents who are also entitled to continuation coverage may be extended to 29 months provided the qualifying individual or dependent, if applicable, notifies the Plan Administrator in writing within the 18-month continuation coverage period and within 60 days after receiving notification of determination of disability.

If a second qualifying event occurs (for example, your death or divorce) during the 18- or 29-month coverage period resulting from your termination of employment or reduction in hours, the maximum period of coverage will be computed from the date of the first qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

A special rule applies if the qualifying individual is your spouse or dependent child whose qualifying event was the termination or reduction in hours of your employment and you became entitled to Medicare within 18 months before such qualifying event. In that case, the qualifying individual's maximum period of continuation coverage is the longer of 36 months from the date of your Medicare entitlement or their otherwise applicable maximum period of coverage.

Cost of Continuation Coverage

The cost of continuation coverage is determined by the Employer and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102 percent of the Plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150 percent of the Plan's cost of coverage.

Premium payments for continuation coverage for you or your eligible dependent's "initial premium month(s)" are due by the 45th day after electing continuation coverage. The "initial premium month(s)" are any month that ends on or before the 45th day after you or the qualifying individual elects continuation coverage. All other premiums are due on the first of the month for which coverage is sought, subject to a 30-day grace period. Premium rates are established by your Employer and may change when necessary due to Plan modifications. The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

When Continuation Coverage Ends

Continuation of coverage ends on the earliest of:

1. The date the maximum continuation coverage period expires;
2. The date your Employer no longer offers a group health plan to any of its employees;
3. The first day for which timely payment is not made to the Plan;

4. The date the qualifying individual becomes covered by another group health plan. However, if the new plan contains an exclusion or limitation for a pre-existing condition of the qualifying individual, continuation coverage will end as of the date the exclusion or limitation no longer applies;
5. The date the qualifying individual becomes entitled to coverage under Medicare; and
6. The first day of the month that begins more than 30 days after the qualifying individual who was entitled to a 29-month maximum continuation period is subject to a final determination under the Social Security Act that he or she is no longer disabled.

Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a pre-existing condition exclusion. In order to be eligible to apply for such coverage from a carrier after ceasing participation in the Plan, you or your eligible dependents must elect continuation coverage under the Plan, continue through the maximum continuation coverage period (18, 29, or 36 months, as applicable), and then apply for coverage with the individual insurance carrier before a 63 day lapse in coverage. For more information about your right to such individual insurance coverage, contact an independent insurance agent or your state insurance commissioner.

Notice of Termination Before Maximum Period of COBRA Coverage Expires

If continuation coverage for a qualifying individual terminates before the expiration of the maximum period of continuation coverage, the Plan Administrator will provide notice to the individual of the reason that the continuation coverage terminated, and the date of termination. The notice will be provided as soon as practicable following the Plan Administrator's determination regarding termination of the continuation coverage.

The Plan intends to comply with all applicable law regarding continuation (COBRA) coverage. If for some reason the information presented in this Plan differs from actual COBRA requirements, the Plan reserves the right to administer COBRA in accordance with such actual COBRA requirements.

Genetic Information Nondiscrimination Act of 2008 (GINA)

Under GINA, an insurance provider or your employer may not discriminate against you on the basis of genetic information, including by adjusting premiums and contribution amounts.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**

Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential information. As an employee welfare benefit plan under ERISA, the Plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, Plan administration or as required or permitted by law. A description of the uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the plan's Notice of Privacy Practices, which is furnished to all Plan participants and can also be accessed on the Plan's internet site at: http://www.paisc.com/members.aspx. The Plan also will comply with applicable requirements under the HITECH Act, which include providing notice to affected individuals if the Plan or its business associates discover a breach involving unsecured protected health information.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) establishes requirements that employers must meet for certain employees who are involved in the uniformed services
As used in this provision, "Uniformed Services" means:

- The Armed Forces;
- The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (pursuant to orders issued under federal law);
- The commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or national emergency.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty training;
- Inactive duty training;
- Full-time National Guard duty,
- A period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties;
- A period for which you are absent from your job for the purpose of performing certain funereal honors duty; and
- Certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

If you were covered under this Plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

- You fail to make a premium payment within the required time;
- You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or
- You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described below under the section entitled "COBRA Continuation Coverage."

If your coverage under the Plan terminated because of your Service in the Uniformed Services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

When coverage under this Plan is reinstated, all of the Plan's provisions and limitations will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. (For complete information regarding your rights under USERRA, contact your Employer.)

The Plan intends to comply with all existing regulations of USERRA. If for some reason the information presented in the Plan differs from the actual regulations of USERRA, the Plan reserves the right to administer the plan in accordance with such actual regulations.