Hallmark's Self-Insured Minimal Essential Coverage Health Benefit Program

Summary Plan Description
Effective January 1, 2020

HEALTH CARE PLAN
TABLE OF CONTENTS

LE 10/07/2019

INTRODUCTION

This Summary Plan Description describes the benefits available to certain employees of Hallmark Marketing, Hallmark Retail LLC and Halls LLC as described in the eligibility section of this document. The benefits described in this document become effective on January 1, 2020. This document summarizes the Plan rights and benefits for covered employees and their dependents. By carefully reading your summary plan description and understanding your relationship to your plan, you can be an informed participant. So know your plan, what it requires of you, how to become eligible for benefits, and what steps you can take to assure that you will receive your earned benefits.

When you become a Covered Person, you will have available to you a listing of the participating physicians of the Preferred Provider Organization (PPO). At the time of service, it is your responsibility to confirm with the medical provider and/or facility that they continue to participate in the PPO. A telephone number is provided on the front of your Identification Card to contact the network to assist you with locating providers in your area. Additionally, The Loomis Company website www.loomisco.com contains links to many online provider directories. Printed provider directories are also available to you free of charge; however, due to changes the printed directories become obsolete quickly.

IMPORTANT HIGHLIGHTS

(1) **PATIENT PROTECTION AND AFFORDABLE CARE ACT**

Hallmark believes this plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act).

Questions regarding what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

(2) **YOU MUST NOTIFY THE HUMAN RESOURCES DEPARTMENT / BENEFITS PERSONNEL WHEN ONE OF THE FOLLOWING EVENTS OCCURS.**

- Birth of a child. *(Within 30 days).*
- Divorce. *(Within 60 days).*
- Marriage. *(Within 30 days).*
- Adoption of a child. *(Within 30 days).*

Failure to notify the Human Resources Department / Benefits Personnel of these events could result in loss of eligibility and claims being denied.

(3) **YOU MUST BE SURE PROVIDERS HAVE CURRENT BILLING INSTRUCTIONS PROVIDED ON YOUR IDENTIFICATION CARD. FAILURE TO SUBMIT CLAIMS PROPERLY WILL RESULT IN DELAYED CLAIMS PROCESSING.**

(4) **BILLS SHOULD BE SUBMITTED FOR PAYMENT ON A TIMELY BASIS.**

Claims filed more than 12 months after the date of service will not be eligible for payment.

A Summary Plan Description (SPD) is intended to summarize the features of your Health Care Plan in clear, understandable and informal language. The terms under which the Plan administers benefits are contained in this booklet.

MEC PREVENTIVE CARE
SCHEDULE OF MEDICAL BENEFITS

Maximum Annual Benefit for Medical Care — Unlimited

	Network	Comments
Calendar Year Deductible:		
Per Covered Person	$0	
Per Family	$0	
Benefit Percentage:		
Medical Plan Pays	100%	
Covered Person Pays	0%	

Benefits and Services	In-Network Plan Pays Allowed Amount	Non-Network Plan Pays UCR	Comments
PREVENTIVE CARE			
Well Child Exam *Includes child immunizations and lead screening.*	100%	*Not Covered	Benefits include all services recommended by the US Preventive Services Task Force and the CDC. One preventive care visit per plan year for an adult to obtain the recommended preventive screening services that are age appropriate and developmentally appropriate.
Well Woman Care	100%	*Not Covered	
Well Adult Care	100%	*Not Covered	
*If the Plan has a network of preferred providers, the services are only covered if provided by a network provider or, if the Plan does not have in its network a provider who can provide the particular preventive item/service, by a non-network provider. If the Plan does not have a network of preferred providers, the services are covered pursuant to the provider reimbursements based on a formula related to Medicare eligible charges.			
SERVICES THAT ARE NOT PREVENTIVE SERVICES AS DEFINED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ("PPACA") WILL NOT BE COVERED BY THIS PLAN			

- Allowed amount - The Plan will consider the allowed amount designated by the Preferred Provider Organization.
- UCR -The Plan will consider the Usual, Customary and Reasonable amount of the services based on the geographic location of the provider of service.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG BENEFITS			
	Retail *31-day supply*	**Mail-Order** *90-day supply*	**Comments**
Generic	100% *Coverage only available for generic prescription drugs as mandated under the Affordable Care Act (ACA).*	100% *Coverage only available for generic prescription drugs as mandated under the Affordable Care Act (ACA).*	
Preferred Brand	Not Covered	Not Covered	
Non Preferred	Not Covered	Not Covered	

The Department of Health and Human Services (HHS) has compiled a list of prescription drug benefits that will be covered by this Plan with no patient cost sharing. Additional information can be found under this provision by visiting *http://www.healthcare.gov*. Note: It is advised to check this list regularly as it is subject to change without notice.

PRESCRIPTION DRUG EXPENSE BENEFIT

The Hallmark Minimal Essential Coverage Health Care Plan provides a Prescription Drug Plan. This prescription drug program is an independent program, separate from the medical plan and covers preventive prescriptions as mandated under the Affordable Care Act (ACA).

Covered prescription drugs mandated under the Affordable Care Act (ACA) are subject to prescription benefit management review for determination of coverage. The current list of mandated items are as follows:

ASPIRINS
Taking aspirin every day can lower your risk of heart attack or stroke. However, recent guidelines have new suggestions and recommendations regarding patients on Brilinta, NSAIDs, and other drugs. Ask your doctor about taking aspirin if you: • Are a man age 45 to 79 • Are a woman age 55 to 79 • Have high blood pressure, high cholesterol, or diabetes • Have a family history of heart disease • Have already had a heart attack or stroke • Smoke If you are a qualifying patient, the OTC (over-the-counter) drugs shown below may be available to you: • Low-Dose Aspirins (81mg or 162mg), Regular, Enteric Coated, or Chewable • Aspirins (325mg, 500mg, 650mg), Regular, Enteric Coated, or Chewable
BOWEL PREP
Coverage of brand name medications is dependent on the terms of your health plan. Limit of 2 Prescriptions per year. • BISACODYL • MILK OF MAGNESIA • MAGNESIUM CITRATE • PEG 33S0-ELECTROLYTE
FOLIC ACID
All women of childbearing age (16-45) planning or capable of pregnancy should take a daily supplement containing 0.4 to 0.8mg of folic acid, but the ACA only requires coverage of OTC (over-the-counter) medications. If you are a qualifying patient, the drugs shown below may be available to you. • Folic Acid 400mcg • Folic Acid 800mcg
VITAMIN D SUPPLEMENTS
• Vitamin D Supplements • Vitamin D 1,000 Units or less per dose unit • Calcium with Vitamin D

IRON SUPPLEMENTS FOR CHILDREN

Children up to 12 months who are at increased risk for iron deficiency anemia should take routine iron supplements.

If your child is a qualifying patient, the drugs shown below may be available.

- OTC (over-the-counter) Iron Drops
- Poly-Vitamin with Iron Drops
- Ferrous Sulfate Iron Drops
- Multi-Vitamin with Iron: Drops, liquid Suspension

CONTRACEPTION

Female patients with reproductive capabilities (generally considered to be 15-48 years of age) will be offered FDA approved contraceptive methods, sterilization procedures, patient education, and counseling with no cost share.

If you are a qualifying patient, at least one product in each of the categories below will be included.

- OTC contraceptives *(including Female condoms, all products, Spermicides, all products, Sponges, all products and Emergency contraception (i.e. morning after pill, Plan B, ella)*
- Cervical Caps
- Diaphragms
- Injections. Only covered as preventive for Medroxyprogesterone Acetate 150mg, which is the only drug and dosage used for contraception.
- IUDs and Implantable Rods
- Generic oral contraceptives *(All generic contraceptives will be covered as preventive and Brand oral contraceptives will continue to require member cost sharing (e.g. deductible, co-pay, coinsurance)*
- Trans-dermal contraceptives (i.e. contraceptive patches)
- Vaginal rings (Le. NuvaRing)
- Sterilization procedures - medical benefit, not paid under pharmacy program
- Patient education/counseling - medical benefit, not paid under pharmacy program.

SMOKING CESSATION

Physicians should ask adult patients over the age of 18 about their use of tobacco, and provide tobacco cessation interventions for those who use tobacco products. Recommendations for coverage are limited to a 90-day supply in anyone plan year.

If you qualify, the drugs that MAY be included, if covered, include:

- COMMIT
- NICORETTE
- NICODERM / NICODERM CQ
- ZYBAN SR
- CHANTIX
- Bupropion SR 150mg
- Store Brand Smoking Cessation Gums

PRIMARY PREVENTION OF BREAST CANCER

This recommendation applies to asymptomatic women aged 35 years or older without a prior diagnosis of breast cancer, ductal carcinoma in situ, or lobular carcinoma in situ. Generic risk reducing medications are covered as preventive. Prior Authorization required.

- Raloxifene
- Tamoxifen
- Soltamox (liquid Tamoxifen)

ORAL FLUORIDE SUPPLEMENTATION

Primary care clinicians or dentists should prescribe oral fluorides at recommended doses up to age 21, but only where the primary water source does not contain fluoride. This treatment may prevent the occurrence of ongoing tooth decay, leading to potential oral cancers. To determine if your water supply contains fluoride, either contact your local water system or check online at http://apps.nccd.cdc.gov/MWF/index.asp.

If you are a qualifying patient, the drugs shown below may be available to you if your primary water source does not contain fluoride:

- POLY-VI-FLOR
- FLUOR-A-DAY (Sodium Fluoride)
- LURIDE
- Multi-Vitamin with Fluoride: Chewable or drops 0.25 and 0.50, Suspension
- FLUORITAB
- FLURA-DROPS
- Sodium Fluoride 0.25 tablets (chewable)

VACCINES

The vaccines listed will be covered when age appropriate and provided by a network provider (physician):

- Diphtheria, Tetanus-Acellular, Pertussis (DTaP)
- Measles, Mumps, Rubella (MMR)
- Haemophilus influenza Type B (Hib)
- Meningococcal
- Hepatitis A and Hepatitis B
- Pneumococcal
- Herpes Zoster (Shingles)*
- Rotavirus
- Human Papillomavirus (HPV)
- Tetanus-Diphtheria/Tetanus-Diphtheria Acellular Pertussis (Tdap)
- Influenza (Flu)
- Inactivated Poliovirus (JPV)
- Varicella (Chicken Pox)

Adult and Child & Adolescent Immunization Schedules (for persons aged 0-6 years, 7-18 years, and "catch-up schedule")

*The shingles vaccine is covered in accordance with the Food and Drug Administration (FDA) guidelines. Zostavax is FDA approved for people over the age of 50.

IMPORTANT PLAN FACTS

This Summary Plan Description has been compiled in accordance with Public Law 93-406 (known as the EMPLOYEE RETIREMENT SECURITY ACT OF 1974; "ERISA".)

PLAN NAME	Health & Welfare Benefit Plan for Part-Time Field (Mass & Gold Crown) and Retail (CSG & Halls) – Self-Insured Minimal Essential Coverage Health Benefit Program
PLAN ADMINISTRATOR	Hallmark Benefit Plans Welfare Committee 2501 McGee MD #510 Kanas City, MO 64108 (888) 545-6200
EMPLOYER I.D. NUMBER	43-0820871
GROUP NUMBER	IB0230
PLAN NUMBER	501
TYPE OF PLAN	The Plan a self-funded group health Plan and the administration is provided through a Third Party Administrator. The Plan is not insured.
BENEFIT PLAN YEAR	January 1st to December 31st
PLAN COSTS	Employee Paid (no Employer contributions)
THIRD PARTY ADMINISTRATOR	The Loomis Company PO Box 7011 Wyomissing, PA 19610-6011 Customer Service Number (877) 492-4311
PLAN WAITING PERIOD	No waiting period. Eligible to enroll immediately for coverage on the date of hire.
DEFINITION OF AN ELIGIBLE EMPLOYEE	All part-time, active employees in Hallmark's mass service organization, corporate stores, and Hall's retail store working the number of hours per week required by employer
AGENT FOR SERVICE OF LEGAL PROCESS	Process in any legal action may be directed to: Hallmark Cards, Incorporated, MD #339, 2501 McGee, Kansas City, MO 64108

HOW TO FILE A CLAIM

For purposes of this Plan a filed claim for payment of benefits shall mean a completed paper or electronic claim form submitted to the Plan naming the specific claimant, the date of service, the specific medical condition or symptom, a specific treatment or service that was rendered or product provided by a qualified provider.

In-Network (PPO) Claims

When you or a covered dependent utilize the services of PPO Hospitals, physicians and other providers, your involvement in the claims process will be minimal. After you identify yourself as covered through the Hallmark Minimal Essential Coverage Health Care Plan, bills incurred for covered expenses under this Plan will be sent directly to the address identified on your health plan ID card.

When the Hospital or other provider submits their bills, the payment will be sent to the providers directly. You will receive a copy of the Explanation of Benefits showing the payments made and any deductibles or co-insurance involved in the benefits calculation.

Please ensure the PPO Provider has the current billing instructions provided on your identification card. Failure to submit claims properly will result in delayed claims processing.

Claim Timely Filing

If you or a covered dependent claim benefits, a proof of claim must be furnished to The Loomis Company within 12 months following the date of loss. If a written claim form is not furnished to the claims processor within 12 months, the claim may be denied or reduced. Benefits are based on the Plan's provisions at the time that the charges are incurred. Claims submitted after the 12-month period will not be considered for payment or may be reduced unless it is not reasonably possible to submit the claim in that time, such as the person is not legally capable of submitting the claim.

The Plan Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Covered Person seek a second medical opinion.

If a claim is wholly or partially denied, the Covered Person will be notified in writing, of the determination. The denial notification will state: (1) the specific reason(s) for the denial; (2) refer to the pertinent Plan provisions on which the denial is based; (3) describe any additional information needed to perfect the claim and explain why the additional information is necessary; and (4) describe the Plan's appeal procedures including its time limits.

How To Appeal A Claim Denial

You or your representative has 180 days after receipt of an adverse benefit determination to appeal to the Plan Administrator. To appeal an adverse benefit determination or to review administrative documents pertinent to the claim, send a written request to The Loomis Company. *If any appeal is not filed on time, the right to appeal the adverse benefit determination will be lost.* A full and fair review of the claim will be made with no deference given to the initial benefit determination. As part of the review, you or your representative are allowed to review all Plan Documents and other information that affect the claim and are allowed to submit issues, comments, documents, records or other information that had not previously been submitted.

During the period that the claim is being reconsidered, if there is reason to believe that your medical records contain information that should be disclosed by a physician or other health professional, you or your representative will be referred to the physician for the information before the Plan will provide the requested documents directly to you or your representative.

Neither you nor your representative will be provided access to or copies of files of other Plan participants. For any appeal resulting in an adverse benefit determination, the identity of any medical or vocational expert consulted in connection with the appeal will be provided, without regard to whether the advice was relied upon in making the determination. However, the identity will not be provided unless requested by you or your representative.

All interpretations, determinations, and decisions of the reviewing entity with respect to any claim will be its sole decision based upon the Plan documents. All decisions of the Plan Administrator will be deemed final and binding. If appeal is denied, in whole or in part, however, you have a right to bring a civil action under Section 502(a) of ERISA.

Hallmark believes this plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a non-grandfathered health plan provides additional appeal rights to members. Please see the information below regarding the appeal procedures.

What if a Covered Person needs help understanding an adverse benefit determination? Contact The Loomis Company via the customer service phone number on the back of the ID card for assistance in understanding an adverse benefit determination.

What if a Covered Person doesn't agree with the determination? A Covered Person has a right to appeal any adverse benefit determination.

How does a Covered Person file an initial appeal? To appeal an adverse benefit determination or to review administrative documents pertinent to the claim, send a written request to The Loomis Company within 180 days of receipt of the adverse benefit determination.

What if a situation is urgent? If the situation meets the definition of urgent under the law, the review will be conducted on an expedited basis. Generally, an urgent situation is one in which a Covered Person's health may be in serious jeopardy or, in the opinion of the physician, a Covered Person may experience pain that cannot be adequately controlled while waiting for a decision on the appeal. A Covered Person may request an expedited appeal by contacting customer service at the number on the back of the ID Card.

Who may file an appeal? A Covered Person or someone who is named to act for a Covered Person (an authorized representative) may file an appeal. An authorized representative is a person who is chosen by and identified to assist or authorized to represent the Covered Person, including a family member, provider, employer representative or attorney. An assignment of benefits by a Covered Person to a health care provider does not constitute designation of an authorized representative.

Can a Covered Person provide additional information about my claim? Yes, a Covered Person may supply additional information to The Loomis Company.

Can a Covered Person request copies of information relevant to my claim? Yes, a Covered Person may request copies (free of charge) by contacting The Loomis Company at the number on the back of the ID Card.

What happens when an initial appeal is filed? When an appeal is filed, the Plan Administrator will review the decision and provide a written determination. If the Plan Administrator continues to deny the payment, coverage, or service requested or a Covered Person does not receive a timely decision, the Covered Person may be able to request an external review of the claim by an independent third party, who will review the denial and issue a final decision.

How does a Covered person request an external review? You have four months from the date of receipt of the benefits denial notice to file your request for an external review. To request an external review, send a written request to The Loomis Company. An independent organization will review the decision and provide the Covered Person with a written determination. If this organization decides to overturn the Plan Administrator's decision, the Plan Administrator will provide coverage or payment for the Covered Person's health care item or service.

If the denial is upheld, there is no further review available under the appeals process. However, the Covered Person may have other remedies available under Federal law, such as filing a lawsuit.

Who may file a request for external review? A Covered Person or someone who is named to act for a Covered Person (an authorized representative) may file an appeal. An authorized representative is a person who is chosen by and identified to assist or authorized to represent the Covered Person, including a family member, provider, employer representative or attorney. An assignment of benefits by a Covered Person to a health care provider does not constitute designation of an authorized representative.

Adverse Benefit Determination
Any denial, reduction or termination of a benefit, or failure to provide or make payment (in whole or in part) for a benefit. An adverse benefit determination includes denials made on the basis of eligibility and restrictions involving services determined to be experimental or investigational, or not medically necessary or appropriate.

Compliance with Regulations
It is intended that the claims procedures be administered in accordance with the claims procedure regulations of the Department of Labor as set forth in 29 CFR § 2560.503-1. You have a right to these procedures free of charge. Please call The Loomis Company if you wish to obtain a copy of these procedures.

Authorized Representative
A person who is chosen by and identified to assist or authorized to represent the Covered Person, including a family member, provider, employer representative or attorney. An assignment of benefits by a Covered Person to a health care provider does not constitute designation of an authorized representative.

Other Important Claims Information
If you or your representative fail to file a request for review in accordance with the claims procedures as described above, you or your representative will have no right to review and you or your representative will have no right to bring an action in any court. The denial of your claim will become final and binding except as otherwise provided by ERISA.

Right to Receive and Release Needed Information
Certain facts are needed to adjudicate claims in accordance with the provisions set forth in the Plan. The Plan Administrator has the right to decide which facts are required and may obtain the needed facts from or provide them to any other organization or persons. Each person claiming benefits under this Plan must provide any information required to pay the claim.

Medical Privacy
Medical information that is obtained and maintained in the course of processing claims will be secured and protected in accordance with state and federal laws regarding participant privacy rights.

ELIGIBILITY PROVISIONS

If you are a part-time, active employee in Hallmark's mass service organization, corporate stores, or Hall's retail store, regularly scheduled to work the at least the minimum number of hours per week as required by your employer, you are eligible for coverage under the terms of the Self-Insured Minimal Essential Coverage Health Benefit Plan. The effective date of coverage is enrollment in the plan upon completion of any applicable waiting period.

You may obtain coverage for you and your eligible dependents by completing the enrollment process and contributing any required amounts as defined by the Plan. Dependent coverage is only available if the employee is also covered. If a husband and wife / domestic partner are employees, they may be covered as employees, and any eligible dependents may be covered as dependents of one parent but not both.

An eligible dependent shall mean any one or more of the following:

- The lawful spouse of the employee under a legally existing marriage who is a United States citizen.
- Domestic Partner of the employee *(as determined by your employer).*
- Children of the employee or domestic partner, who are under the age of 26 including legally adopted children, children legally placed for adoption, step-children, and children for whom the employee and/or the employee's spouse/domestic partner has been appointed guardian by a court of competent jurisdiction.

  A spouse or biological child of a covered dependent child will not be eligible for coverage under this Plan.
- Children of the employee or domestic partner, including legally adopted children, children legally placed for adoption and step-children as defined above who are primarily dependent upon the employee for support and maintenance and who are incapable of self-sustaining employment due to mental or physical disability, provided such disability started before the attainment of age 26. Also, such children must have been covered prior to the attainment of such age and covered continuously thereafter. The Plan Administrator may require proof of the dependents incapacity status. The Plan Administrator reserves the right to have such dependent examined by a physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

In order to continue a dependent child's coverage beyond age 26, you must furnish written verification of their incapacity for self-support within 60 days of the child's 26th birthday.

- Alternate recipients under qualified medical child support orders (QMCSO) required to be covered according to the provisions of ERISA Section 609 (a) (2) (A). Any child of a Covered Person who is an alternate recipient under a qualified medical child support order shall be considered as having a right to dependent coverage under this Plan. Under a QMCSO, the fact that the child is eligible for, is entitled to, or is provided benefits under Title XIX of the Social Security Act, will not affect the child or children's receipt of benefits under the QMCSO.

A **qualified medical child support order** (QMCSO) is a medical child support order issued by a court, which has jurisdiction, under state law requiring a non-custodial parent to provide medical coverage for his or her children that specifies the individuals involved, the type of coverage to be provided and the Plan that provides the coverage. The QMCSO may not require the Plan to provide any type or form of benefit, or any benefit option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act.

The phrase **primarily dependent upon** shall mean dependent upon the covered employee for support and maintenance as defined by the Internal Revenue Code and the covered employee must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

The phrase **child placed with a covered employee in anticipation of adoption** refers to a child whom the employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such employee of legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

These persons are excluded as dependents: other individuals living in the covered employees' home, but who are not eligible as defined; the divorced former spouse of the employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an employee.

If a person covered under the Plan changes status from employee to dependent or dependent to employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Funding

Contribution Determinations

The level of employee contributions will be set by the Plan Administrator. These employee contributions will be used in funding the cost of the Plan.

Employee Obligations

The coverage afforded to an employee by this Plan require employee contributions. If an employee elects to enroll dependents under the Plan, the employee may be responsible for payment of all of the dependent contributions suitable to cover such enrollment. Employees will be required to provide banking information during the enrollment process before coverage will begin. No payroll deductions for coverage is allowed.

ENROLLMENT

If for any reason eligible dependents are not enrolled within the 30 days following their initial eligibility date and coverage is subsequently desired, coverage may be requested during an Open Enrollment Period or if you qualify subject to the Special Enrollment provisions described herein.

Initial Enrollment Period

If you desire Plan benefits, you must enroll in the Plan by properly completing the online enrollment process within 30 days of your eligibility date. If you also desire dependent coverage, you must enroll your eligible dependents by this deadline. If you do not have any eligible dependents at the time of initial enrollment but later acquire eligible dependents, including newborns, you may enroll them under a special enrollment period.

Failure to enroll by the deadline noted above may result in your and/or your dependents' inability to secure coverage under this Plan except as specified in the special enrollment and late enrollment provisions below.

Special Enrollment Periods

Those individuals who do not enroll in the Plan at the first opportunity and subsequently lose coverage may be able to enroll in the Plan in compliance with the Health Insurance Portability and Accountability Act of 1996. 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.

An individual must be allowed to enroll/terminate under the Plan if:

- The employee or dependent had been covered under another group health plan or had an individual health policy at the time coverage was initially offered and if required by the Plan Administrator, the employee stated at the time initial enrollment was offered that other coverage was the reason for declining enrollment in the Plan;
- The individual lost coverage as a result of a certain event, such as the loss of eligibility for coverage, loss of eligibility due to the Plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time employees), expiration of COBRA continuation coverage, termination of employment, reduction in the number of hours of employment, or employer contributions towards such coverage were terminated;
- A new model notice of special enrollment rights is provided. This notice must be provided on or before the time an employee is initially offered the opportunity to enroll in a group health plan;
- The employee's or dependent's Medicaid or State Child Health Insurance Plan (SCHIP) coverage is terminated as a result of loss of eligibility; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or SCHIP.

The individual must request special enrollment within 30 days of the date coverage is lost, except in the case of a qualifying event involving Medicaid or SCHIP (loss of eligibility or premium assistance eligibility). For these events, the individual must request special enrollment within 60 days of the event.

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.

Dependent Special Enrollment Period
Since the Plan provides dependent coverage, when a person becomes a dependent through marriage, domestic partnership, birth or adoption, the Plan must provide a dependent special enrollment period of not less than 30 days. If an individual seeks to enroll a dependent during the first 30 days, coverage must become effective:

- In the case of marriage, the date of such marriage.
- In the case of a domestic partnership, the date such partnership meets the criteria as determined by your employer.
- In the case of a newborn born to the employee or the employee's spouse / domestic partner, the date of such birth.
- In the case of adoption or placement for adoption by either the employee or the employee's spouse / domestic partner, the date of such adoption, or placement for adoption.
- The date the employee or the employee's spouse / domestic partner is required to provide health coverage to a child under a Qualified Medical Child Support Order (QMCSO), National Medical Child Support Notice (NMCSN) or administrative order.
- The date on which legal guardianship status begins.

If for any reason you do not enroll within 30 days after the termination of coverage or within 30 days after marriage, birth, adoption or placement for adoption, you and your dependents will not be eligible for coverage until the next open enrollment period. The only exception is for special enrollments related to Medicaid or SCHIP (loss of eligibility or gain of premium assistance eligibility), which must be requested within 60 days of the date of the event.

Late Enrollment
If you or your dependents are not enrolled within 30 days of the date you become eligible, under the terms of this Plan you may only request Plan coverage during the next open enrollment period unless you experience a special enrollment situation as outlined above.

Open Enrollment Period
The Open Enrollment Period is typically held in October. Please watch for annual communication on specific dates each year. Also during this time employees will be eligible to change some of their benefit decisions based on which benefits and coverage are right for them.

Benefit choices made during the Open Enrollment Period will become effective January 1st of the following year. Plan Participants will receive detailed information regarding Open Enrollment from their Employer.

TERMINATION OF BENEFITS

Employee's coverage will terminate on the earliest of the following dates:

- The date of the termination of the Plan, the date the Plan ceases for the class of employees to which you belong, or the date the employer terminates its participation in the Plan;
- The end of the month an employee ceases to be an employee;
- The end of the month upon failure to make any required contributions;
- The date of entry to the military service of any country or international organization on a full-time active duty basis other than scheduled drill or other training not exceeding one month in any calendar year *(Additional information regarding continuation of coverage can be found in the Military Leave of Absence section)*; or
- The last day of an approved leave of absence under the Family and Medical Leave Act, if the employee does not return to work *(Additional information can be found in the Family and Medical Leave Act section).*

Dependent's coverage will terminate on the earliest of the following dates:

- The date an employee's coverage is terminated;
- The end of the month in which the dependent ceases to meet the definition of a dependent as defined in the Plan; or
- The date the dependent commences participation in the plan as an Employee.

Fraudulent Claim Filing

The following actions or knowledge of such actions constitute fraud and will result in immediate termination of all coverage under this Plan:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
- Attempting to file a claim for a Covered Person for services that were not rendered or drugs or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the Plan; or
- Providing false or misleading information to the Plan.

NOTE: It is the employee's responsibility to notify the Human Resources Department / Benefits Personnel in writing within the designated time frames as noted in the *Important Highlights* Section when an employee or a dependent has a qualifying event occur and that employee or dependent is no longer eligible for benefits. **Failure to notify the Human Resources Department / Benefits Personnel will result in coverage being terminated as of the original date of the occurrence. Any claims paid after that date must be reimbursed to the employer.**

COVERAGE FOR EMPLOYEES AND DEPENDENTS OVER THE AGE OF 65

If you remain an employee after reaching age 65, you and/or your spouse may elect or reject coverage under this Plan. If you elect to remain covered under the Self-Insured Minimal Essential Coverage Health Benefit Program, this Plan will be the primary payer of benefits and Medicare will be secondary payer. However, if you choose Medicare to be your primary plan, coverage under this Plan will end. If you do not specifically choose one of the options, this Plan will continue to be primary.

If you choose this Plan as your primary payer, this Plan will pay the same benefits as if you or your spouse were under age 65. If you have enrolled in Medicare, you may then also send any unpaid portion of your bills to Medicare. If you are under age 65 and your spouse is over age 65, he or she can make their own choice. Please contact the Human Resources Department / Benefits Personnel for further details in making this important decision.

CONTINUATION OF COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that continuation of employer-sponsored health care coverage be made available to formerly covered employees and dependents for a specified period of time. If you become ineligible for coverage as the result of a change in your employment status, your coverage ends on the last day of the month of termination. You may choose to continue coverage if you lose your group health coverage because of a reduction in hours scheduled or because of termination for reasons other than gross misconduct.

A covered spouse of an employee may elect to continue coverage under the Plan on a self-pay basis if group health coverage is lost for any of the following reasons:

- The death of the employee;
- Reduction in the employee's hours of employment or termination of the employee's employment for other than gross misconduct or;
- Divorce or legal separation from the employee;
- The employee becomes entitled to Medicare; or
- The Employer files for re-organization under Chapter XI of the Bankruptcy Law (only relates to retiree plans).

In the case of a dependent child of an employee covered by the Plan, he or she may choose to continue coverage on a self-pay basis if group health coverage under the Plan is lost for any of the following reasons:

- The death of the employee;
- The termination of the employee's employment for other than gross misconduct or reduction in a parent's hours of employment;
- Parents divorce or legal separation;
- The employee becomes entitled to Medicare;
- The dependent ceases to be a "dependent child" as defined under the Plan; or
- The Employer files for re-organization under Chapter XI of the Bankruptcy Law (only relates to retiree plans).

The employee or the eligible family member has the responsibility to inform the Human Resources Department / Benefits Personnel of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the event. It is the responsibility of the Human Resources Department / Benefits Personnel to notify the COBRA Administrator within 30 days of an employee's termination of employment, reduction in hours, *Medicare entitlement, or *death.

** If a second qualifying event is the death of the covered employee or the covered employee becoming entitled to Medicare benefits, a group health plan may require qualified beneficiaries to notify the Plan Administrator within 60 days of those events, as well. Ordinarily, the employer is responsible for notifying the Plan Administrator of an event that is the death of a covered employee or the covered employee becoming entitled to Medicare benefits. However, if the covered employee's employment has been terminated, the employer may not be in a position to be aware of those events. If the plan does not require qualified beneficiaries to notify the plan within 60 days of a second qualifying event that is the death of the covered employee or the covered employee becoming entitled to Medicare benefits, a qualified beneficiary should provide that notice by the later of the last day of the 18-month period or the date that is 60 days after the date of the second event.*

Children born to, or placed for adoption with a covered employee during a continuation coverage period also have the right to elect COBRA continuation coverage. Enrollment must be completed and submitted in writing within 30 days of the event and any additional premiums *(if applicable)* paid prior to eligibility. Coverage will be retroactive to the date of the event

You will be notified of your rights to continue coverage on a self-pay basis. You have at least sixty days from the date of the notice of your COBRA continuation of coverage rights to elect COBRA continuation coverage. If you do not choose continuation coverage, your group health insurance coverage will end as of the date you became ineligible to continue as a covered member of the Plan.

If an employee becomes ineligible for employer paid health care coverage because of a reduction in hours scheduled or because of voluntary resignation, the employee's continuation of coverage on a self-pay basis may last for up to 18 months. The 18 months may be extended to 29 months if a qualified beneficiary is determined to be disabled under Title II or XVI of the Social Security Act at any time within the first 60 days of continuation coverage. To benefit from this extension, you must notify the Plan Administrator of the disability determination within 60 days after the determination, and prior to the expiration of the initial 18-month COBRA period. The affected individual also must notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

18 to 36-Month Period (Second Qualifying Event): A spouse and dependent children who experience a second qualifying event may be entitled to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered employee, divorce or legal separation from the covered employee, the covered employee becoming entitled to Medicare benefits (under Part A, Part B or both), or a dependent child ceasing to be eligible for coverage as a dependent under the group health plan. The following conditions must be met in order for a second event to extend a period of coverage:

(1) The initial qualifying event is the covered employee's termination or reduction of hours of employment, which calls for an 18-month period of continuation coverage;

(2) The second event that gives rise to a 36-month maximum coverage period occurs during the initial 18-month period of continuation coverage (or within the 29-month period of coverage if a disability extension applies);

(3) The second event would have caused a qualified beneficiary to lose coverage under the plan in the absence of the initial qualifying event;

(4) The individual was a qualified beneficiary in connection with the first qualifying event and is still a qualified beneficiary at the time of the second event; and

(5) The individual meets any applicable COBRA notice requirement in connection with a second event, such as notifying the Plan Administrator of a divorce or a child ceasing to be a dependent under the plan within 60 days after the event.

If all conditions associated with a second qualifying event are met, the period of continuation coverage for the affected qualified beneficiary (or beneficiaries) is extended from 18 months (or 29 months) to 36 months.

18 to 36-Month Period (Special Rule): A special rule for dependents provides that if a covered employee becomes entitled to Medicare benefits (either Part A or Part B) before experiencing a qualifying event that is a termination of employment or a reduction of employment hours, the period of coverage for the employee's spouse and dependent children ends with the later of the 36-month period that begins on the date the covered employee became entitled to Medicare, or the 18-

or 29-month period that begins on the date of the covered employee's termination of employment or reduction of employment hours. (Note that under this special rule, the employee's Medicare entitlement is not a qualifying event because it does not result in loss of coverage for the employee's dependents; thus, the 36-month coverage period would be part regular plan coverage and part continuation coverage.)

Although an employee or eligible dependent may elect to continue coverage as outlined above, this period may be reduced because of any of the following events:

- The employer no longer provides group health coverage to any of its employees;
- The premium is not paid within the 45-day grace period following the election of COBRA continuation coverage;
- The premium for your continuation coverage is not paid; (the premium is due on the first of each month and will not be accepted after the thirtieth calendar day after the due date);
- You become an employee covered under another group health plan (the Covered Person may be able to maintain continuation of coverage if there is a pre-existing condition clause that would limit your coverage under the other group plan); However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.
- You or a covered dependent becomes entitled to Medicare after the COBRA election. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

  Additional information can be found regarding COBRA provisions for public-sector employees at www.cms.hhs.gov/ (The Center for Medicare and Medicaid Services).
- You were divorced from a covered employee and subsequently remarry, and are covered under your new spouse's group health plan.

If an employee or covered dependent elects to continue coverage on a self-pay basis, they may do so without proving insurability. However, if the election is not made within 60 days, health care coverage under the Plan will terminate retroactively to the day of the qualifying event. Further if the eligible employee or eligible dependent fails to make the initial COBRA continuation coverage premium payment within the 45-day grace period following the election of COBRA coverage they will be deemed ineligible for COBRA continuation coverage.

NOTE: Payment will not be considered made if a check is returned for non-sufficient funds.

The Plan Administrator reserves the right to terminate Plan coverage retroactively to the date the employee or covered dependent lost their eligibility under the terms of the employer-sponsored health care plan. This section of the Summary Plan Description is a summary of a very complicated law. In the event of any inconsistency between this Notice and federal law, federal law will take precedence.

Special Additional Continuation Coverage Election Period For "TAA-Eligible Individuals"
In addition to the other COBRA rules described above, there are some special rules that apply if you are classified as a "TAA-eligible individual" by the U.S. Department of Labor. (This applies only if you qualify for assistance under the Trade Adjustment Assistance Reform Act of 2002 because you become unemployed as a result of increased imports or the shifting of production to other countries.) The Plan Administrator will require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, federal income tax filings, etc. The plan need not require every available document to establish evidence of TAA

eligibility. You will be responsible for providing evidence of TAA eligibility when applying for coverage under the plan. The plan will not be required to assist you in gathering such evidence.

If you are classified by the Department of Labor as a TAA-eligible individual, and you do not elect continuation coverage when you first lose coverage, you may qualify for an election period that begins on the first day of the month in which you become a TAA-eligible individual and lasts up to 60 days. However, in no event can this election period last later than 6 months after the date of your TAA-related loss of coverage. If you elect continuation coverage during this special election period, your continuation coverage would begin at the beginning of that election period, but, for purposes of the required coverage periods described in this notice, your coverage period will be measured from the date of your TAA-related loss of coverage.

The Trade Adjustment Assistance Act also provides for a tax credit that may apply to some of your expenses for continuation coverage. You should consult with a financial advisor if you have questions about the tax credit.

Applicable Premium Payments
Payments of any portion of the applicable COBRA premium by the federal government on behalf of a TAA-eligible individual pursuant to TAA will be treated as a payment to the plan. Where the balance of any premium owed the plan by such individual is determined to be significantly less than the required applicable premium, as explained in IRS regulations 54.4980B-8, A-5 (b), the plan will notify such individual of the deficient payment and permit 30 days to make full payment. Otherwise the plan will return such deficient payment to the individual and coverage will terminate as of the original premium due date.

If You Have Questions
If you have questions about your COBRA coverage, you should contact the COBRA Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) provides leaves of absence up to 12 weeks for the birth or adoption of a child, care of an immediate family member with a serious health condition, or because of the employee's inability to perform the functions of his or her job due to the employee's own serious health condition. Health coverage benefits during your approved leave of absence under The Family and Medical Leave Act will continue as long as you pay any required contributions. If you do not return to work at the end of an approved leave, you will be required to reimburse the employer the difference between any required contributions and the total monthly premium.

It is the employee's responsibility to request leave under the FMLA and to comply with all requests for information, such as medical certifications, made by your employer. When the need for leave is foreseeable, the employee must provide reasonable prior notice and make efforts to schedule leave so as not to disrupt company operations. If you have any questions concerning your rights under the Family and Medical Leave Act, or your employer's responsibilities under the Act, please contact the Human Resources Department.

Service Member Family Leave: An eligible employee who is the spouse, son, daughter, parent, or next of kin of a service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to 26 weeks of leave in a single 12-month period to care for the service member. This leave is available during a "single 12-month period" during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA Leave combined.

Military Leave of Absence

(The Uniformed Services Employment and Reemployment Rights Act of 1994)

In the event an employee is called to active duty, he may elect to continue Plan coverage for up to 24 months, beginning on the date the employee's absence starts. The employee may be required to pay up to 102% of the full premium cost for continuation coverage, except a person on active duty for 30 days or less will not be required to pay more than the employee's share, if any, for the coverage. These rights apply only to employees and their dependents covered under the Plan before leaving for military service. If you have any questions regarding military leave of absence, continuation of coverage, the cost of continued coverage or the maximum period of such coverage, please contact the Human Resources Department.

If your participation in this Plan is terminated by reason of service in the uniformed services, your coverage will be reinstated upon re-employment without any exclusions or waiting periods that would not have applied if coverage had not been terminated. However, applicable exclusions may be imposed with respect to coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during service in the military.

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; the commissioned corps of the Public Health Service; and, any other category of person designated by the President in time of war or national emergency. Military fitness examinations also are considered service in the uniformed services. ROTC members are considered to be in uniformed services.

COORDINATION OF BENEFITS PROVISION

The purpose of this Plan is to provide you with reimbursement of your covered medical expenses based on the description of coverage as outlined in this Summary Plan Description. In the event that you or any of your covered dependents incur expenses for which benefits are payable under this Plan and at the same time benefits are payable under any other plan, the Plan will coordinate benefits.

In coordinating benefits, one of the two or more Plans involved will be the primary Plan, and the other Plan(s) will be secondary to it. The primary Plan pays without regard to the other Plan(s). The secondary Plans will coordinate their payments so that the total paid from all plans shall not exceed the allowable expenses.

An allowable expense is defined as any necessary health care service or supply when the service or supply is covered at least in part under any of the Plans involved. An example would be the difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an allowable expense if both the plans did not allow the cost.

Benefits, however, will still be limited under this Plan such that it will pay no more than what the Plan would have paid in the absence of this coordination provision. The applicable deductible and co-insurance limits will be applied to those expenses for which this Plan is liable either as the primary Plan or the secondary Plan.

Examples of other types of coverage with which benefits will be coordinated are:

- Insurance or any other arrangement of benefits for individuals of a group, including coverage for students sponsored by or provided through a school or other educational institution.
- Pre-payment coverage or any other coverage toward the costs of which any employer makes contributions or payroll deductions or any labor union makes contributions.
- Any governmental program or coverage required by statute including Medicare.
- Liability, homeowner's or automobile insurance, which is subject to any Motor Vehicle Financial Responsibility Law. This Plan shall have secondary liability for those medical expenses incurred as a result of a motor vehicle accident, on behalf of a Covered Person subject to any state automobile insurance law, regardless of the terms and conditions of any specific automobile policy. Furthermore, if a Covered Person has no Personal Injury Protection or medical benefits coverage, in a state where such coverage is mandated, coverage under this Plan shall be reduced by the minimum coverage requirement of the state with jurisdiction. In addition to the above, for those Covered Persons subject to no-fault automobile insurance law or the law of any other state which permits issuance of a state mandated motor vehicle policy with an optional high personal injury protection deductible, this Plan shall not recognize as a covered expense, the personal injury protection deductible selected by any Covered Person. Such deductible amount shall be the direct responsibility of the Covered Person.

The rules establishing the order of benefit determination are as follows:

No Coordination of Benefit Provision
If the other plan contains no provision for coordination of benefits, then its benefits shall be paid before all other Plan(s).

Non-Dependent or Dependent
The Plan covering the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is the primary plan, and the plan covering the person as a dependent is the secondary plan.

Medicare rules provide one exception to this rule. If the person is a Medicare beneficiary and covered as a dependent by a group health plan then Medicare is secondary to the plan covering the person as a dependent.

Employee or Retiree
If an individual is covered under one plan as an employee and another plan as a retiree, the employee plan is primary. However, if an individual is covered both as a retiree under one plan and as a dependent under a spouse's employee plan, order of benefit determination is that the retiree plan pays first and the dependent plan pays second.

Continuation Coverage (COBRA)
If an individual has continuation coverage under the federal COBRA law or state continuation laws and also is covered under another group health plan as an employee or retiree, then the continuation coverage pays second.

The specific rules establishing the order of benefit determination for a child covered under more than one plan are as follows:

Birthday Rule
If the parents are married or if a court order awards joint custody without specifying which parent has responsibility for providing health care coverage, the primary plan is the plan of the parent whose birthday is earlier in the year.

Court Order
If a court order specifies that one parent is responsible for health coverage, the plan of that parent will be the primary plan.

Parents are Separated or Divorced
In the absence of a specific court order the order of benefit determination is as follows:

- The plan of the custodial parent.
- The plan of the spouse of the custodial parent.
- The plan of the non-custodial parent.
- The plan of the spouse of the non-custodial parent.

When the above referenced rules fail to establish an order of benefit determination, the plan that has covered the person for the longer period of time is the primary payer.

Coordination with Medicare
Individuals may be eligible for Medicare Part A at no cost if they: (i) are age 65 or older, (ii) have been determined by the Social Security Administration to be disabled, or (iii) have end stage renal disease. Participation in Medicare Part B and D is available to all individuals who make application and pay the full cost of the coverage.

1. When an employee becomes entitled to Medicare coverage (due to age or disability) and is still actively at work, the employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.

2. When a dependent becomes entitled to Medicare coverage (due to age or disability) and the employee is still actively at work, the dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.

3. If the employee and/or dependent is also enrolled in Medicare (due to age or disability), this Plan shall pay as the primary plan. If, however, the Medicare enrollment is due to end stage

renal disease, the Plan's primary payment obligation will end at the end of the thirty (30) month "coordination period" as provided in Medicare law and regulations.

4. Notwithstanding Paragraphs 1 to 3 above, if the employer (including certain affiliated entities that are considered the same employer for this purpose) has fewer than one hundred (100) employees, when a covered dependent becomes entitled to Medicare coverage due to total disability, as determined by the Social Security Administration, and the employee is actively-at-work, Medicare will pay as the primary payer for claims of the dependent and this Plan will pay secondary.

5. If the employee and/or dependent elect to discontinue health coverage under this Plan and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

Right to Receive or Release Necessary Information
To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment
This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery
This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY

The Covered Person may incur medical or dental charges due to injuries, which may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against the liable third party, including but not limited to any Third Party's liability insurance and uninsured or underinsured motorist. The benefits advanced, or to be advanced by this medical plan will be paid only if the Covered Person fully cooperates with the terms and conditions of the Plan. When the Plan advances benefits for accidental injury or illness or other loss for the benefit of a Covered Person, the Plan shall be subrogated to all rights of recovery that the person, his heirs, guardians, executors, agents or other representatives may have as a result of the loss.

The Covered Person under the Plan who claims and receives an advance(s) of benefits on account of an injury caused by a third party must execute a reimbursement agreement at the time the first claim is submitted. The signed reimbursement agreement indicates that the Covered Person agrees to promptly reimburse the Plan for benefits advanced, out of any monies recovered against the person causing the injury or any other source as the result of judgment, award, settlement or otherwise.

Accepting advanced benefits under this Plan for incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim, which the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement from the first dollars recovered. The Plan specifically states that it has priority over **any and all** funds paid by any party to a Covered Person relative to the injury or sickness, including a priority over any claim for non-medical or dental charges, attorney fees, other costs or expenses, whether or not the Covered Person is made whole. If the Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursement received, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. The Plan may not pay for any additional care or treatment for the Covered Person, whether anticipated or unanticipated, until the Plan is reimbursed in accordance with the Plan terms.

If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds. If the injury or condition giving rise to subrogation involves wrongful death of a Covered Person, this provision applies to the parent, guardian or the executor, agent or other personal representative of the estate.

When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan advance benefits. Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan.

The Plan shall have no obligation to share the costs of, or pay any part of, the Covered Person's attorney's fees and costs incurred in obtaining any recovery. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of this Plan Document. Please refer to the *Defined Terms* Section for definitions of Subrogation, Recovery and Reimbursement.

COVERED MEDICAL EXPENSES

The Plan will provide preventive health care services as described in the Schedule of Medical Benefits. Information can be found by visiting http://www.healthcare.gov. It is advised to check regularly as the services listed herein are subject to change in accordance with federal law.

Preventive Care and Screening Services for Adults

The following evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"). This listing may change from time to time. For additional information go to: www.uspreventiveservicestaskforce.org

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked;
2. Alcohol Misuse screening and counseling;
3. Aspirin use to prevent cardiovascular disease for adults of certain ages;
4. Blood Pressure screening for all adults;
5. Cholesterol screening for adults of certain ages or at an increased risk for coronary heart disease;
6. Colorectal Cancer screening for adults over 50;
7. Depression screening for adults;
8. Diabetes screening for type 2 diabetes for adults with sustained high blood pressure;
9. Falls prevention screening for exercise or physical therapy or vitamin D supplementation in adults age 65 and older who are at increased risk for falls;
10. Healthy diet and physical activity counseling to prevent cardiovascular disease for adults who are overweight or obese and have additional risk factors for cardiovascular disease;
11. Hepatitis B screening for adults at high risk for infection;
12. Hepatitis C virus infection screening for adults of certain ages;
13. HIV screening for all adults at higher risk;
14. Lung cancer screening for adults of certain ages who have a history of smoking and currently smoke or quit within the past 15 years;
15. Obesity screening and counseling for all adults;
16. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
17. Skin cancer behavioral counseling in young adults to 24 years of age who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
18. Syphilis screening for all adults at higher risk;
19. Tobacco Use screening for all adults and cessation interventions for tobacco users.

Immunization vaccines for adults that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention, including: Hepatitis A; Hepatitis B; Herpes Zoster; Human Papillomavirus; Influenza (Flu Shot); Measles, Mumps, Rubella; Meningococcal; Pneumococcal; Tetanus, Diphtheria, Pertussis; and Varicella. The ACIP recommendations include the ages when the vaccine should be given, the number of doses needed, the amount of time between doses, and precautions and contradictions. For an up-to-date listing of the ACIP immunization vaccines' recommendations go to: http://www.cdc.gov/vaccines/acip/recs/

Preventive Care and Screening Services For Women, Including Pregnant Women
In addition to the USPSTF "A" or "B" rating preventive services for adults described above, the following is a listing of the USPSTF recommendations with respect to women:

1. Anemia screening for iron deficiency anemia on a routine basis for pregnant women;
2. Bacteriuria screening with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later;
3. BRCA risk assessment and generic counseling/testing for women who have family members with breast, ovarian, tubal or peritoneal cancer;
4. Breast Cancer preventive medications counseling for women at increased risk for breast cancer;
5. Breast cancer screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older;
6. Breastfeeding counseling during pregnancy and after birth to promote and support breastfeeding;
7. Cervical Cancer screening for sexually active women, in women ages 21 to 65 years with cytology (pap smear) every 3 years, or for women ages 30-65 who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years;
8. Chlamydia Infection screening for pregnant and non-pregnant women age 24 years and younger and for older women at increased risk;
9. Folic Acid supplements for women planning or capable of pregnancy;
10. Gestational Diabetes mellitus screening for pregnant women 24 to 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be high risk for diabetes;
11. Gonorrhea screening for all women at increased risk for infection, including those who are pregnant;
12. Hepatitis B screening for pregnant women at their first prenatal visit;
13. Human Immunodeficiency Virus (HIV) screening and counseling for all adults, including pregnant women who present in labor who are untested and whose HIV status is unknown;
14. Intimate partner violence, such as domestic violence, screening for women of childbearing age who do not have signs or symptoms of abuse;
15. Osteoporosis screening for women age 65 and older and in younger women whose fracture risk is equal to or greater than that of a 65-year old white women who has no additional risk factors;
16. Preeclampsia prevention medication of aspirin use after 12 weeks gestation in women who are at high risk for preeclampsia;
17. Rh incompatibility screening for Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care; and for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative;
18. Sexually Transmitted Infections (STI) counseling for women at increased risk for STIs;
19. Syphilis screening for all pregnant women;
20. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users;

With respect to women, such additional preventive care and screenings not addressed above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration including:

1. One well-woman preventive care visit per plan year for an adult woman to obtain the recommended preventive screening services that are age appropriate and developmentally appropriate, including preconception.

   More than one visit may be needed to obtain all the recommended preventive screening services, depending on a woman's health status, health needs and other risk factors. Additional well-woman visits will be covered if the Physician determines they are necessary to help establish what preventive screening services are appropriate and to set up a plan to help the woman get the care she will need to be healthy.

   If covered preventive screening services are received during an office visit, and the primary purpose of the office visit is other than the delivery of preventive care services, only the portion of the billed services pertaining to the preventive screening services will be reimbursed by SSL under the Excess Loss coverage.
2. High-risk human papillomavirus DNA testing in women with normal cytology results. One screening is covered for females 30 years of age and over and will be covered no more frequently than once every 3 years.
3. One counseling session per plan year for counseling on sexually transmitted infections for all sexually active women.
4. One counseling session and screening per plan year for human immune-deficiency virus infection for all sexually active women.
5. All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include coverage for abortifacient drugs.
6. One screening and counseling for interpersonal and domestic violence per plan year.
7. Breastfeeding support, supplies and counseling in conjunction with each birth: Comprehensive lactation support and counseling by a trained Provider during Pregnancy and/or in the postpartum period. Coverage includes the costs for renting or purchase of one breast pump per Pregnancy for the duration of the breast feeding.
8. Routine prenatal obstetrical office visits, up to one visit per month for women at 4-24 weeks' gestation, 2 visits per month for 28-36 weeks' gestation, one visit per week at 36 weeks' gestation to birth, and one postpartum office visit after birth. This also covers lab services explicitly identified in the health reform Affordable Care Act, tobacco cessation counseling specific to pregnant women, and immunizations recommended by the Advisory Committee on Immunizations Practices. This does not cover radiology (i.e., obstetrical ultrasounds) delivery and high-risk pre-natal services (i.e., chorionic villus sampling and amniocentesis and other genetic testing).

Preventive Care and Screening Services For Children

With respect to infants, children and adolescents, evidence based items or services that have in effect a USPSTF "A" or "B" rating, and evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; For an up-to-date listing of the preventive services for children, including the recommended ages and schedules, and immunization vaccines, go to: http://www.hhs.gov/healthcare/prevention/children

1. Alcohol and drug use assessments for adolescents;
2. Autism screening for children at 18 and 24 months;
3. Behavioral assessments for children of all ages (ages 0-11 months; 1-4 years; 5-10 years; 11-14 years 15-17 years);
4. Blood Pressure screening for children (ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years);
5. Cervical Dysplasia screening for sexually active females;
6. Congenital Hypothyroidism screening for newborns;
7. Depression screening for adolescents;
8. Developmental screening for children under age 3, and surveillance throughout childhood;
9. Dyslipidemia screening for children at higher risk of lipid disorders (1-4 years; 5-10 years; 11-14 years; 15-17 years);
10. Fluoride Chemoprevention supplements starting at age 6 months for children without fluoride in their water source; and the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption;
11. Gonorrhea preventive medication for the eyes of all newborns;
12. Hearing screening for all newborns;
13. Height, Weight, and Body Mass Index measurements for children (ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years);
14. Hematocrit or Hemoglobin screening for children;
15. Hemoglobinopathies or sickle cell screening for newborns;
16. Hepatitis B screening for adolescents at high risk for infection;
17. HIV screening for adolescents at higher risk;
18. Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis; Haemophilus influenza type b; Hepatitis A; Hepatitis B; Human Papillomavirus; Inactivated Poliovirus; Influenza (Flu Shot); Measles, Mumps, Rubella; Meningococcal; Pneumococcal; Rotavirus; Varicella;
19. Iron supplements for children ages 6 to 12 months who are at increased risk for anemia;
20. Lead screening for children at risk of exposure;
21. Medical history for all children throughout development (ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years);
22. Obesity screening and counseling;
23. Oral Health risk assessment for young children (ages 0-11 months; 1-4 years; 5-10 years);
24. Phenylketonuria (PKU) screening for this genetic disorder in newborns;
25. Sexually Transmitted Infection (STI) prevention counseling and Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
26. Tuberculin testing for children at higher risk of tuberculosis disorders (ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years);
27. Vision screening for all children.

MEDICAL EXCLUSIONS AND LIMITATIONS

No payment will be made under any provision of this Plan for expenses incurred by a Covered Person for:

Administration Fees – Expenses for missed appointments, completion of claim forms or provided medical information to determine coverage, and/or charges for telephone consultations.

Excess Charges – The part of an expense for care and treatment that is in excess of the Usual and Reasonable Charge.

Experimental or Investigational – Drugs, medicines, treatments, procedures and therapies. A drug or medicine will be considered experimental unless, at the time it is provided, it is commercially available and approved for general use by the United States Food and Drug Administration as effective for treatment or diagnosis of the condition for which the charge is made. The approval must not be on a limited or an experimental basis. A treatment, procedure or therapy will be considered experimental unless at the time it is provided or performed, it is considered effective for the treatment or diagnosis of the condition for which the charge is made. The treatment, procedure or therapy must not be considered effective on a limited or an experimental basis.

Government Coverage – Care, treatment or supplies furnished by a program or agency funded by any government for which the Covered Person is not liable for payment. This does not apply to covered expenses rendered by a United States Veteran's Administration Hospital when services are provided for a non-service related illness or injury, Medicaid or when otherwise prohibited by law.

No Charge – Charges for which the Covered Person and/or the Plan are not legally required to pay, including charges, which would not have been made if no coverage existed.

No Obligation to Pay – Expenses for services, which are furnished under conditions, which the Covered Person has no legal obligation to pay. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires the Employer's plan to be primary.

No Physician Recommendation – Care, treatment, services or supplies not recommended, prescribed, performed or approved by a legally qualified Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment that is appropriate care for the injury or sickness.

Relative Giving Services – Charges for treatment or services of physicians, nurses, or other practitioners, who live in your home and/or if the provider of service is the employee, employee's spouse, child, brother, sister or parent, whether the relationship is by blood or exists in law.

Services Before or After Coverage – Charges for services and/or supplies provided before the effective date of coverage under the Plan, or provided after termination of coverage under the Plan.

REFER TO THE COVERED MEDICAL EXPENSES SECTION FOR A COMPLETE LISTING OF WHAT SERVICES ARE COVERED BY THIS PLAN

DEFINED TERMS

Amendment (Amend) – A formal document signed by the representatives of the Self-Insured Minimal Essential Coverage Health Benefit Program. The amendment adds, deletes, or changes the provisions of the Plan and applies to all Covered Persons, including those persons covered before the amendment becomes effective, unless otherwise specified.

Assignment of Benefits – Authorization by the employee for the Plan to pay benefits directly to the provider of the service.

Business Associate – A person who, on behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement:

- Performs, or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management and repricing; or
- Provides, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Company – The Company is Hallmark Marketing LLC, and any affiliates who have adopted the Plan.

Covered Entity – In terms of the HIPAA Privacy Regulations a Covered Entity includes a health plan; a health care provider who transmits any health information in electronic form in connection with a covered transaction; or a health care clearinghouse that handles electronic claims from a provider.

Covered Person – An employee or dependent covered under this Plan.

Eligible Charge – The negotiated amount a network provider has agreed upon for a specific service or the Usual, Reasonable and Customary amount for the area in which the service is rendered by a non-network provider.

Employee – A person directly employed in the regular business of, and compensated for services by Hallmark on a regularly scheduled, part-time basis, and regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer – Hallmark Marketing LLC, 2501 McGee MD #510, Kansas City MO 64108, (888)-545-6200

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

Experimental/Investigational – Any treatment, procedure, facility, equipment, drugs, drug usage or supplies that are not recognized by the national board of the appropriate medical specialty as a generally accepted course of treatment for the medical condition being treated or which is performed for research or educational purposes or which has not been approved by a federal or state agency having jurisdiction and authority to approve such treatment, procedure, facility, equipment, drug or supplies.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Fiduciary – The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan. The named fiduciary for this Plan is the Plan Administrator – Hallmark Benefit Plans Welfare Committee.

Group Health Plan – Any individual or group plan, private or governmental, that provides or pays for medical care, to the extent specified in the HIPAA Privacy Regulations, 65 Fed. Reg. No. 250 (82463).

HIPAA – The Health Insurance Portability and Accountability Act of 1996.

Late Enrollee – A Covered Person who enrolls under the Plan other than during the earliest date on which coverage can become effective under the terms of the plan; or during a special enrollment period.

Lifetime – Refers to benefit maximums and limitations while covered under this Plan.

Medically Necessary (Medical Necessity) – Care and treatment recommended or approved by a physician, which is consistent with the patient's condition and accepted standards of medical practice, medically proven to be effective treatment of the condition, not performed solely for the convenience of the patient or provider, not conducted for investigative, educational, experimental or research purposes, and is the most appropriate level of service that can be safely provided to the patient. The fact that a physician may prescribe, order, recommend, or approve a service does not,

of itself, make it medically necessary or make the charge a covered expense, even though it is not specifically listed as an exclusion under this Plan.

Medicare – The program established by Title 1 of Public Law 89.97 (79 Stat. 291) as amended, entitled Health Insurance for the Aged Act, and which includes: Part A - Hospital Insurance Benefits for the Aged; Part B - Supplementary Medical Insurance Benefits for the Aged.

Medicare Entitlement – Receiving coverage from Medicare. Normally this is accomplished when an individual who is age 65 signs up for Social Security benefits, which automatically enrolls the individual in the Medicare Program. Medicare coverage also is possible for individuals with kidney (end-stage renal) disease, or for individuals younger than age 65 who Social Security deems disabled, effective on the first day of the 25th month after the date the individual's Social Security disability began. Social Security disability benefits do not begin until the sixth full month of disability.

Physician – Physician shall mean a legally qualified and licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dentistry (D.M.D. or D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Ophthalmology (D.O. or M.D.) or Optometry (O.D.). Any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license must be pre-approved by the Plan Administrator.

All medical services provided must be within the scope of his or her license or certificate.

Plan – Self-Insured Minimal Essential Coverage Health Benefit Program, which is a benefits plan for certain employees of Hallmark Marketing, Hallmark Retail, and Halls LLC and is described in this document.

Plan Sponsor – Distinguished from Health Plan for privacy purposes. Defined at section 3(16)(B) of ERISA, 29 U.S.C. 1002 (16)(B).

Plan Year – The 12-month period beginning on either the effective date of the Plan or on the day following the end of the first plan year, which is a short plan year.

Preferred Provider Organization (PPO) – A company that contracts with a selected group of Hospitals and physicians (preferred providers) offering quality care. The Plan pays network providers on a fee-for-service basis, usually at discounted rates. The Plan is designed to provide financial incentives in the form of increased benefits to members utilizing preferred providers.

Pregnancy – Childbirth and conditions associated with pregnancy, including complications.

Protected Health Information – Information that is created or received by the Plan, or a Business Associate of the Plan, whether oral, written, or in electronic form, and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Individually Identifiable Health Information includes information of persons living or deceased.

Qualified Medical Child Support Order – An issued order, judgment, decree or settlement agreement by a court of competent jurisdiction that requires a non-custodial parent to provide medical coverage for his or her child who might not otherwise be eligible for coverage. A qualified order includes information regarding: 1) The Covered Person's name and address; 2) The name and last known mailing address of the alternate recipient (i.e., the child); 3) The name of the Plan the child will be covered by; 4) A reasonable description of the type and scope of health coverage provided under the Plan; 5) The period of time to which the order applies; and 6) The order must be

signed by the Judge, Commissioner or Magistrate who is presiding over the divorce. The enacted Omnibus Budget Reconciliation Act of 1993 (OBRA 93) provides for the recognition of qualified medical child support orders (QMCSO) by group health plans.

Recovery – Monies paid to the Covered Person by way of judgment, settlement or otherwise to compensate for all losses caused by the injuries or sickness whether or not said losses reflect medical, dental or other charges covered by the Plan.

Recovery from another plan under which the Covered Person is covered. This right of refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

Reimbursement – Repayment to the Plan for medical or dental benefits that it has advanced toward care and treatment of the injury or sickness.

Subrogation – The Plan's right to pursue the Covered Person's claims for medical or dental charges against the person causing injury.

Third Party Administrative Functions – Activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the plan or solicit bids from prospective issuers. Plan administration functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans – such as vision and dental. Protected Health Information for these purposes may not be used by or between Covered Entities or Business Associates of a Covered Entity in a manner inconsistent with HIPAA's Privacy Regulation, absent an authorization from the individual. Plan administration specifically does not include any employment-related functions.

Usual, Customary and Reasonable (UCR) – **Usual** means the provider's most frequent charge for the service or treatment. **Customary** means the charge made, for the same service in the same area, by other physicians or medical service providers with similar training and experience. **Reasonable** means the medical care or supplies; usually given and the fee usually charged for the cases in that area. The Plan will reimburse the actual charge billed if it is lesser than the usual and reasonable charge. The Plan Administrator has the discretionary authority to decide whether a charge is usual, customary and reasonable.

GENERAL PROVISIONS

Administration – This plan of benefits is administered through the Human Resources Department / Benefits Personnel of Hallmark Cards. As Plan Administrator, the Hallmark Benefit Plans Welfare Committee shall have the discretionary power and authority to: determine eligibility for benefits; interpret or construe the terms of the Plan and any other writing affecting the establishment or operation of the Plan; determine questions of fact which arise in connection with the Plan; and decide all matter arising under the Plan, based on the applicable facts and circumstances. The Loomis Company has been retained to provide independent services in the area of claims processing.

Assignment of Benefits – In the event a Plan participant has executed an Assignment of Benefits, the Plan shall direct amounts payable under the terms of this Plan to the provider of service. If the Plan receives notification from a provider that the provider has the Plan participant's authorization to assign benefits on file, then that shall be acceptable notice to the Plan that an Assignment of Benefits has been executed. Benefits may not, however, be assigned to anyone other than the provider of service without the approval of the Plan Administrator.

Funding – The benefits outlined in this booklet are paid directly from the required employee contributions.

Plan Amendment or Termination – The Plan Administrator reserves the full, absolute and discretionary right to amend, modify, suspend, withdraw, discontinue or terminate the Plan in whole or in part at any time for any and all participants of the Plan by formal action taken by the Board of Directors, or by the execution of a written amendment by the Plan Sponsor. If the Plan is amended, modified, suspended, withdrawn, discontinued or terminated, covered employees and covered dependents will be entitled to benefits for claims incurred prior to the date of such action. Such changes may include, but are not limited to, the right to (1) change or eliminate benefits, (2) increase or decrease participant contributions, (3) increase or decrease deductibles and/or co-payments, and (4) change the class of employees or dependents covered by the Plan.

Medical Care Decision – The benefits under the Plan provide solely for the payment of certain health care expenses. All decisions regarding health care are solely the responsibility of each Covered Person in consultation with the health care providers selected. The Plan contains rules for determining the percentage of allowable health care expenses that will be reimbursed, and whether particular treatments or health care expenses are eligible for reimbursement. The Covered Person in accordance with the Plan's appeal procedures may dispute any decision with respect to the level of health care reimbursements, or the coverage of a particular health care expense. Each Covered Person may use any source of care for health treatment and health coverage as selected, and neither the Plan nor the employer shall have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a Covered Person not to seek or obtain such care, other than the liability of the Plan for the payments of benefits as outlined herein.

RIGHTS AND PROTECTIONS

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, 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 Pension and Welfare Benefit Administration.

- Obtain copies of all plan documents such as the Form 5500, insurance contracts, collective bargaining agreements, updated summary plan descriptions, and other plan information upon written request to the Plan Administrator. The 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 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 or the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this 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 the other Covered Persons and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If a claim for a welfare benefit is denied 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 a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests information from the Plan and does not receive it within 30 days, they may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until the Covered Person receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrators. If anyone has a claim for benefits, which is denied or ignored, in whole or in part, they may file suit in a state or federal court. In addition, if a Covered Person disagrees 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 a federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if anyone is discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or file suit in a federal court. The court will decide who should pay court costs and legal fees. If the individual is successful, the court may order the persons sued to pay these costs and fees. If the individual loses, the court may order that person to pay these costs and fees, for example if it finds the claim is frivolous.

If there are any questions about the Plan, contact the Plan Administrator. If there are any questions about this statement or about ERISA rights, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Area 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, NW, 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.

LEGISLATIVE COMPLIANCE

All provisions of the Plan shall at all times be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), ERISA and other applicable governmental laws, statutes, regulations, or rules promulgated by any governing unit having appropriate jurisdiction. The Plan Administrator shall administer the Plan accordingly, as well as complying with any changes to such statutes, regulations or rules affecting these provisions.

Pursuant to HIPAA, the Plan will at no time take into consideration any health status related factors, (physical or mental illnesses, prior receipt of health care, prior medical history, genetic information, evidence of insurability, conditions arising out of acts of domestic violence, or disability) which exist in relation to a person who is eligible for coverage under the Plan for purposes of determining the initial or continued eligibility of coverage under the Plan, for determining the level of contribution to Plan funding, or to determine the level of benefits which will be made available to a person. All Plan participants will be given written notice of any material reduction in benefits provided by the plan within 60 days of the adoption of such material reduction.

No provision contained in this booklet nor any portion of the Plan shall give a Plan participant or entity acting on their behalf any right or cause of action, either at law or in equity against the Plan Administrator, the Third Party Administrator or the Plan Sponsor for the acts of any Hospital where care is received, for the acts of any physician, or other provider from whom services are received and benefits are provided under this Plan.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how protected health information (or "PHI") may be used or disclosed by us (or your Group Health Plan) to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your PHI, and describes your rights to access, amend and manage your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact: The Loomis Company at the customer service number listed on your ID card.

Effective Date: This Notice of Privacy Practices became effective on September 23, 2013.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your PHI. We are obligated to: provide you with a copy of this Notice of our legal duties and of our privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will make the revised Notice available by posting on the group website.

PERMISSIBLE USES AND DISCLOSURES OF PHI

Payment and Health Care Operations

We have the right to use and disclose your PHI for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

- ***Payment:*** We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

- ***Health Care Operations:*** We will use or disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business

development. For example, we may use or disclose your PHI: (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your PHI.

- *Required by Law:* We may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

- *Public Health Activities*: We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- *Health Oversight Activities:* We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

- *Abuse or Neglect:* We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence.

- *Legal Proceedings:* We may disclose your PHI: (i) in the course of any judicial or administrative proceeding; (ii) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

- *Law Enforcement:* Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.

- *Coroners, Medical Examiners, Funeral Directors; Organ Donation Organizations:* We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

- *Research:* We may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.

- *To Prevent a Serious Threat to Health or Safety:* Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- *Military Activity and National Security, Protective Services:* Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

- *Inmates:* If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.

- *Workers' Compensation:* We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- *Emergency Situations:* We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will disclose only the PHI that is directly relevant to the person's involvement in your care.

- *Fundraising Activities:* We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- *Group Health Plan Disclosures:* We may disclose your PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to you. We can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.

- *Underwriting Purposes:* We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.

- *Others Involved in Your Health Care:* Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

USES AND DISCLOSURES OF YOUR PHI THAT REQUIRE YOUR AUTHORIZATION

- *Sale of PHI:* We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.
- *Marketing:* We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.
- *Psychotherapy Notes:* We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

REQUIRED DISCLOSURES OF YOUR PHI

The following is a description of disclosures that we are required by law to make.

- *Disclosures to the Secretary of the U.S. Department of Health and Human Services:* We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.
- *Disclosures to You:* We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

  We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

  Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.
- *Business Associates:* We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform

these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, subrogation, or pharmacy benefit management.

- *Other Covered Entities:* We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

- *Plan Sponsor:* We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

YOUR RIGHTS

The following is a description of your rights with respect to your PHI.

- *Right to Request a Restriction:* You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. *We are not required to agree to any restriction that you may request.* If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. You may request a restriction by contacting the Plan Administrator. It is important that you direct your request for restriction to the Plan Administrator so that we can begin to process your request. Requests sent to persons or offices other than the Plan Administrator might delay processing the request.

  We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

  Right to Request Confidential Communications: If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

  You may request a restriction by contacting the Plan Administrator. It is important that you direct your request for confidential communications to the Plan Administrator so that we can

begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.*, an Explanation of Benefits, or "EOB"). *Unless* you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within two business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely important that you contact the Plan Sponsor as soon as you determine that you need to restrict disclosures of your PHI.

If you terminate your request for confidential communications, the restriction will be removed for all your PHI that we hold, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

Right to Inspect and Copy: You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your PHI that is contained in a designated record set, you must submit your request to the Plan Administrator. It is important that you contact the Plan Administrator to request an inspection and copying so that we can begin to process your request. Requests sent to persons or offices other than the Plan Administrator might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the Plan Administrator. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will

not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

Right to Amend: If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by contacting the Plan Administrator. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to the Plan Administrator so that we can begin to process your request. Requests sent to persons or offices, other than the Plan Administrator might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Right of an Accounting: You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to the Plan Administrator. It is important that you direct your request for an accounting to the Plan Administrator so that we can begin to process your request. Requests sent to persons or offices other than the Plan Administrator might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

Right to a Copy of This Notice: You have the right to request a copy of this Notice at any time by contacting the Plan Administrator. If you receive this Notice on our Website or by electronic mail, you also are entitled to request a paper copy of this Notice.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the customer service number listed on your ID card. A copy of a complaint form is available from this contact office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

HIPAA SECURITY REGULATIONS

We are required to:

- Implement administrative, physical, and technical standards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
- Ensure that the firewall required by the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- Ensure that any agent or subcontractor to whom the Plan Administrator provides electronic PHI agrees to implement reasonable and appropriate security measures; and
- Report to the Plan any security incident of which the Plan Administrator becomes aware.

NO VERBAL MODIFICATIONS

The Covered Person shall not rely on any oral statement from any employee of The Loomis Company which modifies or otherwise affects the benefits, general limitations and exclusions, or other provisions of this Plan and increases, reduces, waives or voids any coverage or benefits under this Plan.

In addition, such oral statement shall not be used in the prosecution or defense of a claim under this Plan.

Any written or oral verification received from the Plan is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a participant.

MISSTATEMENTS

In the event of any misstatement of any fact(s) affecting coverage under the Plan, the true facts will be used to determine the proper coverage. Coverage means eligibility as well as the amount of any benefits herein.

This booklet is not a contract. It explains in non-technical language the essential features of your Employee Benefit Program. Contact the Human Resources Department / Benefits Personnel if there are any questions concerning coverage.