

Frantz Manufacturing Company Employee Group Health Benefit Plan

Plan Dated: January 1, 1987

Plan Restated: January 1, 2009

Summary Material Modification Notice for Amendment #2

Effective date: January 1, 2009, April 1, 2009 and January 1, 2010

To the Plan Participant:

Frantz Manufacturing Company has amended the Frantz Manufacturing Company Employee Group Health Benefit Plan (the "Plan") effective January 1, 2009, April 1, 2009 and January 1, 2010. Accordingly, certain provisions in your Summary Plan Description (SPD) should be modified to describe and explain the Plan, as amended, which are outlined below.

PART ONE

Effective January 1, 2009, the description below is added to the information in your SPD, in the section entitled *ELIGIBILITY FOR COVERAGE*.

Recall from Lay-Off

Coverage for a Covered Individual who has been laid off from work and is subsequently called back to work from lay-off will be reinstated on the first day of work after being called back, and will not be required to satisfy the Eligibility and Enrollment requirements.

PART TWO

Effective January 1, 2010, the description below replaces the information in your SPD, in the section entitled *PLAN SUMMARY*, in the subsection entitled *OPTION 1: COMPREHENSIVE MEDICAL EXPENSE BENEFIT SUMMARY*, under the heading *DEDUCTIBLE*.

The Annual Individual Deductible and Deductible Limits are increased to:

	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Individual Deductible	\$500	\$1,000
Deductible Limit for Employee plus one (1) Dependent enrollment	\$1,000	\$2,000
Deductible Limit for Employee plus two (2) or more Dependents enrollment	\$1,500	\$3,000

PART THREE

Effective January 1, 2010, the description below replaces the information in your SPD, in the section entitled *PLAN SUMMARY*, in the subsection entitled *OPTION 1: COMPREHENSIVE MEDICAL EXPENSE BENEFIT SUMMARY*, under the heading *OUT-OF-POCKET EXPENSE LIMIT*.

The Annual Family Out-of-Pocket Expense Limits are increased to:

	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Family Out-of-Pocket Limit	\$5,000	\$10,000

PART FOUR

Effective January 1, 2010, the description below replaces the information in your SPD, in the section entitled *PLAN SUMMARY*, in the subsection entitled *OPTION 1: COMPREHENSIVE MEDICAL EXPENSE BENEFIT SUMMARY*, under the heading *BENEFIT PERCENTAGES* for the provision entitled *PHYSICIAN SERVICES*.

The Office Visit Co-Pay of \$10 has been eliminated; Physician Services will now be subject only to the Annual Deductible and Coinsurance.

PART FIVE

Effective January 1, 2010, the description below replaces the information in your SPD, in the section entitled *PLAN SUMMARY*, in the subsection entitled *OPTION 1: COMPREHENSIVE MEDICAL EXPENSE BENEFIT SUMMARY*, under the heading *BENEFIT PERCENTAGES* for the provision entitled *PREVENTATIVE CARE*.

- The Office Visit Co-Pay has been eliminated.
- The \$1,000 Limit for waiving the Deductible has been eliminated for In-Network Services.
- A limit of one (1) Colonoscopy (for preventive purposes) per any five (5) year period has been added.
- All Out-of-Network Preventative Care services are subject to the Out-of-Network Deductible and Coinsurance.

PART SIX

Effective January 1, 2010, the description below replaces the information in your SPD, in the section entitled *PLAN SUMMARY*, under the headings *MEDICAL EXPENSE BENEFIT LIMITATIONS AND MAXIMUMS* and *BENEFIT PERCENTAGES*, for the provisions regarding *MENTAL HEALTH AND/OR SUBSTANCE ABUSE TREATMENT*.

The frequency limitations for in-patient and out-patient mental health and substance abuse treatment have been removed. (In-patient admissions must still be pre-certified.) The benefit percentage for in-network services is 80% (after the Annual Deductible has been satisfied); the benefit percentage for out-of-network services is 60% (after the Annual Deductible has been satisfied).

PART SEVEN

Effective January 1, 2010, the description below replaces the information in your SPD, in the section entitled *GENERAL EXCLUSIONS*, under the heading *WAR OR ACT OF WAR*.

The words "active participation in" have been struck from this exclusion, which now reads:

77. **War or any Act of War:** Charges as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country or international organization, or in any auxiliary or civilian noncombatant unit serving with such forces, political terrorist actions, or atomic or thermonuclear explosion or resulting radiation.

PART EIGHT

Effective January 1, 2010, the description below replaces the information in your SPD, in the section entitled *ELIGIBILITY FOR COVERAGE*, under the heading *DEPENDENT ELIGIBILITY AND EFFECTIVE DATE*, and in the section entitled *DEFINITIONS*, under the headings *DEPENDENT* and *SPOUSE*.

The definition of "spouse" is limited to mean "the person to whom a covered employee is legally married, as determined and defined by the laws of the state of the covered employee's residence, but only to the extent that "spouse" and "marriage" are defined by the federal Defense of Marriage Act (Public Law No. 104-199, 110 Stat. 2419).

PART NINE

Effective April 1, 2009, the description below replaces the information in your SPD, in the section entitled *ENROLLMENT*, under the heading *SPECIAL ENROLLMENT*.

Special Enrollment

Special Enrollment rights may be triggered upon the occurrence of certain types of events: loss of other health coverage, addition of a new dependent and upon becoming eligible for a state premium assistance subsidy. When a triggering event occurs, an eligible individual will have certain rights to enroll in this Plan, provided that enrollment requirements are satisfied. A description of triggering events, special enrollment rights and enrollment requirement for each type of event are listed below. An individual who does not enroll in the Plan within the deadlines explained below will lose Special Enrollment rights for that event.

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Loss of Other Health Plan Coverage: Eligible Employees and their Dependents who, at the time they were offered coverage under the Plan were eligible for the coverage and declined it because of other health coverage, are entitled to enroll in the plan when the other coverage ends. If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

- **Other Coverage is COBRA Coverage.** If the other coverage is COBRA coverage, the eligible Employee must exhaust COBRA coverage to be eligible for special enrollment in the Plan. Exhaustion of COBRA coverage means that COBRA coverage ends for any reason other than failure to pay contributions on time or for cause.
- **Other Coverage is Not COBRA Coverage.** If the other coverage is not COBRA coverage, the Employee must lose the other coverage as a result of loss of eligibility for the coverage, termination of employment or employer contribution toward the other coverage terminates.
- **Other Coverage is Medicaid or state Children's Health Insurance Program.** If the other coverage is Medicaid or a state's Children's Health Insurance Program (CHIP), the Employee or his eligible Dependent(s) must lose such coverage due to a loss of eligibility for Medicaid or CHIP.
- **Deadline for Special Enrollment Period.** The eligible Employee is required to request special enrollment in the Plan not later than thirty (30) days (in the case of loss of eligibility for Medicaid or CHIP, sixty (60) days) after:
 1. the exhaustion of the other coverage; or
 2. the termination of the other coverage as a result of the loss of eligibility for the other coverage; or
 3. the termination of employer contributions toward that other coverage.

If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, the eligible Employee and his or her Dependents lose special enrollment rights for that event.

- **Effective Date of Enrollment.** Enrollment in the Plan under this Special Enrollment provision will be effective not later than the first day of the calendar month beginning after the date the Plan Administrator receives the completed request for enrollment.

Addition of a Dependent: Eligible Employees and their Dependents who, at the time they were offered coverage under the Plan were eligible for the coverage and declined it, are entitled to enroll in the plan upon the eligible Employee's marriage, or the birth or adoption of his or her child.

- **Non-Participating Employee May Also Enroll.** The addition of a new dependent triggers enrollment rights for an eligible Employee even if he or she does not participate in the Plan at the time of the event. For example, upon the birth of an eligible Employee's child, the eligible Employee (assuming that he or she did not previously enroll), his or her spouse, and his or her newborn child may all enroll because of the child's birth. The same rule applies to the eligible Employee's marriage or adoption of a child if the eligible Employee had not previously enrolled in the Plan.
- **Deadline for Special Enrollment Period.** An eligible Employee must request special enrollment within thirty (30) days of marriage, or birth, adoption or placement for adoption of his or her child. If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, he or his Dependents lose special enrollment rights for that event.
- **Effective Date of Enrollment.** The date of enrollment for coverage will be the date of the event.

Attainment of Eligibility for Premium Assistant under Medicaid or state Children's Health Insurance Program:

Eligible Employees and their Dependents who, at the time they were offered coverage under the Plan were eligible for the coverage and declined it, are entitled to enroll in the plan when that Employee and/or dependent(s) becomes eligible for a state's premium assistance subsidy, with respect to coverage under the plan, under either a Medicaid plan under Title XIX of the Social Security Act, or the state Children's Health Insurance Program under Title XXI of the Social Security Act. (States may choose to voluntarily offer a premium assistance subsidy to eligible low-income children and their families for "qualified employer-sponsored coverage." This subsidy may be provided as a reimbursement to the employee or as a direct payment to the employer (unless the employer opts out of receiving direct payments)).

- **Non-Participating Employee May Also Enroll.** A dependent's eligibility for a state's premium assistance subsidy triggers enrollment rights for an eligible Employee even if he or she does not participate in the Plan at the time of the event.
- **Deadline for Special Enrollment Period.** An eligible Employee must request special enrollment within sixty (60) days of becoming eligible for such state premium assistance. If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, he or his Dependents lose special enrollment rights for that event.
- **Effective Date of Enrollment.** Enrollment in the Plan under this Special Enrollment provision will be effective not later than the first day of the calendar month beginning after the date the Plan Administrator receives the completed request for enrollment.

PART TEN

Effective January 1, 2010, the description below replaces the information in your SPD, in the section entitled *PLAN SUMMARY*, under the heading *BENEFIT PERCENTAGES*, and in the section entitled *COMPREHENSIVE MEDICAL EXPENSE BENEFITS*, under the heading *ELIGIBLE MEDICAL EXPENSES*.

The "Healthplace America™ Benefit" has been removed from the health plan.

PART ELEVEN

Effective January 1, 2010, the description below replaces the information in your SPD, in the section entitled *PLAN SUMMARY*, under the heading *BENEFIT PERCENTAGES*, and in the section entitled *COMPREHENSIVE MEDICAL EXPENSE BENEFITS*, under the heading *ELIGIBLE MEDICAL EXPENSES*.

The "DirectHealth Benefit" has been removed from the health plan.

This notice is considered legally to be a component of your Summary Plan Description (SPD) and should be inserted into your copy of the SPD immediately.