

THIS NOTICE DESCRIBES IMPORTANT INFORMATION ABOUT YOUR GROUP HEALTH PLAN. THIS SHOULD BE REVIEWED CAREFULLY.

PLEASE KEEP THIS DOCUMENT FOR YOUR RECORDS

PLEASE NOTE THAT THE TRUST GIVES YOUR EMPLOYER THE RIGHT TO ELECT THE BENEFITS THAT WILL BE OFFERED TO EMPLOYEES. ACCORDINGLY, YOU MAY NOT BE ELIGIBLE TO PARTICIPATE IN ALL OF THE BENEFITS DESCRIBED BELOW.

MEDICAL SOCIETY HEALTHCARE TRUST Summary Plan Description (SPD)

Your employer participates in the Medical Society Healthcare Trust (“Trust”). The Trust is a multiple employer welfare arrangement created by the National Medical Health Collaborative and the Arizona Medical Association. The Trust sponsors medical, prescription drug, dental, vision, life and accidental death and dismemberment (AD&D) benefit plans (“Plans”) for eligible employees of participating employers and their dependents. The Trust is governed by a Board of Trustees.

The purpose of this Summary Plan Description is to inform you about the Trust’s benefit Plans and direct you to where you can obtain additional information about the Trust’s Plans.

This SPD, your employer’s Master Application on file with the Trust, the insurance contracts and policies issued by the insurance companies that provide benefit coverage, and the enrollment forms on which you and your dependents sign up for coverage collectively constitute the Plan Document. While this SPD and the Trust’s benefit summaries describe the principal features and limitations of Plan benefits in general, they are not intended to explain every detail. In the event of any conflict between this SPD and the Employer’s Master Application, the insurance contracts and policies, and the enrollment forms, this SPD will control.

The Plan’s third-party administrator, Vimly Benefit Solutions (Vimly), has the employer’s Master Application and the insurance contracts and policies available for your examination. If you have questions about the Plan or a benefit it provides, you can find more information at <https://www.azmed.org/page/ahp> or by calling Vimly at (425) 771-7359.

Board of Trustee Discretion

The Board of Trustees has the exclusive authority to interpret the provisions of the Plan, to determine eligibility for an entitlement to Plan benefits or to amend the Plan. Any interpretation or determination by the Trustees made in good faith, which is not contrary to law, is conclusive on all persons affected. The Board of Trustees has hired various insurance companies to provide benefits to eligible Plan participants. The Board of Trustees has delegated to these insurance companies and to the Plan’s third-party administration office the authority to administer the Plan and provide information relating to the amount of benefits, eligibility, and other Plan provisions.

An interpretation of Plan benefits is subject to review by the relevant insurance carrier and the insurance carrier is responsible for its decision. An interpretation of Plan eligibility, Plan funding, selection of benefit providers or other non-benefit related issues is subject to review by the Board of Trustees. No individual trustee, employer, or employer association, or any individual employed by an employer or employer association, has any authority to interpret or change this SPD or the Plan.

The Trustees reserve the right to make any changes they deem necessary to promote efficiency, economy and better service for the Plan participants and their covered dependents. The Trustees have no obligation to furnish benefits beyond those that can be provided by the Trust. The Plan is provided to the extent that money is currently available to pay the cost of such Plan.

Employee Eligibility

Employees of a participating employer who have satisfied conditions stated in the employer's Master Application are eligible to participate in the Plan provided the applicable premium is received on their behalves. Conditions set forth in the employer's Master Application, may include, but are not limited to, one or a combination of the following:

- Limitation to employees scheduled to work at least a specified number of hours per week (at least 20 hours);
- Limitation to a particular class or classes of employee;
- Completion of a permissible probationary period (not to exceed 90 days); or
- Limitation to completion of a look back period for variable hour employees.

An employee's eligibility will terminate at the end of the month in which the employee no longer satisfies the eligibility criteria set forth in the employer's Master Application, the applicable employer or employee premium is not received, the employer ceases to be eligible to participate in the Trust or the Trust ceases to provide a benefit plan.

Dependent Eligibility

Dependents of an eligible employee may also be eligible for Plan benefits provided that they are enrolled in the Plan and the applicable premium is paid on their behalves. Eligible dependents may include:

- The person to whom you are legally married (spouse);
- Your Domestic Partner, **if your employer has elected Domestic partner coverage**, and provided the insurance carriers' guidelines are satisfied;
- Your (or your spouse's or your domestic partner's) child who is under age 26 and who meets any of the following criteria:
 - Your (or your spouse's or your domestic partner's) natural child, stepchild, adopted child or child legally placed with you (or your spouse or your domestic partner) for adoption;
 - A child for whom you (or your spouse or your domestic partner) have court-appointed legal guardianship; or
 - A child for whom you (or your spouse or your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO);
- Your (or your spouse's or your domestic partner's) otherwise disabled child who is age 26 or over and who meets all of the following criteria:
 - Has been covered under this plan up to the day he or she is no longer eligible for coverage based on the age limit(s) specified in this plan;
 - Is totally disabled due to a continuous physical or behavioral impairment or condition, as defined by current evidence-based criteria, on the date the dependent reaches age 26; and
 - Is dependent on you for maintenance and support, as determined by the insurers criteria.
- A dependent's eligibility will terminate at the end of the month in which the employee's coverage ends or the dependent ceases to meet the definition of dependent as set forth above.

Continuation Rights

In the event your coverage would normally terminate, you may be eligible to continue your coverage under State or Federal law, including the Family Medical Leave Act (“FMLA”), the Uniformed Services Employment and Reemployment Rights Act (“USERRA”) or the Consolidated Omnibus Budget Reconciliation Act (“COBRA”). Additionally, you may be able to convert your coverage to an individual policy to the extent permitted by the insurance carrier or enroll in an individual plan provided through the State or Federal Health Insurance Marketplace (Exchange) at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. The Plan’s major continuation right, COBRA, is described more fully below.

COBRA. To obtain COBRA continuation coverage you or your dependents must have a qualifying event, make a timely election to continue coverage, and make timely self-payments. These requirements are described more fully below. Employees and enrolled dependents who have the right to elect continuation coverage under COBRA are called “qualified beneficiaries.”

COBRA Qualifying Events/Length of Coverage. For you and your enrolled dependents to be eligible for continuation coverage your coverage must have ended because of an 18-month qualifying event. An 18-month qualifying event is either:

- Your termination of employment for any reason (this includes retirement and voluntarily quitting) other than gross misconduct; or
- Your reduction in hours of employment.

Additionally, your enrolled dependent may elect COBRA continuation coverage for a maximum of 36 months if their coverage would otherwise end due to one of the following:

- Death of the employee;
- Divorce; or
- Ceasing to meet the Plan’s definition of an eligible dependent.

Second Qualifying Event. An 18-month period of COBRA may be extended to 36 months for the affected dependent if one of the 36-month qualifying events occurs during the first 18 months of COBRA continuation coverage. In no event will COBRA continuation coverage extend beyond 36 months from the date coverage was first lost due to the initial qualifying event.

29-Month Qualifying Events. If Social Security determines an individual is totally disabled prior to the 18-month qualifying event or within the first 60 days of COBRA continuation coverage, the disabled individual and all qualified beneficiaries may extend COBRA coverage an additional 11 months, to a maximum of 29 months. In order to qualify for this extension, the individual or qualified beneficiary must provide the Trust with proof of the Social Security disability determination within 60 days of the later of the date COBRA continuation begins or the date Social Security issues the disability determination, but no later than the date that the initial 18-month COBRA continuation period ends.

COBRA Notification Responsibilities. For any initial or second qualifying event, you or your dependents must notify the Trust Administration Office:

- Within 60 days of a death, divorce, or child losing dependent status prior to age 26;
- Upon becoming covered under any other group health plan, including Medicare, after electing COBRA continuation coverage;
- For a Social Security disability extension, within 60 days of the later of the date COBRA continuation begins or Social Security determines an individual is disabled, but not later than the date the initial 18-month COBRA period ends; and

- Within 30 days of Social Security determining an individual is no longer disabled.

An employer has the responsibility to notify the Trust of the employee's termination of employment or reduction of hours.

Election of COBRA Coverage. Upon receiving notification that a qualifying event may have occurred, the Trust will notify you and your dependents of their right to elect continuation coverage. You and your dependents must then select continuation coverage by the later of:

- 60 days after the coverage ends; or
- 60 days after the qualified beneficiary is furnished with notification of the continuation rights from the Trust.

Failure to elect continuation coverage within this 60-day period will result in the loss of the right to elect COBRA.

Newly Acquired Dependents During COBRA Coverage. If you acquire an eligible dependent while eligible for COBRA continuation coverage you may elect to enroll the dependent for continuation coverage in accordance with the Plan's normal enrollment rules. However, only child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage are qualified beneficiaries entitled to an extension of coverage as a result of a second qualifying event. Spouses and stepchildren acquired after a qualified event are not eligible for 36 months of coverage due to a second qualifying event.

Types of COBRA Coverage Available. If you or your dependents choose continuation coverage, you and your dependents are entitled to the same benefits you and your dependents had in the month immediately before you lost coverage. Medical, prescription drug, dental and vision are available under COBRA, depending on what your employer has elected to provide.

Continuous COBRA Coverage Required. You and your dependents' coverage under COBRA must be continuous from the date Trust coverage would have ended if monthly self-payments were not made.

Monthly Self-Payments for COBRA Coverage Required. You or your dependents are responsible for the full cost of continuation coverage. The payments must be made to the Trust Administration Office within 30 days of the premium due date. The only exception is that the initial self-payment for the period preceding the election of continuation coverage may be made up to 45 days after the date of election. Failure to make timely payments will result in the permanent loss of continuation coverage. Eligibility will not be granted until payment has been received.

End of COBRA Coverage. Continuation coverage will end on the earliest of the following dates:

- 18 months from the date continuation began for individuals whose coverage ended because of a reduction of hours or termination of employment.
- 29 months from the date continuation began if the individual was disabled as of the time their eligibility ended, or within 60 days thereafter, and they provide timely proof of the Social Security Administration's disability determination.
- 36 months from the date continuation began for individuals whose coverage ended because of the death of the employee, divorce or from the employee, or the dependent ceasing to meet the definition of an eligible dependent. If an employee has an 18-month qualifying event after becoming entitled to Medicare, continuation coverage for dependents (lawful spouse or dependent child) will end on the later of 18 months from the date continuation began because of a reduction of hours or termination of employment, or 36 months from the date the employee becomes entitled to Medicare;
- End of any month for which the required premium for your COBRA coverage is not paid within 30 days of the first of the month for which the payment applies. Checks returned for nonsufficient funds will be

treated as failing to make a self-payment if not reissued by the end of the coverage period.

- The date the individual becomes covered under any other group health plan (except to the extent the other group health plan limits benefits for preexisting conditions that affects the individual's coverage);
- The date the qualified beneficiary becomes entitled to Medicare; or
- The date this Plan ends.

If You Have Questions. Questions concerning your plan or your COBRA continuation coverage rights should be addressed to Vimly. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa (addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes. To protect your family's rights, you should keep Vimly 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 Vimly.

Benefits Provided to You under the Plan

You and your eligible dependents are provided benefits as described in the benefit summaries, but only if 1) your employer has elected to participate in the benefit; 2) you have enrolled yourself and dependents in that benefit on a form provided by Vimly; and 3) your employer and you have paid any required employee premium contribution disclosed at the time of enrollment. The description of each benefit in the benefit summary may include: cost-sharing provisions; limits on benefits; coverage of preventive services, drugs, medical tests, devices, or procedures; provisions governing network providers; conditions or limits on selection of primary or specialty care providers or emergency care; and provisions on preauthorization or utilization review.

Circumstances Which May Result in Ineligibility or Denial of Benefits

The following are circumstances that may result in ineligibility or denial of benefits for a participant or beneficiary:

- Failure to pay a premium required as a condition for insured coverage;
- Failure to pay a deductible or copay with respect to a particular benefit;
- Expenses exceeding the allowed amount of an insured benefit;
- Coordination of benefits with coverage provided by another insurer;
- Benefits excluded under a specific exclusion listed in the Plan booklet; or
- Failure to meet the Plan's eligibility requirements.

The circumstances which may result in disqualification, ineligibility, denial, or loss of benefits appear throughout this SPD.

Claims Procedures

If you wish to claim a Plan benefit under any of the insurance policies or contracts, you must submit the claim to the insurer directly using the contact information in the benefit summary for that insurer. You may instead submit the claim for a Plan benefit under an insurance policy or contract in writing to the Plan Administrator, who will forward it to the insurer for decision on the claim. Any claim regarding Plan eligibility or any claim regarding an adverse impact of a Trust action should be submitted in writing to the Plan Administrator. Claims must be submitted within one year of the first day the claim was incurred. Claims submitted longer than one year after the claim was incurred will be denied as untimely.

General Timelines for Claim Determinations. The claimant shall be notified of an adverse determination on a claim for eligibility or other Trust's decisions within a reasonable time not longer than 90 days after the claim or request

was received unless special circumstances require an extension of time. The claimant must be notified in writing of the need for an extension before the end of the initial 90 days, and any extension will be no longer than another 90 days after the initial period. Any notice of extension will indicate the special circumstances requiring the extension and the date by which a determination is expected.

Notification of Adverse Determinations. The claimant shall be provided with written or electronic notification of an adverse determination on a claim, including:

- The identity of the claim.
- The specific reason or reasons for the determination.
- Reference to the specific Plan provisions on which the determination is based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why it is necessary.
- A description of the review procedures described below and the applicable time limits.
- A statement of the claimant's right to bring a legal action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") following any adverse determination on review.

Right to Appeal. A claimant receiving a notification of an adverse determination on a claim may request review of that determination within 180 days of the adverse determination. The decision of the claimant to request review of a claim shall have no effect on the claimant's rights to any other benefits. The claimant may submit written comments, documents, records and other information relating to the claim. Upon request and at no charge, the claimant may have copies of any document, record or other information that: was relied on in making the determination; was submitted, considered or generated in the course of making the determination, whether or not relied on; demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with the Plan documents applied consistently to similarly situated claimants. The review must take into account all comments, documents, records and other information submitted by the claimant relating to the claim, whether or not considered in the initial determination.

The review shall afford no deference to the initial determination. No individual who either participated in consideration of the initial determination or who is the subordinate of such an individual shall participate in review on appeal.

Timelines for Determination on Appeal. The claimant shall be notified of the determination on review within a reasonable time not longer than 60 days after the request for review unless an extension of time is required for a hearing or other special circumstances. The claimant shall be notified in writing of the need for any extension before the end of the initial 60 days, and no extension will be longer than another 60 days after the initial period. Any notice of extension will indicate the special circumstances requiring the extension and the date by which a decision is expected.

Notification of Determination on Appeal. The claimant shall be given written or electronic notification of the determination on appeal. If the determination is adverse, the notification will include:

- The identity of the claim;
- The specific reason or reasons for the determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that, upon request and free of charge, the claimant may have copies of any document, record or other information relevant to the claim;
- A statement of the claimant's right to bring a legal action under ERISA.

Judicial Review of Denied Claims. The Trust provides for no voluntary alternative dispute resolution procedures. If you remain dissatisfied after the issuance of the Trustees' decision on appeal, you may bring a civil action under ERISA § 502(a). Any civil action must be brought no later than 180 days after the date of issuance of the Trustees'

decision on an appeal. The question on review will be whether, in the particular instance, the Trustees:

- were in error upon an issue of law;
- acted arbitrarily or capriciously in the exercise of their discretion; or
- whether their findings of fact were supported by substantial evidence.

A lawsuit to obtain benefits will be deemed untimely if it is filed before:

- You have appealed the denial of your claim to the insurance carrier or Board of Trustees, or
- The insurance carrier or Board of Trustees has issued a decision on appeal; or
- You have exhausted the Plan's appeals processes for every issue you deem relevant.

Time Counting. Time periods for determinations on claims run from the time the claim is submitted in writing or a request for review is submitted in writing, without regard to whether all needed information is filed. In the case of an extension of time because more information is needed, the period for making the determination is tolled from the time the claimant is notified of the need until the claimant responds.

Plan Information

Plan Name and Type: The name of the Plan is the Medical Society Healthcare Trust. The Plan is a welfare benefit plan that provides group health benefits, prescription drug, dental, vision.

Plan Sponsor:

National Medical Health Collaborative
2401 W. Peoria Ave. Suite 130
Phoenix, AZ 85029
(602) 347-6900
EIN: 85-3060422

Plan EIN: 87-2160747; Plan No. 501

Plan Year: 12-month period ending December 31st

Plan Administrator:

Board of Trustees of the Medical Society Healthcare Plan
c/o Vimly Benefit Solutions
P.O. Box 6
12121 Harbour Reach Dr., Suite 105
Mukilteo, WA 98275-0006

Other Participating Employers Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer participates in the Plan.

Agent for Service of Process: The Plan's third-party administrator, Vimly Benefit Solutions, is designated as agent for purposes of accepting service of legal process on behalf of the Plan at:

Vimly Benefit Solutions
P.O. Box 6
12121 Harbour Reach Dr., Suite 105
Mukilteo, WA 98275-0006

425-771-7359

Also, each member of the Board of Trustees is authorized to accept service of legal process on behalf of the Plan. The names, titles, and addresses of the individuals currently serving on the Board of Trustees are:

Libby McDannell
Interim Trustee
2401 W. Peoria Ave. Suite 130
Phoenix, AZ 85029

Type of Administration: This plan is a fully-insured plan.

Sources of Contributions: Plan contributions are paid by participating employers on behalf of participants and their dependents and, to the extent disclosed in enrollment information and permitted by the Plan, contributions may be paid by employees.

Funding Medium: The employer contributions and employee self-payments are received and held by the Board of Trustees in trust pending payment of insurance premiums and/or claims and administrative expenses. Below are the names and addresses of the administrative and benefit claim providers that are contracted with the Plan. Please note: Your employer has the option of electing which of the Trust's plan benefits will be available to its employees. Accordingly, you may not be eligible for all of the benefits identified below.

BlueCross BlueShield of Arizona [Medical, Prescription Drug and Dental Claims]

2444 W. Las Palmaritas Drive, Phoenix, AZ 85021

<https://www.azblue.com>

(884) 422-2729

Administers medical, prescription drug and dental benefits

VSP Vision Care, Inc. [Vision]

3333 Quality Drive, Rancho Cordova, CA 95670

<https://www.vsp.com>

(800) 877-7195

Administers vision benefits

Equitable [Life/AD&D]

1290 Avenue of the Americas

New York, NY 10104

<https://equitable.com>

(877) 222-2144

Administers life and AD&D benefits

Vimly Benefit Solutions

P.O. Box 6

12121 Harbour Reach Drive, Suite 105

Mukilteo, WA 98275

<https://Vimly.com>

(425) 771-7359

Third Party Administrator - Administers Eligibility and COBRA

Maternity and Newborn Infant Coverage

Group health plans and health insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this Plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Protheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

Contact Vimly or the medical insurer for more information.

No Right to Continued Employment

Nothing in this SPD or the Plan shall create a right to continued employment or affect your employer's right to terminate the employment relationship or alter its terms at any time.

Notice of Privacy Practices

The Trust and Trust's insurance providers have adopted certain practices to ensure the privacy of your Protected Health Information. A copy of the Trust's Privacy Practices is available upon request from Vimly. A copy of the insurance provider's Privacy Practices may be obtained by contacting the insurance providers.

Notice of Medicare Part D Creditable Coverage

If you and/or your dependents are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D prescription drug benefits. If you do not enroll in a Medicare Part D plan when eligible and you go 63 continuous days or longer without prescription drug coverage that is "creditable coverage," – that is, coverage expected to pay out as much as standard Medicare prescription coverage – your monthly premium for a Medicare Part D prescription drug plan will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your Medicare Part D premium will be at least 19% higher. To determine whether the Trust's prescription drug plan provides creditable coverage, please refer to the most recent creditable coverage notice you received, or contact the Trust's administrator, Vimly, at the address above.

You may enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. In addition, participants losing creditable employer sponsored coverage may also be eligible to join a Part D plan at that time using a 2-month Special Enrollment Period. More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov

- Call your State Health Insurance Assistance Program (see your copy of the “Medicare & You” handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

ERISA Rights

As a participant in the Medical Society Healthcare Trust, 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 Vimly's office and at other specified locations, such as worksites and 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 Employee Benefits Security Administration.
- Obtain, upon written request to Vimly, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

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

and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions. If you have any questions about your Plan, you should contact Vimly. 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, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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 Employee Benefits Security Administration.

Future of the Plan

The Trustees have reserved the right to amend or terminate the Plan or any Plan benefit described in this SPD for any reason or for no reason at any time. Furthermore, the Employer has the right to change or discontinue any benefit it previously had chosen to provide through the Plan for any reason or for no reason at any time. As a result, you may receive different benefits than those described in this SPD, or such benefits on different conditions, or no benefits. This may happen while you are actively employed by the Employer or after you terminate employment. No employee of the Employer or individual Trustee has authority to amend or modify the Plan by any oral promise or representation nor to amend or modify any Plan benefit or provision of any insurance contract or policy.

Amendment and Termination

In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all participants, the Board of Trustees expressly reserves the right, in their sole discretion at any time and from time to time, but on a nondiscriminatory basis, to:

- Terminate or amend the Plan;
- Alter or postpone the method of payment of any benefit;
- Construe the provisions of the Plan and determine any and all questions pertaining to administration, eligibility, and benefit entitlement, including the right to remedy possible ambiguities and inconsistencies or omissions. Any construction or determination by the Trustees made in good faith shall be conclusive on all persons affected thereby;
- Reduce or eliminate any plan subsidy; and
- Amend or rescind any other provision of this Plan.

The Trust may be terminated by the Trustees in writing at any time, subject, however, to all of the requirements and procedures for plan termination under ERISA and all regulations issued thereunder. In the event of the termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund, after payment of expenses, will be used for the continuance of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted.