
SUMMARY PLAN DESCRIPTION
of the
FLEXIBLE SPENDING PLAN
for
EMPLOYEES OF
FRANTZ MANUFACTURING COMPANY

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PLAN ADMINISTRATION

Plan Sponsor/Plan Administrator: Frantz Manufacturing Company

Address: 603 1st Avenue
Sterling, IL 61081

Telephone Number: (815) 625-7063

Employer I.D. Number: 36-1102120

Type of Plan: Cafeteria Plan, adopted pursuant to Section 125
of the Internal Revenue Code

Plan Number: 503

Contract Administrator: Progressive Benefit Services, Inc.

Address: 2214 North University Street
Suite 310
Peoria, IL 61604

Telephone Number: (309) 687-3502

Agent for Service of Legal
Process: David N. Schellenberg, Esq.

Address: Elias, Meginnes, Riffle & Seghetti, P.C.
416 Main Street, Suite 1400
Peoria, Illinois 61602

Telephone Number: (309) 637-6000

NOTE: Proper service can also be obtained by serving
the Employer/Plan Administrator

Effective Date of Plan: January 1, 2005

Ending Date of Plan's
Fiscal Year: December 31

I. INTRODUCTION

The purpose of the Plan is to enable each Participant to establish a Flexible Spending Account. Through such an account, an employee of Frantz Manufacturing Company can purchase certain approved employee benefits with pre-tax dollars. Without a Flexible Spending Account, the same benefits could only be purchased on an after-tax basis. The cost of the benefits purchased through the Flexible Spending Account is thereby reduced by the amount of the taxes saved by the employee on the contributions to the Flexible Spending Account. Stated another way, since the dollars contributed to the Flexible Spending Account are unreduced by taxes, those dollars can purchase more benefits than the same dollars applied on an after-tax basis. Each employee decides how much, if any, that employee wants to contribute to the Flexible Spending Account.

This booklet contains a convenient summary of the Plan in ordinary language. It does not give full details nor does it cover all aspects of the Plan. The actual terms of the Plan are stated in the formal plan document which is the legal document governing all rights and benefits under the Plan.

You should read this booklet carefully to obtain a clear understanding of the benefits to which you may be entitled, as well as the circumstances that affect the availability of those benefits. Where a specific interpretation of the Plan is involved, or a provision of the Plan is related to a specific situation, you should consult the Plan Administrator. If there is any conflict between this Summary Plan Description booklet and the formal Plan, the terms and conditions of the Plan will govern. The Plan is available for inspection by participants and their beneficiaries upon request to the Plan Administrator.

II. ELIGIBILITY AND PLAN PARTICIPATION

1. Eligibility Requirements

You will be eligible to participate in the Plan when you satisfy the eligibility requirements for benefits under the terms of the Frantz Manufacturing Company Health Plan. Eligibility for participation in the Flexible Spending Plan does not automatically qualify you for participation in the Health Plan.

2. Participation

Your participation will begin on the first Participation Date which occurs on or after you have met the eligibility requirements. If you are absent from work due to (i) an FMLA Leave or (ii) a period of duty in the Uniformed Services you have the right to continue to participate in the Plan with respect to any benefit offered through the Plan that does not limit continued participation on the basis of a requirement that you remain actively at work. Your right to participate in the Plan while on a leave of absence is conditioned on you (i) continuing to have an employment relationship with the Employer, and (ii) making the required premium contributions, as provided in the CONTRIBUTIONS and BENEFITS Sections on Pages 5 and 7.

III. DEFINITIONS

CHANGE IN STATUS - Those events which are contemplated or specified in the regulations accompanying Code Section 125, the occurrence of which will permit a Participant to revoke an existing election under the Plan and make a new election. Those events, which are considered to be a "Change in Status", are limited to the following:

- (1) An event that changes a Participant's legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment;
- (2) An event that changes a Participant's number of dependents (as defined in Section 152 of the Code), including birth, adoption, placement for adoption, or death of a dependent;
- (3) Any of the following events that changes the employment status of the Participant, the Participant's spouse or the Participant's dependents: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if an eligibility condition of an employee benefit plan of the Employer of the Participant, spouse or dependent depends on the employment status of that individual and there is a change in individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under that plan, then that change also constitutes a change in employment for purposes of the preceding sentence.
- (4) An event that causes a Participant's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the accident or health plan under which the dependent receives coverage;
- (5) A change in the place of residence or work of the Participant, spouse, or dependent;
- (6) An event that constitutes a special enrollment under the Health Insurance Portability and Accountability Act of 1996 (Medical Reimbursement Plan Only);
- (7) An election by the Participant, spouse, or dependent to select COBRA continuation coverage under Sections 600-608 of ERISA, or a similar State or federal law (Medical Reimbursement Plan Only);
- (8) A judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that (i) requires a Participant to provide health coverage for a Participant's child or foster child who is a dependent of the Participant or (ii) requires a Participant's spouse, former spouse or other individual to provide health coverage for the dependent (Medical Reimbursement Plan Only);

- (9) An event that changes a Participant, spouse or dependent's entitlement to coverage under Medicare or Medicaid (Medical Reimbursement Plan Only);
- (10) A significant cost increase, significant curtailment, or termination of coverage or of a coverage option occurs with respect to an accident or health plan or by a dependent care provider, unless, in the case of a dependent care provider, the significant cost increase is imposed by a provider who is a relative of the Participant;
- (11) A change in benefit options becomes available under an accident or health plan maintained by the Employer and the Participant elects such option (Medical Reimbursement Plan Only);
- (12) A change in benefit options becomes available under a plan of another employer affecting a Participant and the Participant elects such option (a Participant's change in dependent care provider shall be treated as a change in benefit option);
- (13) An election by the Participant's spouse or dependent under a plan maintained by his employer if:
 - (A) the election change by spouse or dependent satisfies the regulations under Code §125, or
 - (B) the period of coverage under the plan maintained by the employer of the spouse or dependent does not correspond to the Plan Year of this Plan;
- (14) An FMLA Leave; or
- (15) Any other event which the Employer or Contract Administrator determines will permit a Participant to revoke an existing election under Code Section 125 and accompanying regulations and rulings of the Internal Revenue Service.

CODE - Internal Revenue Code of 1986, as amended from time to time.

EMPLOYEE - Means any person employed by the Employer.

EMPLOYEE BENEFIT PLAN: Any health or welfare plan now or hereafter adopted by the Employer for the exclusive benefit of its employees, and, if so designated by the Employer, through which benefits are available under the Plan to its Employees.

EMPLOYER: Means Frantz Manufacturing Company.

FMLA: Means the Family and Medical Leave Act of 1993.

FMLA LEAVE: Means a leave of absence that the Employer extends to an Employee under the provisions of the FMLA.

PARTICIPANT: An Employee who has satisfied the Eligibility Requirements and has elected to participate in the Plan.

PARTICIPANT ACCOUNT: An account maintained by the Employer for bookkeeping purposes to record each Participant's contributions and deductions for benefits as provided herein.

PARTICIPATION DATE: For Employees eligible to participate as of the Effective Date, participation shall commence as of the Effective Date. For Employees who become eligible to participate after the Effective Date, participation shall commence as of the date the Employee first satisfies the Eligibility Requirements specified herein. For Employees who do not elect to participate as of their initial Participation Date and who subsequently elect to do so, and for former Participants whose prior period of participation in the Plan had terminated for whatever reason, participation shall commence as of the first day of the next succeeding Plan Year following the Year during which the Employee made such election. For new Employees hired after the Effective Date, participation shall commence as of the later of (a) the date they satisfy the Eligibility Requirements, or (b) their date of hire.

UNIFORMED SERVICES: Means the U.S. 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, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

IV. CONTRIBUTIONS

1. Participant Contributions

(a) Alternatives

Each Participant can choose, from among the available options, both the type of benefits that Participant wishes to purchase through the Plan and the amount of compensation the Participant wishes to defer into the Plan to be applied toward the purchase of those benefits.

(b) Election

Prior to the date you initially become eligible to participate in the Plan, and then prior to the beginning of each Plan Year thereafter, you must decide among the available alternatives as to the amount and type of benefits you wish to fund through the Plan. The Plan Administrator will assist you in making these elections and completing the required forms. Once you make an election as to the amount and type of benefit, you cannot change your election until the beginning of the next Plan Year, unless the change is requested due to a Change in Status as defined on page 3. However, the amount of any such election shall be automatically adjusted to take into account prospective increases (or decreases) in the cost of contributions required under the Employer's health plan or the cost of dependent care rendered by a provider unless that provider is your relative.

Changes due to a Change in Status can be made within 30 days of the date of the Change in Status. All changes due to a Change in Status must be consistent with that Change in Status as described in the formal plan document.

(c) Application of Contributions

The value of any contributions you make to the Plan can only be used to purchase the benefits you have specified in your election forms or to offset the cost of administering the Plan.

(d) Termination of Participation

(1) Medical Expense Reimbursement

You may elect to discontinue participation in the Plan only as of the end of each Plan Year. Your participation will not automatically terminate upon your termination of employment. When your employment terminates, you will remain obligated to continue to contribute to the Plan for the balance of the Plan Year during which your employment terminates. The Employer may require you to sign certain documents agreeing to continue to make contributions for the balance of that year. These contributions may be deducted from any final paychecks which you are entitled to receive. You can continue to receive benefits under the Plan for the balance of the Plan Year during which your employment terminates, up to the maximum amount that you can contribute to the Plan for that particular year.

You may elect to reduce your election to the greater of (i) the amounts already contributed to your Participant Account for medical expense reimbursement or (ii) the amount of claims filed with the Plan for medical care reimbursement. This modification of election must be made within 30 days of your termination of employment.

(2) Dependent Care

No further contributions are allowed to your Participant Account for dependent care expenses following your termination of employment. However, you may continue to submit claims for reimbursement for dependent care claims for the remainder of the Plan Year until your dependent care contributions are exhausted.

2. Contributions by Employees on FMLA and Uniformed Service Leaves of Absence

You may elect to maintain coverage while on a FMLA Leave or leave of absence for duty in the Uniformed Services, but you must continue to make any required contributions specified in Section 1 above. During the absence, you may choose to make these contributions by:

- (a) remitting payment to the Employer on or before each pay period for which the contributions would have been deducted from your paycheck if leave had not

been taken, provided that any delinquent payments must be made within thirty (30) days of their due date;

- (b) prepaying the amounts that will become due during the leave out of one or more of your paychecks preceding the leave; or
- (c) remitting payment to the Employer following a return from the leave, provided you elect this option in advance of the leave in accordance with the schedule of payments established by the Employer.

If you are absent from work for any paid leave of absence, you must continue any and all benefits elected under this Plan not prohibited by any policy or program requiring you to be actively at work, and employee contributions for those benefits will continue to be deducted from your paychecks during the absence.

3. Eligibility For Other Employee Benefits

Participation in the Plan will not affect the calculation of your employee benefits, such as life insurance and medical benefits or Section 401(k) plan benefits. However, it may affect the calculation of your Social Security benefits.

V. BENEFITS

As a participant in the Plan, you can choose among the following benefits:

1. Health Plan Premiums

The cost of premiums you are required to pay for coverage under the health plan. To the extent that you want health coverage, you may elect to pay the required premiums through the Plan.

2. Medical Expense Reimbursement

Any of the following types of expenses you currently pay toward the cost of your health benefits:

- (a) the deductible and shared expenses you are required to pay under the terms of the health plan, and
- (b) other expenses not covered under the health plan but which are nevertheless considered "medical care" under Section 213(d) of the Internal Revenue Code. Examples of qualifying expenses are included in the list attached hereto. This list is not intended to be comprehensive. You may incur other expenses not on the list but which nevertheless are considered "medical care" under the Internal Revenue Code and therefore are eligible for reimbursement under the Plan.

3. Dependent Care

The cost of dependent care expenses which you incur to permit you (and your spouse, if you are married) to work.

Before electing this benefit, you should compare its effect with the effect of the child care credit available for federal income tax purposes. You can then choose the method of paying for dependent care that saves more tax dollars. This comparison must be made prior to your filing an election under the Plan, since the child care tax credit is not available for benefits paid through the Plan.

VI. CLAIMS

1. Claims for Benefits

Benefits which had previously been paid directly by the Employer, such as health insurance premiums, will continue to be paid in the same manner. It is not necessary that you file a claim to provide for payment.

You should file a claim for other benefits after you have incurred and paid these expenses. You must file your claims on the proper forms, which can be obtained from the Employer or Contract Administrator. You must submit proof of expense with your claims, such as paid bills or other receipts.

2. Payment of Claims

The Contract Administrator has been retained by the Employer to process claims. Claims will be processed on a continuous basis. Disbursements will be made by check payable to you. The following rules apply to the processing of all claims:

(a) (1) Dependent Care

If a claim or claims are filed which exceed the balance in your Participant Account, the claim or claims will be processed and you will receive partial reimbursement. The claim or claims will then automatically be reprocessed after each pay period and, to the extent that additional amounts have been deposited in your Participant Account, you will receive additional reimbursements until the claim is reimbursed in full or until the end of that calendar year and the 2½ months following the end of such calendar year, whichever occurs first.

(2) Medical Expense Reimbursement

If a claim or claims are filed which exceed the balance in your Participant Account, a claim or claims will be processed and you will be reimbursed up to the maximum amount which you could contribute to your Participant Account, assuming that you had remained a Participant for the balance of that Plan Year. You will not be reimbursed for claims which exceed the maximum

amount which you could contribute to the Plan assuming you had remained a Participant and continued to contribute at the same rate for the balance of that Plan Year.

- (b) The check stubs you receive with your expense reimbursement will also include the current balance in your Participant Account.
- (c) You can only be reimbursed for claims that are filed for the same calendar year, or the 2½ month period following the end of that Plan Year, as the year during which the applicable expense was incurred.

3. Authorized Representatives

You may pursue a benefit claim or appeal an adverse benefit determination on your own behalf or through an authorized representative. An authorized representative may be (i) a health care professional with knowledge of your medical condition, (ii) an attorney at law representing you, (iii) your spouse or relative, or (iv) any other individual authorized to act on your behalf. The authorized representative shall provide evidence, sufficient to the Employer or Contract Administrator, that the representative is duly authorized by you to act on your behalf. A written instrument signed by you shall be sufficient authorization until revoked.

4. Timing of Notification of Benefit Determination

The Contract Administrator shall notify you of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Contract Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with Section 1 above, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to this Section due to your failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

5. Manner and Content of Notification of Benefit Determination

The Contract Administrator shall provide you with written or electronic notification of any adverse benefit determination. The notification shall set forth, in a manner calculated

to be understood by you:

- (a) The specific reason or reasons for the adverse determination;
- (b) Reference to the specific Plan provisions on which the determination is based;
- (c) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- (e) A description of any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request; and
- (f) An explanation of any scientific or clinical judgment relied upon in making the adverse benefit determination in applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request, if the adverse determination is based on medical necessity, experimental treatment, or similar limitation.

6. Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied or is not acted on after filing of proof of loss within the time periods described herein, you, or your duly authorized representative, may request a review upon written application to the Plan Administrator. Any such request for a review must be mailed to the Plan Administrator within 180 days after receipt by you of a written notification of denial of a claim or from the date the claim was made and not acted on.

The Plan Administrator shall provide you as part of the review process:

- (a) The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- (b) Reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- (c) A review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to

whether such information was submitted or considered in the initial benefit determination;

- (d) A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- (e) In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- (f) The identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- (g) The health care professional engaged for purposes of a consultation described above shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

7. Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify you of the Plan's benefit determination on review within a reasonable period of time but not later than 45 days after receipt by the Plan of your request for benefit determination.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with this Section, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to this Section due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in Section 6 as is appropriate.

8. Manner and Content of Notification of Benefit Determination on Review

The Plan Administrator shall provide you with written or electronic notification of a Plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by you:

- (a) The specific reason for the adverse determination;
- (b) Reference to the specific plan provisions on which the benefit determination is based;
- (c) A statement that the claimant 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;
- (d) A statement of your right to bring an action under section 502(a) of ERISA;
- (e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
- (f) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the applicable medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- (g) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance regulatory agency."

A document record or other information shall be considered "relevant" to a claimant's claim if such document record or other information:

- (1) Was relied upon in making the benefit determination;
- (2) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
- (3) Demonstrates compliance with the administrative processes and safeguards required by law in making the benefit determination; or

- (4) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

VII. COBRA CONTINUATION COVERAGE

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), continuation coverage under the Plan is available to Qualified Beneficiaries under certain specified conditions.

For the purpose of this Section, "Qualified Beneficiary" means any beneficiary defined as such pursuant to Section 607(3) of ERISA, and generally includes any person whose coverage under the Plan would otherwise terminate upon occurrence of any of the events specified in this Section. A Qualified Beneficiary also includes a child who is born to or placed for adoption with the Participant during the continuation coverage elected under this Section, to the extent required by applicable law.

1. Eligibility to Make Election

A Qualified Beneficiary may elect to continue coverage under the Plan if coverage would otherwise cease under the Plan due to:

- (a) the Participant's death;
- (b) termination of the Participant's employment or reduction of the Participant's hours (whether voluntarily or involuntarily);
- (c) divorce or legal separation of the Participant and his spouse;
- (d) the Participant becoming entitled to Medicare benefits;
- (e) a Participant's child ceasing to be an Eligible Dependent; or
- (f) a proceeding in bankruptcy under Title 11, United States Code, commencing on or after July 1, 1986, with respect to the Employer.

Notwithstanding the above, a Qualified Beneficiary is not entitled to elect continuation coverage if the Participant's termination of employment is for gross misconduct as determined by the Employer. In the case of bankruptcy proceedings as described in (f) above, a loss of coverage includes a substantial elimination of coverage with respect to a Qualified Beneficiary within one (1) year before or after the date of commencement of the proceedings.

2. Election Period and Procedure

The election to continue coverage must be made during the period beginning on the day when coverage would otherwise cease under the Plan and ending 60 days after the

later of (i) such date, or, (ii) if applicable under Section 6 below, the date when the Qualified Beneficiary is notified of the right to make such election. A Qualified Beneficiary's failure to comply with the procedures and requirements established by the Employer for making the election, as described herein or in the Employer's notice of election, shall constitute the failure to make an election to continue coverage as provided herein. The written waiver by a Qualified Beneficiary (or by the Participant or his spouse on behalf of a Qualified Beneficiary) of the election to continue coverage shall terminate the Qualified Beneficiary's right to later make an election, unless the Qualified Beneficiary revokes the waiver within the 60 day election period described above. However, if a waiver is revoked, continuation coverage will be effective on the date the revocation is made and will not be retroactive to the date of the event described in Section 1 above.

3. Benefits

A Qualified Beneficiary who elects continuation coverage as provided herein shall be eligible to receive the same benefits to which a Participant or dependent under similar circumstances are otherwise entitled. If Benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to the Qualified Beneficiary's election of continuation coverage, each Qualified Beneficiary will be entitled to benefits comparable to those available to a Participant or dependent under similar circumstances.

4. Payment for Benefits

A Qualified Beneficiary is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of Qualified Beneficiaries shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium which shall be described in the Employer's notice of election form. A Qualified Beneficiary's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the Qualified Beneficiary's termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Qualified Beneficiary shall be precluded from extending, renewing or reelecting such continuation coverage.

5. Duration of Continuation Coverage

A Qualified Beneficiary electing to purchase continuation coverage under the Plan shall be eligible to continue coverage until the end of the Plan Year in which the Qualifying Event occurs.

6. Administration

- (a) Notice on Death, Termination, Reduction of Hours, or Entitlement to Medicare

Within 30 days of a Participant's death, termination of service, reduction of hours, or entitlement to Medicare, the Employer shall inform the Plan Administrator of:

- (1) the Qualified Beneficiaries eligible to elect continuation coverage;
- (2) the event precipitating such notice; and
- (3) the date of the event.

The Employer or Plan Administrator, at the direction of the Employer, shall then notify the Qualified Beneficiaries of their rights to elect pursuant to procedures established by the Employer and applicable law.

(b) Notice of Change in Marital Status or Dependent Status

If a child or spouse of a Participant ceases to be eligible for coverage under the Plan because that person becomes divorced or legally separated from the Participant, or if a child of a Participant ceases to be eligible for coverage under the Plan because he is no longer a dependent, either the Participant, the Participant's former spouse or the Participant's child must notify the Employer of these events within 60 days of their occurrence in order for the respective Qualified Beneficiary to be eligible to elect continuation coverage. The notice may be provided to the Employer orally or in writing and must disclose:

- (1) the name and Plan identification numbers of the Participant and the individuals affected by the event;
- (2) the individual's divorce, separation, or loss of status as a dependent; and
- (3) the date of such event.

Notice by a Qualified Beneficiary of the occurrence of an event giving rise to an election does not act as an election to receive continuation coverage under the Plan. In the event of divorce, legal separation, or change in dependent status, the Employer, if notified within the time period specified in this Subsection (b), shall notify the Qualified Beneficiaries of their eligibility to elect continuation coverage.

(c) Notice of Coverage Under Group Health Plan or Entitlement to Medicare

If a Qualified Beneficiary (i) becomes covered (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary, or (ii) becomes entitled to benefits under Medicare, the Qualified Beneficiary must notify the Employer of such event in writing within 30 days of such coverage date.

(d) General

- (1) Notices to Employer. Notices to the Employer shall be provided to the person or organizational unit of the Employer that customarily handles employee benefits matters of the Employer.
- (2) Current Addresses. The notification of election rights under COBRA will generally be made by U.S. Mail to the Qualified Beneficiary's last known address. As a result, it is important for each person to timely provide the Employer with his current mailing address.
- (3) Interpretation. In the event of any inconsistency or omission, this Article VII and the applicable provisions of the Plan shall be construed, interpreted, and administered in a manner which meets the minimum requirements of COBRA.

VIII. GENERAL

1. Year End

Expenses can be reimbursed up to 90 days following the end of a particular Plan Year and still be deducted from your Participant Account for that year. Any balance remaining in your Participant Account after the 90-day period has expired is forfeited.

2. Right to Receive and Release Information

The Contract Administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the Plan Administrator or Contract Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, *et seq.*, or other applicable law, the Plan Administrator or Contract Administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Contract Administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the protected health information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

In addition, the Plan Sponsor hereby certifies and agrees that it will:

- (a) Not use or further disclose the information other than as permitted or required by the Plan or as required by law;

- (b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;
- (c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- (d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (e) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- (f) Make available protected health information in accordance with 45 C.F.R. 164.524;
- (g) Make available health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526;
- (h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;
- (i) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, *et seq.*;
- (j) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, *et seq.* Any issues of noncompliance with

the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

3. Questions/Forms/Information

Any questions, requests for forms or other inquiries should be directed to the Employer or the Contract Administrator.

4. Nondiscrimination

It is the intent of the Employer that the Plan not discriminate in favor of any Employee or group of Employees. If the Employer determines that the Plan is discriminatory, the Employer shall select and exclude from coverage under the Plan such Participants, or reduce the contributions and/or benefits of such Participants, as shall be necessary to comply with the nondiscrimination provisions of the Internal Revenue Code.

5. Right to Amend or Terminate the Plan

The Employer may amend or terminate the Plan at any time, provided that no such amendment or termination shall diminish or eliminate any claim for any benefit to which a Participant shall have become entitled prior to such amendment or termination of the Plan.

IX. YOUR RIGHTS UNDER ERISA

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

1. **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.

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the plan, including an 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 if such report is required to be prepared. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report;

2. **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.

3. 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, 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.

4. Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a 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.

5. 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 office of the Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

Examples of Expenses Eligible for Reimbursement

Acupuncture
Artificial limbs
Birth control pills
Braille-books and magazines
Car controls for the handicapped
Care for mentally handicapped dependents
Chiropractors
Christian Science practitioner's fees
Crutches, wheelchairs, and similar equipment
Day care expenses for eligible dependents as necessary due to employment
Deductible and co-insurance amounts you pay for health or dental benefits
Dental expenses, including dentures and braces
Diagnostic and laboratory fees, x-rays
Drug and medical supplies
Eyeglasses or contact lenses, including examination fee
Hearing devices and batteries
Home improvements motivated by medical considerations
Hospital bills
Hypnosis for treatment of an illness
Laetrile by prescription
Lead-base paint removal (for children with lead poisoning)
Membership fees in association furnishing medical services, hospitalization and clinical care
Nurses' fees (including nurses' board and Social Security tax where paid by Taxpayer)
Obstetrical expenses
Orthopedic shoes
Oxygen
Physician fees
Psychiatric care or psychologist fees
Routine physicals and other non-diagnostic services or treatments
Seeing eye dog and its upkeep
Special education for the handicapped
Special plumbing for the handicapped
Sterilization fees
Surgical fees and related treatment
Telephone, special for deaf
Television audio display equipment for the deaf
Therapeutic care for drug and alcohol addiction
Therapy treatments
Transportation expenses primarily incurred in the rendering of medical service
Vitamins by prescription