



America's Administrative Employer

Eligibility and Administration Plan Document

Restated January 1, 2010 and Effective January 1, 2010

TABLE OF CONTENTS

1. Introduction.....	3
2. General Information about the Plan.....	4
3. Eligibility and Participation Requirements.....	4
4. Cost of the Plan	5
5. Employee and Dependent Eligibility.....	6
6. Effective Date of Coverage for Employee and Dependent.....	8
7. Open Enrollment, Timely Enrollment, Late Enrollment, and Special Enrollment	9
8. Termination of Coverage/Leaves of Absence.....	11
9. Rehire Provision.....	13
10. Employees on Military Leave	13
11. Continuation of Coverage under Federal Law (COBRA)	14
12. COBRA Plan Eligibility Summary.....	18
13. Health Insurance Portability and Accountability Act (HIPAA)	20
14. Claims and Appeal Procedure	20
15. Dispute Resolution	21
16. Definitions.....	22
17. Questions.....	23

1. Introduction

This document serves only as a comprehensive summary of the benefit plans as it relates to eligibility requirements. As such, the certificate of insurance, summary plan description or another governing document of each benefit plan will supersede this summary document. In the event of a conflict between the information in this summary and the contract, the terms of the governing document will prevail.

A copy of each booklet, summary, summary annual report, or other governing document is available at www.employersresource.com.

All questions regarding the benefit programs should be directed to the Employers Resource Management Benefit Department at 1-866-214-9506.

You may not be eligible or enrolled in each benefit program listed in this document. Only certain benefit programs are available to you depending on your employer's client service agreement (CSA) with Employers Resource Management (ERM).

Note: Any self-funded medical plan offered through Employers Resource Benefit Trust (and sponsored by Employers Resource) is not insurance and does not participate in any state guarantee association. Such plans are registered with the State of Idaho Department of Insurance (Certificate of Registration No. 3842) with claim payment through P5 Health Plan Solutions (State of Idaho Department of Insurance License No.146787).

This summary provides information for the following benefit programs:

- **Flexible Spending Accounts (Health & Dependent Daycare)**
- **Health Reimbursement Account (HRA)**
- **Medical/Prescription Drug:**
 - i. **HMO's**
 - ii. **Limited Medical Plan**
 - iii. **Self Funded Medical Plans (Deluxe, Preferred, Sensible & Sensible Basic)**
- **Vision**
- **Dental**
- **Employee Assistance Program (EAP)**
- **Group Short Term Disability**
- **Group Long Term Disability**
- **Group Term Basic Life/AD&D**
- **Supplemental (Voluntary)Term Life**

2. General Information About the Plan

ERM is a company in the business of providing employment related services to client companies who contract with ERM to provide those services and, in some cases, to provide certain other employment-related benefits such as medical, prescription drug, vision, dental, EAP, disability and death benefits as may be selected by such client companies.

Employer Resource of America, Inc. (“ERA”) is an Idaho corporation and a subsidiary of ERM. ERA provides the same services as ERM in certain geographic areas of the United States and whenever reference is made to ERM in this document that reference includes ERA with respect to those geographic areas.

Employers Resource Benefit Trust (“ERBT”) is an Idaho based trust. The trustee of the trust is American Guaranty Title & Trust, Inc. which is incorporated pursuant to the state of Idaho’s Guaranty Title and Trust Company provisions. By agreement with ERM, ERBT provides certain benefit programs for companies which have contracted with ERM and which have elected to provide their employees the benefits that are available through ERBT.

In addition to the benefits provided through ERBT, other benefits are made available to contracting employers (see below) directly through ERM.

When a client company and ERM enter into a business relationship, they execute an agreement (the “Client Service Agreement” or sometimes, “CSA” or other written agreement) which describes the services to be provided by ERM and, in some cases, the benefit plans which are to be provided to employees of the client company. All of the benefit plans which are available for selection by the client company are described in this document.

Since ERM acts, in some respects, as an employer of the employees of its client companies, the relationship between ERM and the client is a co-employment relationship and the client is therefore referred to as the “co-employer.”

The benefit plans that are available to employees of any Co-employer, either through ERM or ERBT, depending upon the selection of such plans made by the Co-employer when it signs a Contract (Client Service Agreement) with ERM or at annual enrollment, when Co-employers have the opportunity to elect other benefits. Each employee of a Co-employer will be advised as to which, if any, of the benefits described in this document are available to the employee.

It is important to note that whenever the word “Employer” appears in this document the term may mean either ERM or Co-employer, or both, as the context may require.

3. Eligibility and Participation Requirements

The benefits available for any given employee is dependent on certain selections made in the CSA or other written document. Coverage under the Plan will take effect for an eligible employee and designated dependents when the employee

and such dependents satisfy the waiting period and all the eligibility requirements of the Plan as stated in the CSA, Client Participation Agreement and plan documents.

Employee Enrollment Requirements

An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee is required to enroll for Dependent coverage also if Dependent coverage is needed.

For applicable medical coverage only, if the Employee does not complete an enrollment form (online or paper) as defined below under Timely Enrollment (refer to Table of Contents for Timely Enrollment section), the Employee will be enrolled (after the waiting period) with employee only coverage on the respective Default Medical Plan for the applicable state. Also, when the Employee completes an Enrollment Form and is extended certain applicable medical plans, should the Employee not select a plan or provide adequate proof of other coverage to waive medical coverage, the Employee will be enrolled (after the waiting period) with employee only coverage on the respective Default Medical Plan for the applicable state. Documents governing this requirement include, but are not limited to, Client and Employee enrollment materials.

Benefit choices made during the initial enrollment will remain in effect until the next January 1, unless plan provisions differ, or there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

Active Employee Requirement

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Active Employee is an Employee who is on the regular payroll of this Employer and who has begun and continues to perform the duties of his or her job with the Employer on a full-time basis. This does not include someone who is simply "on call" or in an advisory/consulting capacity being paid for occasional advice or work. For the Employee to be an Active Employee they must have regular duties that are defined and can be attested to by the Employer and Employee should records be audited. Should an audit or other information determine that an employee is or was not an Active Employee, past, current and future claims for that Employee and any "covered" dependents may be denied.

Newborn Children Enrollment Requirements

A newborn child of a covered Employee is not automatically enrolled in this Plan. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, the enrollment will be considered a late enrollment, there will be no payment from the Plan and the covered parent will be responsible for all costs.

4. Cost of the Plan

Your company may share in the cost of Employee and Dependent coverage under this Plan with its covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is determined by the terms of the CSA, Client Participation Agreement or other written agreement.

The Plan Administrator reserves the right to change the level of Employee contributions at any time. If required contributions are not met, coverage may be terminated by the Plan Administrator.

5. Employee & Dependent Eligibility

Eligibility Requirements for Employee Coverage

An employee is eligible for Employee coverage from the first day that he or she

(1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she:

(i) normally works at least 30 hours per week. This means regularly scheduled, and subject to verification, to work 30 or more hours per week. In the audit verification process, the result would be at least 11 weeks of a 13 week quarter and/or 44 weeks of a 52 week year, working 30 or more hours per week. This does not mean 30 hours or more on average; AND

(ii) is on the regular payroll of the Employer, meaning an employee with a completed W-2 Form. This does not include a contract employee, temporary employee, casual employee, 1099 employee or other form of employee; AND

(iii) has a rate of pay and/or salary that is commensurate with the job duties, based on a fair and just review by the Employer and Employers Resource Benefit Trust.

Determination of satisfaction of this eligibility may be subject to employment and payroll record audits and attestation by the Employer and Employee at the discretion of Employers Resource Benefit Trust. Should an audit or other information determine that an employee is or was not eligible according to the above requirements, past, current and future claims for that Employee and any "covered" dependents may be denied.

Note, a part-time employee may only be covered under the Accident Reimbursement Arrangement (ARA) for employee only coverage.

(2) is in a class eligible for coverage as determined in accordance with the CSA or other written agreement including enrollment forms.

(3) completes the employment Waiting Period as an Active Employee. A "Waiting Period" is the amount of time determined in the Client Service Agreement or other written agreement that elapses between the first day of employment and the first day of coverage under the Plan. The Waiting Period is counted in the Pre-Existing Conditions exclusion time. Also, if an employee moves from part-time to full-time they must complete the full applicable Waiting Period. If you have a change in employment status (ie full-time to part-time) and are reinstated to full-time status within 31 days of your change in status,, coverage may be reinstated on the first day of the month following the date you are considered benefits eligible, if enrollment requirements are met.

(4) makes timely contributions requirements.

Dependent Eligibility

A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

A Dependent is any one of the following persons:

- (1) Unless otherwise specified by a particular career benefit plan/certificate/Summary Plan Description, a covered Employee's Spouse and unmarried children from birth to the limiting age of 25 years (up to the 25th birthday). The Dependent children must be unmarried and rely on the Employee for over one-half of his/her support (as defined in Section 152 of the Internal Revenue Code). When the child reaches the limiting age, coverage will end on the last day of the child's birthday month.

Proof of dependency may be required at initial enrollment, at annual enrollment and as part of any periodic dependency audit. If a plan has a full-time student requirement, coverage continues only between semester/quarters if the student is enrolled as a fulltime student (full-time student defined and documented by the institution of higher learning) in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship. Domestic partner (same/opposite sex relationship) and/or common law coverage may be available depending on the state you reside and the Plan you are enrolled in. Refer to the Plan Administrator for additional information.

The term "children" shall include natural children living in the same household as the Employee, adopted children or children placed with a covered Employee in anticipation of adoption or Foster Children. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

If a covered Employee is the legal guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents. 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 a 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.

Any child of a Plan Participant 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. A participant of this Plan may

obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The phrase “primarily dependent upon” shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent’s reaching the limiting age, subsequent proof of the child’s Total Disability and dependency. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. 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.

These persons are excluded as Dependents: other individuals living in the covered Employee’s home, but who are not eligible as defined; the legally separated or 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 this 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.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both. Also, if both an employee and their spouse are Employees of the same Co-employer, they cannot be covered under each other’s plan as a Dependent.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

6. Effective Date of Coverage for Employee & Dependent

Effective Date of Employee Coverage

An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

(4) Moving from part-time to full-time status after completing any waiting probationary period of the Co-employer (unless otherwise stated in the Co-employee's policy handbook).

**Effective Date of
Dependent Coverage**

A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met. If timely enrolled, coverage for newborns, adopted children and children placed for adoption will begin as of the date of birth, adoption or placement for adoption.

**7. Open Enrollment, Timely Enrollment, Late Enrollment &
Special Enrollment**

Open Enrollment

Every October to November, the annual open enrollment period occurs allowing covered Employees and their covered Dependents to change their benefit decisions based on which benefits and coverages are right for them. Previously satisfied coverage Waiting Periods and Pre-Existing Conditions Limits will be considered satisfied when changing from one plan to another. Certain benefits offered during this open enrollment may be restricted to an initial enrollment and limit enrollment at a future date and/or require underwriting. Such limitations will be communicated at the time of enrollment and/or specified in plan administrative and/or summary plan description documents.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages and present enrollment tier provided the Co-Employer maintains the same level of coverage and those plans continue to be available and provided proof of other coverage for medical waiver provisions are current.

Plan Participants will receive information regarding open enrollment from their Co-Employer and will be subject to any plan default provisions should they not timely enroll or re-enroll during open enrollment.

Timely Enrollment

The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

Late Enrollment

An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption

of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Special Enrollment Period

- a) Individuals losing other coverage. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met: (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual. (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment. (c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated. (d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received by the Plan Administrator.

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.

- b) Dependent beneficiaries. If: (a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption, then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. The coverage of the Dependent enrolled in the Special Enrollment Period will be effective: (a) in the case of marriage, on the date of marriage, provided qualified proof and enrollment is timely (within 31 days of marriage); (b) in the case of a Dependent's birth, as of the date of birth; or (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

- c) Effective April 1, 2009, you will be eligible to enroll yourself and eligible dependents if either of two events occur:
 - (i) You or your dependent loses Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible.
 - (ii) You or your dependent qualifies for state assistance in paying your employer group medical plan premiums.
 Regardless of other enrollment deadlines, you will have 60 days from the date of the Medicaid/CHIP event to request enrollment in the Employers Resource Benefit Trust medical plan.
- d) Please note that special enrollment rights allow you to either:
 - (i) Enroll in your current medical coverage; or
 - (ii) Enroll in any medical plan benefit option for which you and your dependents are eligible.

8. Termination of Coverage/Leaves of Absence

When coverage under any employer sponsored medical plan ceases, Plan Participants will receive a certificate that will show the period of coverage under the applicable Plan. Please contact the Plan Administrator for further details.

When Employee Coverage Terminates

Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

- (1) The date the Plan is terminated.
- (2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee.
- (3) The date the Covered Person's Co-employer and ERM cease to be parties to the CSA or other written agreement through termination of such Agreement by any means whatsoever.
- (4) The date you are unable to pay your premiums through payroll deductions. Your benefits will terminate at the end of the month following your second missed deduction. Coverage will be available at the next open enrollment or if a qualified status change should occur prior to the next open enrollment.

Leave of Absence

If the Employee ceases to be actively at work on a full time basis due to non-FMLA issues (such as medical leave, work related injury, or leave of absence), the Employee's coverage may be continued at the written option of the Co-employer until the Employee recovers or returns to work, but not beyond sixty (60) calendar days after the end of the month when cessation of active full time employment occurs. COBRA continuation of coverage may apply after the extension of benefits under this Leave of Absence provision.

Family and Medical Leave Act

If you qualify for an approved family or medical leave of absence (as defined in the Family Medical Leave Act of 1993), eligibility may continue for the duration of the leave if you pay for any required contributions toward the cost of the coverage. Your employer has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due dates established by your employer will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, your employer has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave.

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence (as defined by the FMLA Leave Act of 1993), coverage for you and your eligible dependents will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible under the plan. All accumulated annual and lifetime maximums will apply.

It is the intent of the plan to comply with all existing FMLA regulations. If for some reason the information presented in the plan differs from actual FMLA regulations, the plan reserves the right to administer FMLA in accordance with such actual regulations.

When Dependent Coverage Terminates:

A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Options.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status.
- (4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Options.)
- (5) The date you are unable to pay your premiums through payroll deductions. Your benefits will terminate at the end of the month following your second missed deduction. Coverage will be available at the next open enrollment or if a qualified status change should occur prior to the next open enrollment.
- (6) The date the Covered Person's Co-employer and ERM cease to be parties to the Client Service Agreement or other written agreement through termination of such Agreement by any means whatsoever.

Termination of the Plan

ERM fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at anytime and for any reason. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like. Failure to follow the eligibility or enrollment requirements (including contribution requirements) of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of medical necessity, lack of timely filing of claims or lack of coverage. These

provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

9. Rehire Provision

If you terminate employment for any reason and are rehired within 31 days between your termination date and rehire date, coverage may be reinstated on the first day of the month following the date you are rehired, if the enrollment requirements are met. All previous accumulated annual and lifetime maximums will apply. If you terminate employment and are rehired more than 31 days after the date of the loss of the benefits, you will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements. All previous accumulated annual and life time maximums will apply.

10. Employees on Military Leave

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of: (a) The 24-month period beginning on the date on which the person's absence begins; or (b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

d) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

11. Continuation of Coverage under Federal Law (COBRA)

If a Client Service Agreement (CSA) is terminated by a client, generally no COBRA benefits will be extended. Refer to the section titled COBRA Plan Eligibility Summary for additional details. Currently enrolled COBRA participants for that client will end at the end of the month in which the CSA is terminated.

COBRA Rights

As mandated by federal law (COBRA), the plan offers optional continuation coverage to you and/or your dependents if coverage would otherwise end due to one of the following qualifying events:

- Termination of your employment for any reason except gross misconduct. Coverage may continue for you and your eligible dependents.
- A reduction in hours worked by you. Coverage may continue for you and your eligible dependents.
- Your death. Coverage may continue for your eligible dependents.
- Divorce or legal separation from your spouse. Coverage may continue for that spouse and your other eligible dependents.
- You become entitled to Medicare. Coverage may continue for eligible dependents.
- Loss of eligibility of a covered dependent child. Coverage may continue for that dependent.
- Your employer files a Title 11 bankruptcy petition. Coverage may continue for retirees and their beneficiaries if the plan covers such retirees and beneficiaries within one year of the date of the bankruptcy petition and if such retiree coverage ends or is substantially reduced within one year before or after the filing for bankruptcy. (Please note that the plan may not cover retirees, in which case employer bankruptcy is not a qualifying event.)

NOTE: To choose this COBRA coverage, an individual must be a covered person under the plan on the day before the qualifying event. You can also obtain COBRA coverage for children born to, adopted by or placed for adoption with you during the period of your COBRA coverage if they are timely enrolled under the terms of the plan. In the case of bankruptcy, an individual must have retired on or before the date coverage was substantially reduced, or be a beneficiary of the retired employee on the day before the bankruptcy.

Your Notification Requirements

You or other qualifying individual(s) have the responsibility to inform the plan administrator in writing of a divorce, legal separation or a child losing dependent status under the plan within 60 days of the qualifying event or, if later, the date coverage under the plan would end. Failure to provide this written notification within 60 days will result in the loss of COBRA coverage rights.

Your employer has the responsibility of notifying the plan administrator of your death, termination of employment, reduction in hours, and entitlement to Medicare or the employer's bankruptcy within 30 days of the qualifying event.

Subject to the plan administrator being timely informed of the qualifying events described in the above paragraphs, the plan will promptly notify you and other qualifying individual(s) of their COBRA coverage rights. You and any other qualifying individuals must elect COBRA coverage within 60 days after plan

coverage would otherwise end, or, if later, within 60 days after the date of the notice of COBRA coverage rights. Failure to elect COBRA coverage within this 60-day period will result in loss of COBRA coverage rights.

Notice of Unavailability of COBRA

If the plan administrator receives notice of a qualifying event and determines that the individual is not entitled to COBRA coverage, the plan administrator will provide to such individual an explanation as to why the individual is not entitled to COBRA coverage. This notice will be provided within the same time frame that the plan administrator would have provided the notice of right to elect COBRA coverage.

Maximum Period of COBRA

Except as described below, the maximum period of COBRA coverage for individuals who qualify due to the employee's termination of employment or reduction in hours worked is 18 months from the date of the qualifying event.

If a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of COBRA coverage, COBRA coverage for the qualifying individual and any non-disabled family members who are also entitled to COBRA coverage may be extended to 29 months provided the qualifying individual or family member, if applicable, notifies the plan administrator within the 18-month COBRA coverage period and within 60 days after you receive notification of determination of disability.

The maximum period of COBRA coverage for individuals who qualify due to any other described qualifying event, except bankruptcy, is 36 months from the date of the qualifying event. If a second qualifying event occurs (for example, your death or divorce) during the 18 or 29 month coverage period resulting from a termination of employment or reduction in hours, the maximum period of coverage will be computed from the date of the first qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

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

Cost of COBRA Coverage

The cost of COBRA coverage is determined by your employer and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102% of the plan's cost of providing coverage. The cost of coverage during a period of extended COBRA coverage due to a disability cannot exceed 150% of the plan's cost of coverage.

Premium payments for COBRA coverage for you or your dependent's "initial premium month(s)" are due by the 45th day after electing COBRA coverage. The "initial premium month(s)" are any month that ends on or before the 45th day after you or the qualifying individual elects COBRA coverage. All other premiums are due on the 1st of the month for which coverage is sought, subject to a 30-day grace period. Premium rates are established by your employer and

may change when necessary due to plan modifications. The cost of COBRA coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make payment for the initial premium month(s) within 45 days or any subsequent monthly premium payment within 30 days of the established due date will result in the permanent cancellation of COBRA coverage.

When COBRA Coverage Ends

Continuation of coverage ends on the earliest of:

- The date the maximum period of COBRA coverage expires.
- The date the qualifying individual becomes entitled to coverage under Medicare, if the Medicare entitlement date is after the date that the individual elected COBRA coverage.
- The last period for which payment was made when coverage is canceled due to non-payment of the required cost.
- The date the employer no longer offers a group health plan to any of its employees.
- The date the qualifying individual becomes covered under any other group health plan that does not exclude or limit coverage for a pre-existing condition the qualifying individual may have.
- The first day of the month that begins more than 30 days after the qualifying individual who was entitled to a 29-month maximum continuation period is subject to a final determination under the Social Security Act that he or she is no longer disabled.
- Notice of Termination Before Maximum Period of COBRA Coverage Expires

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

COBRA Subsidy

Certain persons will have the right to a premium subsidy equal to 65% of your COBRA (continued medical plan coverage) premiums, provided you meet all required conditions stated in this section, applicable federal law, and guidance from the enforcing federal agencies. This subsidy applies to you and your qualified beneficiaries.

Under the American Recovery and Reinvestment Act of 2009 (as amended), enacted on February 17, 2009, most persons who were or are terminated involuntarily between September 1, 2008 and February 28, 2010 are eligible for a subsidy of 65% of the cost of COBRA coverage. This subsidy is available for up to fifteen months, beginning from the first month the person was eligible for the subsidy. If you believe you are qualified to elect coverage under this subsidy, your election materials are due within 60 days of the date of notification.

Dates of Termination

If you were terminated after September 1, 2008 and prior to February 17, 2009, you are entitled to re-consider whether you want to elect COBRA if you are not currently covered by the plan through COBRA. You may have even previously elected but failed to pay your monthly premiums. Now you may elect to begin COBRA coverage again as of March 1, 2009 with the government subsidizing 65% of the cost. Your coverage will be effective as of the first of the next monthly period (generally March 1, 2009). You are not eligible for coverage or the subsidy prior to that date. The length of your COBRA coverage (generally 18 months) will be determined starting with your termination date, not the date you now elect to continue coverage.

If you are terminated involuntarily after February 17, 2009 and prior to February 28, 2010, you may elect COBRA as well and will receive a subsidy from the government of 65% of the cost.

Conditions for Subsidy Eligibility

The federal government pays for the subsidy at great cost to taxpayers and imposes certain conditions on eligibility. You are not eligible for the subsidy if:

1. You voluntarily terminated. You are asked to sign a binding statement regarding the circumstances of your termination, and your employer will verify this statement against the records they have kept on your employment history. Failure to answer this question honestly generally results in a penalty owed by you to the U.S. government under federal law.

2. You (or a covered family member) are eligible for any other group health plan coverage such as through your own employment, your spouse's employment, or (if you are young) perhaps your parents' plans. (Note you cannot claim the subsidy if you are eligible for the other coverage -- you need not be enrolled in the other coverage to lose your eligibility for paying the reduced cost of COBRA.)

3. You (or a covered family member) are eligible for Medicare. (Note you cannot claim the subsidy if you are eligible for Medicare --you need not be enrolled in Medicare to lose your eligibility for paying the reduced cost of COBRA.)

4. You experienced an event other than termination of employment that resulted in your loss of medical coverage. Again, the federal government and IRS will impose penalties when persons who are offered this subsidy by mistake take improper advantage.

You must cooperate with your employer in providing all the required information for the government subsidy to apply. You are required to sign a statement provided by your plan sponsor indicating you are not ineligible for coverage due to one of the four reasons stated above.

An individual will no longer be eligible for the subsidy and must then begin paying 100% of the cost of your coverage as of the earliest of the date:

1. You (or a covered family member) are eligible for other group health plan coverage such as through your own employment, your spouse's employment, or (if you are young) perhaps your parents' plans.

2. You (or a covered family member) are eligible for Medicare.

If you lose eligibility for the subsidy for one of these reasons, you can remain on COBRA continuation until it terminates due to the end of your continuation period measured from the date of your termination (generally 18 months) or earlier if you lose COBRA coverage for other reasons prior to its expiration.

You must immediately notify the Plan if you are no longer eligible for the subsidy.

The federal government imposes a penalty of 110% of the amount of the subsidy you improperly received after the date you should have been ineligible. The government may forgive you if you had reasonable cause for not notifying them, but not if you failed to do so due to willful neglect.

12. COBRA Plan Eligibility Summary

COBRA eligibility and coverage is available during the period the Client Service Agreement, Client Participation Agreement or other written agreement between the Co-Employer and ERM is in effect. Termination of the Client Service Agreement by any means whatsoever terminates COBRA eligibility and coverage except as noted in the table below. Additionally, should underwriting practices result in the cessation of health benefits for your company (by the client or by ERM), that event alters the terms of the Client Service Agreement. The changing of termination of a contract, like the Client Service Agreement, is not among the "qualifying events" designated by COBRA. For that reason, continuation coverage is not available in conjunction with the change in underwriting.

The chart on the next page provides a summary of COBRA Plan Eligibility:

COBRA Coverage			Client Termination of Plan
Plan Type	Is Plan eligible for COBRA?	Will COBRA continue at Client Service Agreement termination between your company and ERM?	COMMENTS
Framework Limited Medical	Yes	Yes	Framework will handle all aspects of COBRA with or without Client Service Agreement.
HMO Medical	Yes	No	COBRA will not be offered upon termination of Client Service Agreement.
Deluxe Medical	Yes	No	COBRA will not be offered upon termination of Client Service Agreement.
Preferred Medical	Yes	No	COBRA will not be offered upon termination of Client Service Agreement.
Sensible and Sensible Basic Medical	Yes	No	COBRA will not be offered upon termination of Client Service Agreement.
Dental	Yes	No	COBRA will not be offered upon termination of Client Service Agreement.
Vision	Yes	No	COBRA will not be offered upon termination of Client Service Agreement.
Life	No	No	COBRA will not be offered upon termination of Client Service Agreement.
FSA	Yes	No	COBRA will not be offered upon termination of Client Service Agreement.
STD/LTD	No	No	This benefit is not COBRA eligible.
ARA (Accident Reimbursement Arrangement)	Yes	No	COBRA will not be offered upon termination of Client Service Agreement.
HRA (Health Reimbursement Arrangement)	Yes	No	COBRA will not be offered upon termination of Client Service Agreement.

13. Health Insurance Portability and Accountability Act (HIPAA)

Federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for preexisting medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, preexisting condition exclusion generally may not be imposed for more than 12 months. The 12-month exclusion period is reduced by your prior health coverage as long as any lapse in prior health coverage is less than 63 days. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without preexisting condition exclusion.

You have the right to receive a certificate of prior health coverage as of July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Check with your new plan administrator to see if your new plan excludes coverage for preexisting conditions and if you need to provide a certificate or other documentation of your previous coverage.

14. Claim & Appeal Procedures

Claims for Self Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through the Company's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must complete, execute and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal

court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

See the summary plan description or other governing documents located at www.employersresource.com for more information about how to file a claim and for details regarding the claims procedures applicable to your claim.

Claims for Fully Insured Benefits

For purposes of determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance or contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance or contract, which may require you to complete, sign and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

See the summary plan description or other governing documents located at www.employersresource.com for more information about how to file a claim and for details regarding the claims procedures applicable to your claim.

15. Dispute Resolution

As an option in lieu of civil action (or any statutory administrative procedure, if applicable) for claims review and determination, the plan provides for dispute resolution as set forth herein.

Each, every, and all claims, disputes and/or controversies, now existing or hereafter arising, whether known or unknown, may be resolved, as follows:

- a) through mediation utilizing the Rules and Mediator provided by Dispute Systems Inc. or its successor;
- b) And, failing settlement by mediation, the parties agree that all claims and disputes, including those of jurisdiction and arbitrability, may be resolved by neutral binding arbitration conducted by the National Arbitration Forum (NAF), under the NAF Code of Procedure in effect at the time any claim is made. Each party shall pay its own costs of arbitration.

16. Definitions

ARA	Accident Reimbursement Arrangement
Children	Shall include natural children living in the same household as the Employee, adopted children or children placed with a covered Employee in anticipation of adoption or Foster Children. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.
Client Participation Agreement	(Also referred to as Client Contribution Form or Client Contribution Renewal Form) means the document signed by the Client indicating the benefit offerings for their particular co-employees. This includes the desired waiting period for new hires, the plan offerings and client contribution toward benefits. This Agreement/Form is entered into and made part of the Client Service Agreement between the Client/Employer for benefits available for the period indicated and is subject to the terms and conditions of the applicable plans and the Client Service Agreement.
Co-Employee	Means a person who is employed by the Co-employer under the co-employment relationship with ERM/ERA. Co-employees fall into various categories, including but not limited to, active, inactive, part-time, full-time, seasonal and other classifications. Such classifications may result in being eligible or not for various benefit plans according to plan documents and other terms as part of the co-employment relationship with ERM/ERA.
Co-Employer	Means a client of ERM/ERA, which enters into a client service agreement thus establishing a co-employment relationship with ERM/ERA with respect to the employees of the Co-employer.
CSA	Agreement between Employers Resource Management Company and a client whereby client contracts for the provision of certain employment services by ERM. The CSA enables the client to select a level of various benefit programs to offer to its employees.
Default Medical Plan	Means the medical plan that a co-employee would default to in the enrollment process. If an Employers Resource medical plan is offered and a co-employee does not: (a) select a medical plan; (b) provide proof of other medical coverage; or (c) fail to turn in an enrollment form, medical coverage will be defaulted to a lower cost medical plan with employee only coverage, fully paid for with the client contribution. The default medical plan is normally determined by the state an employee resides in and may change from year to year or may be dependent on client offerings to employees. Applicable plan rules are provided in enrollment materials and/or in summary plan descriptions.
ERA	Is an Idaho corporation and a subsidiary of ERM. ERA provides the same services as ERM in certain geographic areas of the United States and whenever reference is made to ERM in this document that reference includes ERA with respect to those geographic areas.

ERBT	Is an Idaho based trust. The trustee of the trust is American Guaranty Title & Trust, Inc. which is incorporated pursuant to the state of Idaho's Guaranty Title and Trust Company provisions. By agreement with ERM, ERBT provides certain benefit programs for companies which have contracted with ERM and which have elected to provide their employees the benefits that are available through ERBT
ERM	Is a company in the business of providing employment related services to client companies who contract with ERM to provide those services and, in some cases, to provide certain other employment-related benefits such as medical, prescription drug, vision, dental, EAP, disability and death benefits as may be selected by such client companies.
Full Time Student	Defined as 12 or more credit hours for undergraduate and 9 or more credit hours for graduate student) at an institution of higher learning and primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 23.
Plan Administrator	Employers Resource Management Company.
Spouse	Shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship. Domestic partner (same/opposite sex relationship) and/or common law coverage may be available depending on the state you reside and the Plan you are enrolled in. Refer to the Plan Administrator for additional information.

17. Questions

If you have any questions regarding your benefits, or your eligibility for, or the amount of, any benefit payable under the self-funded or fully-funded benefit plans, please contact the Employers Resource Management Benefit Department at 1-866-214-9506.