Short Term Disability Income Protection Plan

Effective Date: January 1, 2007
Amended Date: May 1, 2012
Amended Date: January 1, 2015
Amended Date: January 1, 2017

Contact Information

Plan Administrator:	Foth & Van Dyke, LLC
Address and Telephone #:	2121 Innovation Court De Pere, WI 54115-5095

Claims Administrator:	Unum
Address and Telephone #:	Benefits Center PO Box 100158 Columbia, SC 29202-3158 Phone: 800-858-6843 Fax: 800-447-2498

I. Table of Contents

II. Overview of Plan

The Plan is a short term disability income protection benefit plan ("Plan" or "Short Term Disability Plan") sponsored by us to replace a portion of your income in the event a sickness or injury prevents you from working for a period of time. This Plan does not provide benefits for occupational injuries or sicknesses. Detailed information about your eligibility for coverage, what benefits are payable, how to file a claim, and other features of this Plan are contained in this document, which is referred to as your booklet.

The Plan is funded as provided in the Summary of Benefits section of this booklet. We have engaged Unum to provide certain administrative claims handling services for the Plan. Neither Unum nor any of its affiliates or related insuring entities insures the benefits under this Plan, or has any responsibility to fund benefits under the Plan.

We reserve the right to modify, amend, suspend or terminate, in whole or in part, any of the provisions of this Plan at any time for any reason or for no reason. When making a benefit determination under the Plan, we have discretionary authority to determine your eligibility for benefits and to interpret and enforce the terms and provisions of the Plan. We may delegate some or all of this authority to Unum at any time.

"We", "us", and "our", as used in this summary, refer to the Employer identified on the cover page. The Employer is the Plan's sponsor.

This booklet is written in plain English. If you do not understand any of the terms in it, or desire more information, you should contact us using the contact information on the cover page. Many of the terms used in this booklet are defined in the Definitions Section. Be sure to read all the definitions so that you will understand the Plan fully.

III. Summary of Benefits

This Summary of Benefits highlights many of the features of this Short Term Disability Plan. Refer to each section for a more complete description of benefits under the Plan.

EMPLOYER: Foth & Van Dyke, LLC

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

Foth Production Solutions, LLC
Green Bay, WI

Foth Infrastructure & Environment, LLC
Green Bay, WI

Foth Asset Management, LLC
Green Bay, WI

ELIGIBLE GROUP(S):

To be eligible for benefits, you must be a member of the following eligible group:

All employees not eligible in another group in active employment in the United States with the Employer.

Note: Temporary, limited term full-time, limited term part-time, and seasonal employees are excluded from coverage.

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 25 hours per week.

Normal vacation is considered active employment.

WAITING PERIOD:

None; benefits are effective upon the employee's date of hire.

REHIRE:

If your employment ends and you are rehired by us within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other Plan provisions apply.

ELIMINATION PERIOD:

The later of:

- 14 days for disability due to an injury; or
- 14 days for disability due to a sickness; or

Benefits begin the day after the elimination period is completed.

WEEKLY BENEFIT AMOUNT:

60% of weekly earnings to a maximum benefit of $2,500 per week

Your payment may be reduced by deductible sources of income and in some cases by the income you earn while disabled.

WEEKLY EARNINGS:

Your gross weekly income from your Employer in effect just prior to your date of disability. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than your Employer.

MAXIMUM PERIOD OF PAYMENT:

11 weeks

OCCUPATIONAL INJURIES:

Your Short Term Disability Plan does not cover disabilities due to an occupational sickness or injury.

WHO PAYS FOR THE COST OF PLAN FUNDING?

Your Employer pays the cost of funding the plan.

Your Employer includes the cost of your Employer-paid coverage in your taxable income.

The above items are only highlights of the plan. For a full description of your coverage, continue reading this document.

IV. Eligibility

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are in an eligible group, the date you are eligible for coverage is the later of:

- the Plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

You will be covered at 12:01 a.m. at our primary place of business on the date you are eligible for coverage.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury or sickness, your coverage will begin on the date you return to active employment.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage will take effect immediately if you are in active employment. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

WHEN DOES YOUR COVERAGE END?

Your coverage under the Plan ends on the earliest of:

- the date the Plan is terminated by us;
- the date you are no longer in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions to the Plan; or
- the last day you are in active employment.

WHAT HAPPENS IF YOU ARE ON A LAYOFF OR LEAVE?

If you are on a layoff or leave, including a Family and Medical Leave, coverage will commence and continue in accordance with our Human Resource procedures on layoffs and leaves. Similarly, changes in your coverage while you are on a layoff or leave may occur as described in our Human Resource procedures on layoffs and leaves.

V. Benefit Provisions

WHEN ARE YOU CONSIDERED DISABLED?

DEFINITION OF TOTAL DISABILITY
You are disabled when we determine that due to your **sickness or injury:**

- you are unable to perform the **material and substantial duties** of your **regular occupation**; and
- you are not working in any occupation.

DEFINITION OF RESIDUAL DISABILITY
You are disabled when we determine that:

- you are limited from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in weekly earnings due to that same sickness or injury.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

If you have a Cesarean section, you will be considered disabled for a minimum period of eight weeks beginning on the date of your Cesarean section, unless you return to work prior to the end of the eight weeks.

We or our claims representative may require you to be examined by a physician, other medical practitioner and/or vocational expert of our or its choice. This examination will be at no cost to you and can be required as often as it is reasonable to do so. We may also require you to be interviewed in person by us or our representative.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period** in order to be eligible for benefits. A new elimination period will be applied to each disability.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive weekly payments when your claim is approved, providing the elimination period has been met. After the elimination period, if you are disabled for less than one week, you will receive $1/7^{th}$ of your payment for each day of disability.

HOW MUCH WILL YOUR BENEFIT AMOUNT BE WHEN YOU ARE DISABLED AND NOT WORKING?

We will follow this process to figure your payment:

1. Multiply your **weekly earnings** by the weekly benefit percentage amount as stated in the Summary of Benefits.
2. The maximum **weekly benefit** is as stated in the Summary of Benefits.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

WHAT ARE YOUR WEEKLY EARNINGS?

"**Weekly earnings**" means your gross weekly income from us in effect just prior to your date of disability. See Summary of Benefits for a description of how weekly earnings are calculated.

WHAT WILL WE USE FOR WEEKLY EARNINGS IF YOU BECOME DISABLED DURING A LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a layoff or leave of absence and are covered under this Plan, we will use your weekly earnings in effect just prior to the date your absence begins.

WHAT BENEFIT WILL YOU RECEIVE IF YOU ARE WORKING AND DISABLED?

We will send you the weekly payment if you are disabled and your weekly disability earnings, if any, are less than 20% of your weekly earnings.

If you are disabled and your weekly disability earnings are from 20% through 80% of your weekly earnings, you will receive payments based on the percentage of income you are losing due to your disability. We will follow this process to figure your payment:

1. Subtract your disability earnings from your weekly earnings.
2. Divide the answer in Item 1 by your weekly earnings. This is your percentage of lost earnings.
3. Multiply your weekly payment as shown above by the answer in Item 2.

This is the amount we will pay you for each week.

We may require you to send proof of your disability earnings each week. We will adjust your weekly payment based on your disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records which we believe are necessary to substantiate your income.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Payments that you receive as disability income payments are deductible sources of income and will be subtracted from your gross disability payment if they are paid pursuant to or under any:

- state compulsory benefit act or law,
- no fault motor vehicle plan,
- automobile liability insurance policy,
- other group insurance or benefit plan,
- from a third party (after subtracting attorney's fees) by judgment, settlement, or otherwise,
- the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act, or
- Employer Retirement Plan.

Only deductible sources of income that are payable as a result of the same disability will be subtracted from the weekly payment.

Retirement Plan payments will be those benefits that are based on our contribution to the Retirement Plan. Disability benefits that reduce the retirement benefit under the Plan will not be subtracted from the weekly payment.

You must notify us whenever you receive payments that are deductible sources of income. You must repay us for any overpayment of your claim resulting from your failure to notify us in a timely manner of such income.

HOW LONG WILL YOU RECEIVE PAYMENTS?

You will receive a payment each week you qualify for benefits up to the **maximum period of payment**.

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the Plan;
- the date you fail to submit proof of continuing disability;
- the date you die;
- after twelve months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total of six months or more during any twelve consecutive months of benefits.
- when you are able to work in your regular occupation on a part-time basis but choose not to.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME AND YOUR DISABILITY OCCURS AGAIN?

If you return to work with us on a full time basis for fourteen consecutive days or less, and you again become disabled, then your current disability will be treated as part of your prior claim and you will not have to complete another elimination period. If you return to work full time for fifteen or more consecutive days, your current disability will be treated as a new claim. The new claim will be subject to all of the provisions of the Plan and you will be required to satisfy a new elimination period.

VI. Exclusions and Limitations

Benefits will not be paid for any disabilities caused by, contributed to by, or resulting from your:

- occupational sickness or injury,
- intentionally self-inflicted injuries, while sane or insane,
- active participation in a riot,
- loss of a professional license, occupational license or certification,
- cosmetic surgery, except surgery made necessary by accidental injury incurred while covered under the Plan,
- commission of a crime for which you have been convicted, or
- attempt to commit a crime.

The Plan will not cover a disability due to war, declared or undeclared, or any act of war.

We will not pay a benefit for any period of disability during which you are incarcerated.

VII. Claim and Appeal Information

WHEN DO YOU NOTIFY US OF A CLAIM?

We encourage you to notify Unum of your claim as soon as possible, so that a claim decision can be made in a timely manner. Written notice of a claim should be sent to Unum within 30 days after the date your disability begins. In addition, you must send Unum written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required except in the absence of legal capacity.

You must notify Unum immediately when you return to work in any capacity. Unless we have given you different delivery instructions, you should use the contact information on the cover page when notifying Unum of your claim.

HOW DO YOU FILE A CLAIM?

A claim form, which can be used as your proof of claim, is available from Unum or from us. If you do not receive the form within 15 days of your request, send Unum written proof of claim without waiting for the form.

You must fill out the employee section of the claim form, have us complete the employer section and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum. Alternatively, you may follow any claims filing procedures approved by us and Unum. We will separately advise you of any such procedures.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Your proof of claim, provided at your expense, must show:

- that you are under the regular care of a physician;
- the appropriate documentation of your weekly earnings;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- the name and address of any hospital, institution or other source where you received treatment, including all attending physicians' names and addresses.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

In some cases, you will be required to give Unum and us authorization to obtain additional medical information, and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

TO WHOM WILL PAYMENTS BE MADE?

Payments will be made to you.

WHAT HAPPENS IF YOUR CLAIM IS OVERPAID?

We have the right to recover any overpayments due to:

- fraud;
- any error made in processing a claim; and
- your receipt of deductible sources of income.

You must repay us for any overpayment in your claim. Alternatively, we may reduce or eliminate future payments instead of requiring repayment.

FRAUD WARNING

We take fraud very seriously. If you, with intent to defraud or knowing that you are facilitating a fraud against us, submit an application or file a claim containing a false or deceptive statement, we will assert all legal and equitable rights against you and pursue all legal and equitable remedies we have against you.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

Unless special circumstances apply, all administrative appeal procedures offered by us must be completed before you begin any legal action regarding your claim. In no event, can you start any legal action regarding your claim more than three years from the time proof of claim is required, unless other timeframes apply under federal law.

CLAIM AND APPEAL PROCEDURES

Upon receipt of the required proof of claim, a decision on your claim will be made promptly. If you fail to supply the needed information, your claim will be denied.

We will notify you in writing if a claim or any part of a claim is denied. The denial letter will state:

- the specific reason(s) for the denial with reference to the applicable Plan provision(s);
- a description of any additional material or information that is necessary to complete the claim;
- an explanation of why the additional material or information is necessary;
- a statement describing your access to documents; and
- a statement describing your appeal rights.

If you are not satisfied with the reason(s) for the denial, you or your representative may ask to have the claim reviewed by us. Your appeal must be in writing and must be sent to Unum within 180 days of your denial notice. Your appeal should include all supporting materials or information that will help us to review the claim. We will review your appeal and all new information submitted and notify you or your representative of our decision promptly. In some cases, we may request that you provide additional information to assist in the review.

VIII. Definitions

ACTIVE EMPLOYMENT means you are working for us for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the minimum hours requirements.

Your work site must be:

- your employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires travel.

Normal vacation is considered active employment.

Temporary, limited term full-time, limited term part-time and seasonal workers are excluded from coverage.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the Plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could reasonably be expected to receive if you were working to your maximum capacity.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits.

EMPLOYEE means a person who is in active employment in the United States with us.

EMPLOYER means the entity identified on the cover page and any division, affiliate or subsidiary listed in the Summary of Benefits.

GROSS DISABILITY PAYMENT means the benefit amount before we subtract deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means a facility licensed to provide medical care and treatment for the condition causing your disability.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Injury which occurs before you are covered under the plan will be treated as sickness. Disability must begin while you are covered under the plan.

LAW, PLAN OR ACT means the original enactments of any law, Plan or act and all amendments.

LAYOFF or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by us. Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIMITED means what you cannot or are unable to do.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified, except that if you are required to work on average in excess of 40 hours per week, we will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

MAXIMUM CAPACITY means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation that is reasonably available.

MAXIMUM PERIOD OF PAYMENT means the longest period of time the Plan will make payments to you for any one period of disability.

OCCUPATIONAL SICKNESS OR INJURY means a sickness or injury that was caused by or aggravated by any employment for pay or profit.

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your weekly earnings.

PAYABLE CLAIM means a claim for which the Plan is liable.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

You, or your spouse, children, parents or siblings will not be considered as a physician for a claim that you send to us.

PLAN means this Short Term Disability Plan.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care, which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s).

REGULAR OCCUPATION means the occupation you are routinely performing when your disability begins. We will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan includes, but is not limited to, any plan which is part of any federal, state, county, municipal or association retirement system.

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by us of all or part of your weekly earnings, after you become disabled as defined by the Plan. Salary continuation or accumulated sick leave does not include compensation paid to you by us for work you actually perform after your disability begins. Such compensation is considered disability earnings and would be taken into account in calculating your weekly payment.

SICKNESS means an illness or disease.

UNUM means the insuring entity affiliated with Unum Group.

WAITING PERIOD means the continuous period of time (shown in the Summary of Benefits) that you must be in active employment in an eligible group before you are eligible for coverage under the Plan.

WE, **US** and **OUR** mean the Employer.

WEEKLY BENEFIT means the total benefit amount an employee is eligible for under the Plan subject to the maximum benefit.

WEEKLY EARNINGS means your gross weekly income from us just prior to your disability as defined in the Plan.

WEEKLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

YOU means a person who is eligible for coverage under the Plan.

IX. ERISA Provisions

If the Plan is covered by ERISA, then the following additional information will be applicable to your coverage and claims under the Plan:

IS THERE ADDITIONAL INFORMATION YOU SHOULD KNOW ABOUT THE PLAN?

Here is additional information about your Plan that you will find useful:

Name of Plan:
Foth & Van Dyke, LLC Group Short Term Disability Plan

Name and Address of Employer:
Foth & Van Dyke, LLC
2121 Innovation Court
Suite 100
De Pere, WI 54115-5095

Plan Identification Number:
a. Employer IRS Identification #: **39-0749219**
b. Plan #: **507**

Type of Welfare Plan:
Short Term Disability

Type of Administration:
The Plan is administered by the Employer. The Employer has contracted with Unum to provide certain administrative claims handling services for the Plan.

Plan Year Ends:
December 31

Plan Administrator Name, Address, and Telephone Number:
Foth & Van Dyke, LLC
2121 Innovation Court
Suite 100
De Pere, WI 54115-5095
(920) 497-2500

Foth & Van Dyke, LLC is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties including its fiduciary duties. If there are Trustees for this Plan, you will be notified in a separate communication about the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:

Foth & Van Dyke, LLC
2121 Innovation Court
Suite 100
De Pere, WI 54115-5095
(920) 497-2500

Service of legal process may be made upon the Plan Administrator and any Trustee of the Plan.

Funding and Contributions:
The Plan is funded as provided in the Summary of Benefits section. No insurance policies are used to provide benefits under the Plan.

EMPLOYER'S RIGHT TO AMEND THE PLAN

We reserve the right, in our sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents), at any time and for any reason or no reason.

If we cancel the Plan, coverage will end at 12:00 midnight at our primary business location on the last day of the Plan. If the Plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in the Plan. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum using the contact information on the cover page of the Plan.

CLAIMS PROCEDURES

You will receive notice of the decision on your claim no later than 45 days after the Claim is filed. This time period may be extended twice by 30 days if an extension is necessary due to matters beyond the control of the Plan and you are notified of the circumstances requiring the extension of time and the date by which a decision is expected. If an extension is necessary due to your failure to submit the information necessary to decide the Claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, your Claim may be decided without that information.

If your Claim for Benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court; and
- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEALS PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). You will be notified in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal review period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, your appeal may be decided without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, a health professional with appropriate training and experience will be consulted. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, you will be provided with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a civil suit under federal law;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, 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 the Plan Administrator, copies of documents governing the operation of the Plan, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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 benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or 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, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the 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.

DISCRETIONARY ACTS

In exercising our discretionary powers under the Plan, we, as the Plan Administrator, will have the broadest discretion permissible under ERISA and any other applicable laws, and our decisions will constitute final review by the Plan of your claim by the Plan. Benefits under the Plan will be paid only if we decide in our discretion that the applicant is entitled to them. We also have discretion to determine eligibility for benefits and to interpret the terms and conditions of the Plan.