



DENTAL REIMBURSEMENT
SUMMARY PLAN DESCRIPTION
FOR
PLAN PARTICIPANTS

Administered by: CAREFLEX Benefit Solutions
205 West Dares Beach Road
Prince Frederick, MD 20678
(888) 577-2762 (410) 535-0754

Updated 06/09

**SIGMA SPACE CORPORATION
DENTAL REIMBURSEMENT BENEFIT PLAN
SUMMARY PLAN DESCRIPTION**

This is the official Summary Plan Description (SPD) for **Sigma Space Corporation** Dental Reimbursement Benefit Plan (the “Plan”). The Plan is a self-funded benefit plan that reimburses eligible employees and their eligible dependents for covered dental expenses. The Plan is available to the employees of **Sigma Space Corporation** (the “Company”). It does not involve an insurance company. **CAREFLEX Benefit Solutions** is the Claims Administrator.

If you elect to participate in the Plan, and your plan is contributory, your pay will be reduced on a before-tax basis by the amount required to pay for the type of coverage you elected. This is accomplished through automatic salary reduction. Your regular pay is reduced by the cost of your elected benefits, enabling you to save on both social security and income taxes via your benefit contributions. If your plan is non-contributory, your Employer pays 100% of the cost to participate.

You may elect to cover only yourself or you may elect to cover yourself and all of your dependents. As you incur dental expenses, you may submit claims for reimbursement of these expenses. If your dental expenses are eligible for reimbursement under the terms of the Plan, you will receive a check for all or a portion of the reimbursable expenses (as payable under the Plan).

This Summary Plan Description will explain in more detail how the Plan works. However, if you have any questions concerning your benefits, ask your local Human Resources representative.

The Company reserves the right to amend or terminate this Plan at any time. Nothing in this Summary Plan Description is intended to provide vested or non-changeable benefits. The Company also can change the benefits or contributions under the Plan or any other aspect of the Plan at any time and for any reason. The changes will apply to all covered persons, unless otherwise specified by the Company. Generally, these amendments will not apply to expenses incurred prior to the date of enactment of the amendments or termination.

WHO IS ELIGIBLE?

All eligible full-time employees and their eligible dependents, may participate in the Plan. You are a full-time employee if you routinely work at least 20 hours per week. Eligible dependents include your spouse to whom you are legally married and unmarried children under 19 years of age. Unmarried children between the ages of 19 and 23 may be included if they are full-time students. It is the employee's responsibility to provide proof of full-time student status. A full-time student is a dependent in regular attendance at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on, and who receives over half of his or her support from the Participant.

An unmarried child with a mental or physical handicap or developmental disability, who can't support himself/herself may stay eligible for dependent coverage beyond the Plan's age limit if:

- a) the condition started before he/she reached this Plan's age limit;
- b) he/she became covered by this Plan before he/she reached the age limit and stayed continuously covered until he/she reached such limit; and
- c) he/she depends on you for at least half of his/her support and maintenance.

To do this, it is the employee's responsibility to send written proof that the child is handicapped and depends on you for at least half of his/her support and maintenance within 31 days from the date the child reaches the age limit. The employee may be asked for periodic proof that the child's condition continues. The child's coverage ends when yours does.

You can elect individual coverage (which only covers you), or you can elect dependent coverage (which covers Employee/Child, Employee/Spouse, or Family). However, if you are divorced or separated from your spouse, you may be required under the terms of a "Qualified Medical Child Support Order" to provide dental coverage under the Plan to any of your children named in such order. A Qualified Medical Child Support Order is an order satisfying the requirements of ERISA and requiring a dental (or health) plan to recognize the child of parent-employee as a plan participant.

WHAT MUST I PAY FOR COVERAGE?

If the Plan is contributory, the Company and Employee share in the cost. If the Plan is non-contributory, the Company pays 100% of the cost.

HOW DO I ENROLL FOR COVERAGE?

If you want to cover yourself or your dependents under the Plan, you must:

- (1) elect the coverage on the proper form; and
- (2) agree in writing to make the required contributions, if applicable.

Prior to the first day of each Plan Year (**April 1st - March 31st**) the Company will provide an annual enrollment period during which you may elect to be covered under the Plan or, if you are already covered, to change the type of coverage (for example, from individual to one of the dependent coverage options).

The coverage you elect during the annual enrollment period will become effective on **April 1st** following the annual enrollment period. If you become employed after May 1, 2009, or during the Plan Year and you elect coverage during a period other than the open enrollment period, your coverage will be effective on the actual ***"date of hire"*** (***form must be submitted within 60 days of employment***) provided you have completed the proper enrollment form.

CAN I CHANGE MY ELECTION DURING THE YEAR?

Your election to receive dental coverage under the Plan will remain in effect for the Plan Year (**May 1st - April 30th**). If you are a new employee and elected coverage during a period other than the open enrollment period, your initial election will remain in effect from the date your election became effective until the following **April 30th**. If you do not complete a new election form for dental coverage during the next annual enrollment period, your election automatically will remain in effect for the next Plan Year.

You may change your election decisions during the Plan Year only if you have a qualifying change in status, and the change in status results in you, your spouse or your dependent(s) gaining or losing eligibility and the election change corresponds with the gain or loss of coverage. Qualifying status changes include the following:

- ◆ Special Enrollment Rights - Allows you to change your coverage elections in accordance with the special enrollment rights provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- ◆ Legal Marital Status - Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation or annulment;
- ◆ Number of Dependents - Events that change the number of eligible Dependents, including regaining eligibility status (i.e. returning to school full-time), birth, adoption, placement for adoption, or death of a Dependent;

- ◆ Employment Status - Events that change employment status such as termination or commencement of you, your spouse's or your Dependent's employment,
- ◆ a reduction or increase in hours of employment by you, your spouse, or your Dependent, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence and any change in your spouse or Dependent's employment status that results in that person becoming (or ceasing to be) eligible under a Plan.
- ◆ Dependent Satisfies or Ceases to Satisfy the Requirements for Unmarried Dependents;
- ◆ Residence or Worksite - A change in the place of residence or work for you, your spouse, or your Dependent; or
- ◆ Other Events:
 - Judgment, Decree or Order - If you are subject to a judgment, decree or order resulting from a divorce or similar proceeding that requires you to provide medical coverage for your child, subject to the Employer's approval, you may make a corresponding change in your election. If your former spouse or another individual is required to provide coverage for your child pursuant to such a judgment, decree or order, subject to the Employer's approval, you may make a corresponding change in your election.
 - Medicare/Medicaid Coverage - If you, your spouse, or your Dependent becomes entitled to Medicare or Medicaid or loses eligibility, a corresponding election change is permitted.
 - Eligibility for COBRA/State Continuation - If you, your spouse or your Dependent becomes eligible for and elects COBRA/State Continuation under the Plan, you may make a corresponding election to pay for the continuation coverage.
 - Family and Medical Leave Act - If you take leave under the Family and Medical Leave Act of 1993 ("FMLA"), you make other elections concerning group health coverage that are permitted by FMLA.
 - Significant Cost Increases - If the cost of benefits significantly increases during a Plan Year, as determined by the Employer, you may elect to increase your election or you may elect coverage under another benefit option, if any, that offers similar coverage, as determined by the Employer.

- Coverage Changes - If coverage under a benefit option is significantly curtailed during a Plan Year, as determined by the Employer, you may revoke your election or elect coverage under another benefit option that offers similar coverage, as determined by the Employer and may make a corresponding change in your election. If the Employer adds a new benefit option during a Plan Year, you may elect the new benefit option.
- Changes Under Another Employer's Plan - You may also change your elections to correspond to certain changes that your spouse or a Dependent makes to his or her benefit elections under a benefit Plan offered by his or her Employer. These rights are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan.

You must notify the Plan Administrator, in writing, within 30 days of a change in status *and* comply with all other Plan provisions and requirements. Modified elections are effective when the form is received *and* approved by the Plan Administrator. The elections will not be effective until the first pay period after the completed election form is returned to the Plan Administrator.

WHAT HAPPENS IF I DON'T ENROLL WHEN I FIRST BECOME ELIGIBLE?

If you (or your dependents) do not enroll in the Plan when you (or your dependents) first become eligible to participate in the Plan, you may enroll yourself (or your dependents) during the annual enrollment period for the next Plan Year or a later Plan Year, or if there is a Qualifying Status Change.

WHAT DENTAL EXPENSES CAN I GET REIMBURSED?

You will be reimbursed for all properly submitted dental expenses incurred by you or your covered dependents while you are covered under the Plan, except for those expenses discussed below that are not covered under the terms of the Plan. Covered dental expenses include treatment by any properly licensed person who is a dentist and who is rendering services and treatment within the scope of his/her licensure and training.

THINGS TO KNOW WHEN SEEKING DENTAL CARE

1. This dental Plan is a fee-for-service reimbursement plan. You may use any dentist for treatment. There is no network associated with this Plan.
2. Dentists are highly skilled professionals who spend years training and perfecting their technique. Their work is based on the time and materials it takes to correct a problem. As a group, they constantly explore treatment innovation! The cost and quality of materials vary. Discuss with your dentist the treatment proposed, the alternatives available and the relative cost of those alternatives before authorizing treatment. *Remember, you 're the consumer.*
3. Many dentists practice independently. Occasionally, they will form group practices. Regardless of the setting, your relationship should be with one primary dentist of **your** choosing.
4. Prices vary, but not significantly. The cost of routine care (6 month check ups) is fairly standard depending on the patient's age. Some dentists do provide "prompt payment courtesy" to patients settling their accounts at time of treatment. Don't be afraid to ask about pricing, discounts and projected cost. Become familiar with the cost of the most common procedures performed.

Procedure	Range (Amount in \$)
- Periodic Exam	\$ 25-40
- Cleaning – adult	\$ 45-70
- Filling – composite	\$ 60-80
- Root Canal	\$ 600-750
- Crown	\$ 595-750
- Single Tooth Extraction	\$ 65-90
- Sealants – per tooth	\$ 25-45
- Fluoride Application	\$ 50-70
- Bitewing x-rays (4 films)	\$ 35-50
- Filling – amalgam	\$ 60-80
- Diagnostic Cast	\$ 60-85
- Complete Dentures	\$ 900-1,300
- Gum Disease Treatment (gingivectomy)	\$ 375-450

This information is intended to provide you with general pricing information. This list is not all inclusive. Pricing will vary on the basis of the patient's age, dental condition, and scope of work to be performed. Talk to your dentist about charges and payment options before proceeding with treatment. Being an informed patient is always in your best interest.

5. You have responsibilities as well as rights. These include:
 - ◆ Keep all appointments. If you must cancel, call as early as possible.
 - ◆ Recognize your financial obligations. Pay the dentist promptly.
 - ◆ Be informed. Ask questions about treatment options and cost.

ARE THERE ANY DENTAL EXPENSES NOT COVERED?

You will not be reimbursed for the following dental expenses:

- a. Care or treatment for which there would not have been a charge if no coverage had been in force.
- b. Charges incurred for which you or the Plan have no legal obligation to pay.
- c. Elective cosmetic dentistry, unless necessary to correct a condition resulting from Injury or to correct a congenital anomaly.
- d. Expenses covered under Worker's Compensation or employer liability laws.
- e. Expenses covered by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay.
- f. Expenses incurred prior to the date the person became covered under this Plan.
- g. Expenses incurred for procedures covered by any other employer-sponsored benefit program including those of the Plan Sponsor and other employers.
- h. Legal fees and expenses incurred in obtaining treatment.
- i. Liability assumed under any contract or service agreement other than this Plan.
- j. Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.
- k. Treatment of an Illness or Injury that is the result of terrorism, war or any act of war, declared or undeclared or occurring while you are on duty with any military, naval, or air force of any country or international organization.
- l. Expenses incurred for implants and cosmetic procedures.

WHAT AMOUNT OF DENTAL EXPENSES DOES THE PLAN PAY?

Each person covered by the Plan is eligible to be reimbursed for the percentage of his or her dental expenses in the amount indicated below. The Plan Year in which the treatment was provided is the year used to determine the reimbursement.

The Plan will pay:

100% of the first \$125 of eligible expenses then;
80% of the next \$500 of eligible expenses then;
50% of the next \$950 of eligible expenses up to a
Plan Year Maximum Benefit of: \$1,000 per person or
\$2,500 per family
whichever comes first.

Orthodontia included

ARE THERE ANY DEDUCTIBLES?

No, there are no deductibles to satisfy before dental expenses are reimbursed under the Plan. This means there will be no amount of dental expenses that you must pay before you are entitled to be reimbursed for dental expenses.

HOW DO I FILE MY CLAIM?

When you incur dental expenses, you should obtain a written statement (ADA Claim Form) from your provider that describes the date(s) of service, the type of treatment and the charge. This documentation should be submitted to the Claims Administrator (the address for the Claims Administrator is at the end of this Summary Plan Description) within a reasonable period following occurrence of the dental treatment or expense.

- ~ **All claims for dental expenses must be submitted no later than 3 months (90 days) after the end of the Plan Year in which the expenses were incurred.**
- ~ **You “incur” an expense when you receive the service, not when you pay the bill.**

The Company reserves the right to verify all reimbursement requests. A fraudulent claim is grounds for termination of benefits and other disciplinary actions (including termination of employment) determined within the discretion of the Company.

WHAT ARE THE CURRENT REIMBURSEMENT PROCEDURES?

1) How to Submit A Claim for Professional Care/Services

When a Covered Person has a Claim to submit for payment that person must

- (a). Obtain a claim form from your employer and complete ALL sections on the form. *The claim will be denied unless all questions on the form are not answered.*
- (b). Attach a statement of services or ADA form which include the following:
 - Employee's Name and Social Security Number
 - Name of Patient
 - Name, Address, Telephone Number of the Provider
 - Type of Services Rendered, and/or Procedure Codes and Associated Fees
 - Date of Services
- (c). Send the above to the Claims Administrator shown on the DR claim form or at the end of this SPD.

2) When Claims Should Be Filed

After claims are received, each claim will be granted or denied by Claims Administrator. Benefits are based on the Plan's provisions at the time the charges were incurred.

The Claims 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 Plan Participant seek a second opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided after the receipt of the Claim within the specified timeframe noted below. The written notice will contain the following information:

- ◆ the specific reason or reasons for the denial;
- ◆ specific reference to those Plan provisions on which the denial is based;
- ◆ a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

3) Claims Process

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan’s reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. “Days” means calendar days.

4) Post-Service Claim (Routine)

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Pre-Service; in other words, a Claim that is a request for payment under the Plan for covered dental services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
notification of	15 days
response by claimant	45 days
Review of adverse benefit determination appeal	30 days per benefit.

5) Notice to Claimant of Adverse Benefit Determinations

The Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- ◆ The specific reason or reasons for the adverse determination.
- ◆ Reference to the specific Plan provisions on which the determination was based.
- ◆ A description of any additional material or information necessary for the claimant to justify the Claim and an explanation of why such material or information is necessary.

6) How to File an Appeal

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- ◆ was relied upon in making the benefit determination;
- ◆ submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- ◆ demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- ◆ constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a clinical judgment, including determinations with regard to whether a particular treatment or other item is Experimental and/or Investigational, or not a necessity and/or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This provider will have appropriate training and experience in the field of dentistry involved in the judgment. Additionally, clinical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

7) Voluntary Appeals, Including Voluntary Arbitration

During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Plan waives any right to assert that a claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after exhaustion of appeals of an adverse benefit determination as explained in the section above, entitled, "Appeals." However, this voluntary appeal may be conducted as one of the two appeals available to the claimant.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant's right to

representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

8) If You Have Questions About a Claim

If you have questions about a claim, you may call the Claims Administrator at the phone number listed on the ID card or at the end of this booklet.

So that the Claims Administrator can handle your questions properly and promptly, please have the following information available when you call:

- ◆ Name of Plan
- ◆ Employee's Name and Social Security Number
- ◆ Name of Patient and Social Security Number
- ◆ Name, Address, Telephone Number of the Provider
- ◆ Type of Services Rendered, and/or Procedure Codes and Associated Fees
- ◆ Date of Services

Claims must be filed within **90 days** of the end of the plan year to be eligible for reimbursement.

Claims are calculated on the benefit available to the participant on the date of claim processing.

WHEN DOES MY COVERAGE END?

A Participant shall continue to participate in this Plan until the earlier of the following dates:

- (a) The last day of the month that the Participant terminates employment by death, disability, retirement or other separation from service; or
- (b) The last day of the month that the Participant ceases to work for the Employer as an Eligible Employee; or
- (c) The last day of the month that the Participant revokes his/her election on account of and consistent with a change in family status; or
- (d) The date on which maximum benefits are received.

The dependent's coverage with respect to each dependent shall cease on the date the employee's coverage terminates, unless the dependent is eligible for and contributes premiums for continued participation in the Plan as required by COBRA or other applicable State continuation laws.

Sigma Space Corporation
Dental Reimbursement Benefit Plan Summary

Information required by the Employee Retirement Income Security Act of 1974 (ERISA)

Name of Plan: Sigma Space Corporation
Dental Reimbursement Benefit Plan

Sponsor's Name & Address: Sigma Space Corporation
4801 Forbes Boulevard
Lanham, Maryland 20706

Federal EIN: Plan Number: 52-2074422
508

Type of Administration:
Type of Plan: Contract Administration
Welfare Plan

Plan Administrator:
Sigma Space Corporation
4801 Forbes Boulevard
Lanham, MD 20706
(301) 552-6300

The Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and shall be final and binding on all interested parties.

Sigma Space Corporation is the principal employer that maintains the Plan and is the Plan Administrator of the Plan.

Agent for Service of Legal Process: Sigma Space Corporation
4801 Forbes Boulevard
Lanham, MD 20706

Plan Year Ends: March 31st

Contributions to the Plan are provided by: Employer and/or Employee as determined by the Plan Sponsor.

Eligibility: **Date of hire.** *(Form must be submitted within 60 days of employment).*

Claims Administrator: CAREFLEX Benefit Solutions
205 West Dares Beach Road
Prince Frederick, Maryland 20678
Toll Free - (888) 577-2762 ~ Local: (410) 535-0754
Secure Fax: (410) 414-8415

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

Continue care coverage for a Plan participant, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage. Review this summary Plan description and the documents governing the Plan on the rules governing COBRA/State continuation coverage rights.

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 upon request.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits

that is denied or ignored, in whole or in part, you may file in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Your Rights Under Health Insurance Portability and Accountability Act (HIPAA)

This Plan shall be administered at all times in accordance with the preexisting condition limitation, creditable coverage, certificate of coverage delivery, special enrollment period, notification and other applicable requirements of the Health Insurance Portability and Accountability Act of 1996.

This Plan is compliant with Title II of the Health Insurance Portability and Accountability Act of 1996 – Administrative Simplification (45 C.F.R. parts 142, 160, 164). HIPAA Privacy requirements apply to those benefits, plans or options that are subject to the Privacy Regulation, as determined by the Plan Administrator. Operation of the plan is arranged by a Business Associate component within the regulations requirements. HIPAA Privacy Regulations place restrictions on the availability and use of “protected health information” or “PHI” that employers may be accustomed to receiving and imposes civil and criminal penalties for violating the regulations. PHI is generally any individually identifiable health information that is transmitted or maintained by electronic or other media that relates to an individual’s past, present or future physical or mental health, treatment payment for services or health care operations.

As the Plan Sponsor, we recognize the importance of maintaining secure and confidential personal and financial information we receive and keep about you and your family.

In providing this program, we collect the following types of information:

- (1) information you provide us on enrollment forms in order for us to manage the program including personal information such as address, telephone number, date of birth, Social Security number, salary, marital status and dependent data;
- (2) information you or your health care providers give to the program’s claims processors; and
- (3) information related to your health status including diagnosis, testing, treatments, services rendered, prescriptions as well as names and dates of provider visits supplied by you and others in support of claims.

We do not disclose any personal information about you or your dependents to anyone, except as permitted or required by law to conduct our responsibilities for the treatment, payment or health care operations. Any other uses or disclosure are made only with individual written authorization.

We restrict access to personal information about you using physical, electronic and procedural safeguards that comply with state and federal regulations. We abide by the following standards:

- (1) to safeguard and secure the confidential personal financial and health information entrusted to us at all times as required by law;
- (2) to limit the collection and use of personal information to the minimum required to deliver the services for which we are contracted;
- (3) to permit only authorized persons to have access to confidential information; and

- (4) to dispose of paper waste containing personal information using compliant disposal methods.

You have the right to inspect the protected health information (PHI) we have about you. This can be requested in writing and will be reported and released to you in accordance with statutory requirements.

Any requests or complaints arising from our services and/or uses of the information entrusted to us should be filed immediately with our Privacy Compliance Officer. Your rights are further protected by the U.S. Department of Health and Human Services (HHS), Washington D.C.

Important Notice Regarding Your Employee Benefit Continuation Rights

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers (who employ over 20 employees) sponsoring group health and certain other benefit plans to offer the opportunity to continue benefits on a temporary basis to covered employees and/or dependents (Qualified Beneficiaries) whose benefits would otherwise end due to certain events (Qualifying Events). This notice serves to inform you of your rights to continue coverage's. Please read this notice carefully.

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days (or longer period permitted under the terms of the Plan) after the qualifying event occurs.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event (or a longer period if permitted under the terms of the Plan).**

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan 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 EBSA's web site 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 addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.