

***Plan Document and  
Summary Plan Description for the  
Creare Inc. Flexible Benefits Plan***

- Your Health Care Benefits
- Your Life Insurance and AD&D Benefits
- Your Disability Benefits
- Employee Assistance Program ("EAP")
- Other Insurance Benefits

EFFECTIVE DATE: 01/01/2014

**2015 & 2017 SPD Amendments Included**

## **Introduction**

*This booklet provides information about your medical/prescription drug, short-term and long-term disability benefits, basic and voluntary group term life and accidental death and dismemberment benefits, and Employee Assistance Plan Benefit Programs. It serves as the Plan Document and the Summary Plan Description ("SPD") for the Creare Inc. Flexible Benefits Plan ("the Plan").*

*Note: A separate SPD has been issued that describes information for the following Benefit Programs: Health Care FSA and Dependent Care FSA.*

*This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits. It is written to comply with the written plan document and disclosure requirements under the Employee Retirement Income Security Act ("ERISA") of 1974, as amended.*

*The "Benefit Programs" covered by this SPD are shown in Appendix A. For fully insured Benefit Programs, the insurance contracts or policies (including amendments and riders), plan descriptions, benefit summaries, schedule of benefits, the Certificate of Insurance or Certificate of Coverage and other descriptive documents relating to each Benefit Program (collectively, the "insurance certificates") are incorporated herein by reference only to the extent they are the source of eligibility, benefits, claims procedures, or other substantive provisions of the Benefit Programs.*

*We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.*

*This SPD and Plan describe the coverage currently in effect. Be sure to keep this booklet in a safe and convenient place for future reference.*

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## **Plan Overview**

The Plan provides benefits to eligible employees and their dependents through each Benefit Program listed in Appendix A. Fully insured benefits are payable solely by the Insurer listed for the respective Benefit Program.

## **Your Eligibility**

You are eligible for the Benefit Program(s) shown in Appendix A if you are a full-time active employee or a part-time employee (medical and EAP only) who is normally scheduled to work 15 or more hours per week.

The following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency, or leasing organization, contract employees, persons hired on a seasonal or temporary basis, and other individuals who are not on the Employer payroll, as determined by the Employer, without regard to any court or agency decision determining common-law employment status.

## **Eligible Dependents**

The definition of eligible dependents and other provisions, such as whether you may enroll your eligible dependents in a Benefit Program, are defined in the insurance certificates for each Benefit Program. Those provisions, and the definition of a dependent for each Benefit Program, are incorporated by reference herein.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child under age 18 placed in the home during a probationary period in anticipation of the adoption where there is a legal obligation for support);
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

In addition, an eligible dependent who lives outside the U.S. may be restricted from coverage unless the dependent has established his or her primary residence with you. If you have any questions regarding dependent coverage under a Benefit Program, check with the Insurer or Claims Administrator.

Coverage for newly eligible dependents will begin on the date they become a dependent as long as you enroll them within 31 days of the date on which they became eligible. If you acquire a new dependent, such as through marriage, coverage will begin on the date they become an eligible dependent (such as of the date of marriage) as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, the enrollment will be considered a late enrollment.

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Employer, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the

other's coverage, but only one of you may cover your dependent children. It is your responsibility to notify the Employer if your dependent becomes ineligible for coverage.

### **When Coverage Begins**

To be eligible for a Benefit Program, you must satisfy the eligibility requirements described for that Benefit Program in the applicable insurance certificates and other materials provided for that Benefit Program. Unless otherwise stated in those materials, your coverage begins on the first day of employment. Coverage for your eligible dependents begins on the same day as your initial eligibility provided you enroll your dependents within 31 days of eligibility. Certain benefits, such as disability or life insurance, may require you to be actively at work in order to be initially eligible for a Benefit Program and for any change in coverage to take effect. See the materials provided by your Insurer to determine when this applies to you.

If you terminate employment and are subsequently rehired, you will need to satisfy any eligibility requirements to be covered under the Plan.

### **Proof of Dependent Eligibility**

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled retroactively.

### **Your Contribution for Coverage**

Each year, the Employer will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Any required contribution amount will be provided to you by the Employer in your enrollment materials and on your Election Form which are incorporated herein by reference. You may also request a copy of any required contribution amounts from the Plan Administrator.

For most benefits, you pay the employee cost of Plan premiums through pre-tax payroll deductions each pay period; however, some Benefit Programs may require premiums to be paid with after-tax dollars. You must elect coverage for yourself in order to cover your eligible dependents. Your coverage for certain Benefit Programs may also be subject to deductibles, copayments, coinsurance, or other fees as described in the materials for the coverage you select.

### **Enrolling for Coverage**

#### **New Hire Enrollment**

As a newly eligible employee, you will receive an Election Form and enrollment information when you first become eligible for benefits. For each Benefit Program, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Employer to deduct any required premiums from your pay through salary reduction.

The elections you make will remain in effect until the next December 31, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will be deemed to have elected no coverage or the default coverage designated by the Employer for a Benefit Program.

### **Late Entrant**

An enrollment will be considered timely if your completed enrollment form is received within 31 days after you become eligible for coverage. You will be considered a "late entrant" if:

- You elect coverage more than 31 days after you first become eligible
- You again elect coverage after cancelling

Unless the Special Enrollment Rights (see below) apply, if you are a late entrant, you will be required to wait until the next open enrollment period to enroll in coverage.

### **Annual Open Enrollment Period**

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your enrollment materials and Election Form will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on January 1 and stay in effect through December 31, the Plan Year, unless you have a qualifying change in status. The Plan Year may differ from the policy year of an insured benefit, with deductible and out-of-pocket expenses based on the policy year. You should refer to the insurance certificate and other materials provided by the Insurer to determine if a different policy year applies.

### **Effect of Section 125 Tax Regulations on this Plan**

It is intended that this Plan meets the requirements of Code Section 125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the Employer nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days of the following:

- The date you have a qualifying change in status as described below; or
- The date you meet the Special Enrollment Rights criteria described below.

### **Qualifying Change in Status**

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual open enrollment period.



As defined by Internal Revenue Code Section 125, or the regulations thereunder, the following events may be considered a change in status:

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child's eligibility;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- a change in your Employer work location or home address that changes your overall benefit options and/or prices;
- a significant change in coverage or the cost of coverage;
- a reduction or loss of your or a dependent's coverage under this or another plan; or
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child.

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes must be consistent with the status changes as described above. For example, if you get married, you may change your coverage level from you only to you and your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change to the Plan Administrator as soon as possible, but no later than 31 days after the event occurs.

### **Special Enrollment Rights**

If you decline enrollment for yourself or your dependents (including your spouse) because you have other coverage, you may be able to enroll yourself and your dependents in this Plan, without being considered a Late Entrant, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Coverage for newly eligible dependents will begin on the date they become a dependent as long as you enroll them within 31 days of the date on which they became eligible. If you acquire a new dependent, such as through marriage, coverage will begin on the date they become an eligible dependent (such as of the date of marriage) as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, you may not be able to enroll them until the next annual open enrollment period.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

### **When Coverage Ends**

Except as otherwise provided in the insurance certificate, your coverage under this Plan ends on the last day of your employment or upon your death, unless benefits are extended, such as when you take an approved leave of absence.

Coverage will also end for you and your covered dependents as of the date the Employer terminates this Plan or, if earlier, the effective date you request coverage to be terminated for you and/or your covered dependent.

If your coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

### **Cancellation of Coverage**

If you fail to pay any required premium for coverage under a Benefit Program, coverage for you and your covered dependents will be canceled for that Benefit Program and no claims incurred after the effective date of cancellation will be paid.

### **Rescission of Coverage**

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent perform an act, practice, or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. Coverage may also be rescinded for failure to pay required premiums or contributions as required by the Plan.

Coverage may be rescinded to your date of divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent. You will receive 30 days advance written notice of any cancellation of coverage to be made on a prospective basis.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

### **Coverage While Not at Work**

In certain situations, coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you take an unpaid leave of

absence, you will need to make payment arrangements prior to the start of your leave. Your payments will be made on an after-tax basis, unless you are on paid leave, in which case your premium payments will continue to be deducted on a pre-tax basis. You should discuss with Human Resources or your supervisor what options are available for paying your share of costs while you are absent from work.

### **If You Take a Leave of Absence (FMLA)**

If you take an approved FMLA leave of absence, your coverage will continue for the duration of your leave, as long as you continue to pay your share of the cost as required under the Employer's FMLA Policy. Coverage for other benefits can be found in the insurance certificates for the respective Benefit Programs in which you have enrolled.

### **If You Take a Military Leave of Absence**

If you are absent from work due to an approved military leave, coverage may continue for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) starting on the date your military service begins.

Coverage for other benefits can be found in the insurance certificates furnished by the Insurer for the respective Benefit Programs in which you have enrolled and will be governed by the provisions of USERRA.

## **Your Health Care Coverage**

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

The following health care Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Medical/Prescription Drug

### **Participation**

To become a participant in the above Benefit Program(s), you must meet all eligibility requirements and enroll in coverage. You may also enroll your dependents if they are eligible dependents as defined in the Insurer's benefits booklets. You will automatically receive identification cards for you and your enrolled dependents when your enrollment is processed.

### **Benefits Provided**

The benefits provided under each Benefit Program are more fully described in the Certificate of Insurance/Coverage and other benefits booklets provided by the Insurer.

Your health care benefits are delivered through a network of participating physicians, hospitals, and other providers who have agreed to provide services at a negotiated cost.

You may choose from several types of medical plans or programs of benefits under this Plan, including:

- an HMO (Health Maintenance Organization)
- a PPO (Preferred Provider Organization).

When you use network providers, the Plan pays the negotiated amount of covered expenses (after meeting any deductible) to your provider and there are no claim forms to complete. Certain medical options, such as a PPO or HMO, require services to be received only from network providers in order to be covered. You must use network providers in order to receive the maximum benefit payable under the Plan if you are enrolled in this type of plan.

For a listing of current network health care providers (at no cost to you), contact the Insurer at the telephone number or website shown on your identification card.

Certain medical options, such as an HMO or POS, may require you to select a primary care physician ("PCP") to coordinate your care. If so, you may designate any PCP who participates in the network and who is available to accept you or your family members. For dependent children, you may designate a pediatrician as the PCP. You do not need prior authorization from the Insurer or your PCP to obtain access to obstetrical or gynecological care from a network professional who specializes in obstetrics or gynecology. The network professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a PCP, and for a list of participating primary care physicians, contact the Insurer at the telephone number or website shown on your identification card.

## **Source of Payments**

Benefits for covered services and expenses under the Benefit Program(s) listed above are paid by the Insurer and are guaranteed under the insurance contracts. Any cost-sharing provisions, such as your deductible, co-payment, or coinsurance, are set forth in the materials furnished by the Insurer.

Any required premiums for coverage will be shown on your Election Form. Your premiums will be deducted from your pay on a pre-tax basis.

## **Opt-Out Contribution**

If you have medical coverage elsewhere—for example, through a spouse's plan—you may elect to opt out (choose no coverage) under this Plan and receive an opt-out contribution, as described in your enrollment materials.

## **Limitations and Exclusions**

The materials for each Benefit Program contain information about limitations on benefits, covered preventive care services, prescription drugs, pre-authorizations required, utilization reviews required, obtaining emergency care, exclusions and expenses not covered, medical tests and procedures covered, any limits or caps on certain coverage, and relative costs for in-network and out-of-network services.

## **Continuation of Health Care Coverage through COBRA**

If your health care coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan or your (or your dependent's) exceeding a maximum amount under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Health care coverage may continue at your own expense for a specific length of time. See the section entitled "Your HIPAA/COBRA Rights" for additional information. Please note that if your Employer has less than 20 employees, Federal COBRA legislation may not apply to you, but you may instead be eligible for COBRA benefits available through your state. Contact your Insurer for additional information as these provisions vary from state to state.

## **For More Information**

If you have a question about a covered service, or for more information about a specific procedure, coverage of new drugs, tests, or experimental or investigative treatments, you should consult the materials furnished by the Insurer for the coverage in which you are enrolled.

## **Your Life and Accidental Death & Dismemberment (“AD&D”) Coverage**

The following Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Group Term Life Insurance
- AD&D Insurance

### **Participation**

You must meet all eligibility requirements for coverage in order to become a participant. Enrollment in basic coverage is automatic.

### **Benefits Provided**

The benefits and amounts of coverage provided under each Benefit Program are more fully described in the materials provided to you by the Insurer. Life insurance benefits are paid in the event of the death of a covered participant. AD&D benefits are paid if a covered participant becomes dismembered or seriously injured as the result of a covered accident. You will need to designate a beneficiary to receive benefits in the event of your death.

### **Source of Payment**

Group Term Life Insurance and AD&D benefits are paid by the Insurer and are guaranteed under the applicable insurance contracts. The Company pays the full cost of your basic coverage. You are not required to make any contributions.

### **Plan Limitations and Exclusions**

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

### **Coverage Continuation**

If your Group Term Life Insurance coverage ends for any reason other than death, you may have a right to continue your insurance under an individual policy. You should consult your Certificate of Insurance for additional information about continuing your coverage as there may be time limits for making this decision once your coverage under the Plan ends.

### **Imputed Income**

Life Insurance amounts greater than \$50,000 will be subject to IRS imputed income rules. These imputed income amounts will be reflected in your regular payroll.

### **For More Information**

Consult your Certificate of Insurance or benefits booklets for additional questions about your coverage.

## **Your Disability Benefits**

The STD Benefit Program is partially insured; the LTD Benefit Program is fully insured and both are administered by the Insurer(s) listed in Appendix A.

### **Participation**

You are automatically enrolled in the STD Benefit Program after you meet all eligibility requirements as described in the Insurer's materials. No action is required on your part to participate other than completing an application when initially eligible, if required.

Your LTD coverage begins after you satisfy all eligibility requirements for coverage. Enrollment is automatic - no action is required on your part other than completing an application where required. You must also satisfy any required elimination period defined in the Insurer's materials before LTD benefits are payable.

### **Benefits Provided**

Your Certificate of Insurance defines when you are considered disabled. Generally, you are considered disabled when you are unable to perform with reasonable continuity the material duties of your own occupation due to physical disease, injury, or similar disorders.

The STD benefit provided is 60% of your pre-disability pay.

STD benefits continue for a maximum period of 13 weeks, provided you continue to be disabled.

Benefits for sickness/illness will begin after 7 continuous days of illness. Benefits for an accident or injury begin immediately.

LTD benefits are payable following an elimination period of 90 days. LTD benefits are 60% of your base pay. The maximum LTD monthly benefit payable is \$12,000.

You must be under the direct and continuous care of a licensed physician throughout the period for which disability benefits are paid. In order to continue receiving benefits, you are required to submit evidence, as requested, to support your disability claim. You may also be required to apply for Social Security disability benefits during the fifth month of your disability and, if necessary, appeal a denied claim.

### **Source of Payment**

STD disability benefits described above are paid by the Insurer and your Employer; LTD disability benefits are paid by the Insurer. Benefits are guaranteed under the applicable insurance contract(s) or policies.

The Company pays the full cost of your STD and LTD coverage. You are not required to make any contributions.

### **Payment of Benefits**

Your STD and LTD benefits are subject to tax withholding, FICA, and other authorized deductions. Benefit payments will be made for each disability period. A successive period of disability due to the same or related causes will be considered as one continuous period of disability unless it is separated by a return to active employment as described in your Certificate of Insurance.

The Insurer is the Claims Administrator and is authorized to handle the day-to-day administrative tasks and pay claims. The Insurer may obtain the services of a licensed physician who will have the full authority and discretion to determine whether an absence is due to the same or related condition.

### **Offset of Other Benefits**

If you become eligible for any disability benefits under state law or disability fund, Workers' Compensation, the Jones Act or any similar laws, state or Federal government income benefits (excluding military pensions), any self-insured, group, or individual pension plan to which the Employer contributes, or if you become entitled to Social Security disability benefits, your disability benefits may be reduced by the amount of benefits you receive, or are entitled to receive, as the result of your disability.

### **Limitations and Exclusions**

No benefits will be payable for any period in which: 1) you engage in any occupation or perform any work for compensation or profit, except approved rehabilitative employment; 2) you are not under the continuous care of a licensed physician; or 3) you are determined not to be disabled.

You should refer to the materials provided by the Insurer for information concerning any additional limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, taxability of benefits, age reductions, or reductions for other benefits that may apply.

### **Claims and Appeals**

If your claim for disability benefits is denied, you have the right to file an appeal with the Insurer, as described in your Certificate of Insurance and other materials provided by the Insurer. If your claim for benefits is denied, the Insurer will send you written notice of denial which will include the reasons for the decision and other supporting information used to make its decision. Any appeal of a denied claim must be filed within the required time frames specified in the group policy and your Certificate of Insurance.

### **For More Information**

Consult your Certificate of Insurance or benefits booklets for additional questions about your disability coverage.



## **Your Employee Assistance Program (“EAP”)**

The EAP Benefit Program is fully insured and administered by the Insurer listed in Appendix A.

### **Participation**

You are automatically enrolled in the EAP after you meet all eligibility requirements for coverage as described in the Insurer’s materials. No action is required on your part to participate.

### **Benefits Provided**

The benefits provided under the EAP are more fully described in the materials provided to you by the Insurer. The EAP offers short-term counseling and referral services to you and your eligible dependents.

### **Source of Payment**

Benefits under the EAP are paid by the Insurer and are guaranteed under the applicable insurance contract. The Employer pays the full cost of your coverage. You are not required to make any contributions.

### **Plan Limitations and Exclusions**

You should refer to the materials provided by the Insurer for information concerning any limitations or exclusions that may apply to your coverage.

### **For More Information**

If you have a question about the EAP, you should consult with your HR Department.

## **Voluntary Life and Accidental Death & Dismemberment Coverage**

The following Benefit Program is fully insured and administered by the Insurer listed in Appendix A:

- Voluntary Life and Accidental Death & Dismemberment Coverage

### **Participation**

To become a participant in the Voluntary Life and Accidental Death & Dismemberment Coverage Benefit Program, you must meet all eligibility requirements and enroll in coverage. You may elect to cover your eligible dependents.

### **Benefits Provided**

The benefits provided under the Voluntary Life and Accidental Death & Dismemberment Coverage Benefit Program are more fully described in the materials provided to you by the Insurer.

### **Source of Payment**

Benefits under the program are paid by the Insurer and are guaranteed under the applicable insurance contract.

Any required premiums for coverage will be shown on your Election Form. Your premiums are deducted on a **post-tax** basis.

### **Plan Limitations and Exclusions**

You should refer to the materials provided by the Insurer for information concerning any limitations, exclusions, or reduction for other benefits that may apply to your coverage.

### **For More Information**

If you have any questions about the Voluntary Life and Accidental Death & Dismemberment Coverage Benefit Program, you should consult your Certificate of Insurance or other materials provided by the Insurer.

## **Administrative Information**

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Insurer or Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under ERISA and other Federal laws such as COBRA.

**IMPORTANT:** The Employee Retirement Income Security Act (ERISA) is a Federal law. This Summary Plan Description is issued in accordance with ERISA and may not include language or certain mandated coverage required by state insurance laws. State mandated coverage may be addressed separately in the insurance certificates provided by the Insurer.

### **Plan Sponsor and Administrator**

Create Inc. is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

#### **Plan Administrator**

Create Inc.  
P.O. Box 71  
16 Great Hollow Road  
Hanover, NH 03755  
603-643-3800

As set forth in Section 3(16) under ERISA, the Plan Administrator will administer this Plan and will be the "Named Fiduciary" for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Employer. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Employer, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;

- To maintain and preserve appropriate Plan records; and
- To accept all other responsibilities and duties of the administrator of the Plan as specifically set forth in ERISA.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan.

For fully insured benefits, unless otherwise expressly provided in the insurance policy or contract governing a Benefit Program, the Insurer shall be the Plan Administrator and Named Fiduciary only with respect to the benefits provided through the insurance policy or contract. The Insurer shall be responsible for determining eligibility for and the amount of benefits payable under the Benefit Program, and for prescribing claims procedures to be followed by Participants. The Insurer shall also be responsible for paying claims.

**Plan Year**

The Plan Year is January 1 through December 31.

Note: An insured benefit may use a policy year that differs from the Plan Year, with deductible and out-of-pocket expenses based on the policy year. Please refer to the insurance certificate and other materials provided by the Insurer to determine if a different policy year applies to certain annualized benefits.

**Type of Plan**

This Plan is called a “welfare plan”, which includes group health plans under ERISA; they help protect you against financial loss in case of sickness or injury.

**Identification Numbers**

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 02-0259551      PLAN NUMBER: 501

**Plan Funding and Type of Administration**

Funding and administration of the Plan is as follows.

Type of Administration	The Plan is administered by the Employer through an arrangement with Insurers and third-party (claims) administrators. Insured benefits will be payable solely by the Insurer.
Funding	The Employer and employees both contribute to the Plan. Premiums are paid to the Insurers for fully insured Benefit Programs and benefits will be paid by the Insurer in accordance with the applicable insurance contract/policy.

Funding for this Plan shall consist of an aggregation of the funding for all Benefit Programs. The Employer shall have the right to insure any benefits under this Plan, to establish any fund or trust for the payment of benefits under this Plan, or to do neither and pay benefits under this Plan from its general assets, either as mandated by law or as the Employer deems advisable. In addition, the Employer shall have the right to alter, modify, or terminate any method or methods used to fund the payment of benefits under this Plan, including, but not limited to, any trust or insurance policy.

If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the Insurer.

### **Insurers/Claims Administrators**

For fully insured Benefit Programs, the Insurer is responsible for administering benefits and paying claims. They may contract with a separate Claims Administrator to process claims. You may contact the Insurer/Claims Administrator directly, using the information listed below.

While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that Federal law requires that the Plan Documents always control, even if their terms conflict with information given to you by an Insurer or other service provider.

### **Medical/Prescription Drug Benefits**

Harvard Pilgrim Health Care of New England  
1600 Crown Colony Drive  
Quincy, MA 02169  
888-333-4742  
[www.harvardpilgrim.org](http://www.harvardpilgrim.org)

### **Group Term Life Insurance Benefits**

UNUM  
2211 Congress Street  
Portland, ME 04122  
423-294-1011  
[www.unum.com](http://www.unum.com)

### **Accidental Death & Dismemberment Benefits**

UNUM  
2211 Congress Street  
Portland, ME 04122  
423-294-1011  
[www.unum.com](http://www.unum.com)

**Short Term Disability Benefits**

UNUM  
2211 Congress Street  
Portland, ME 04122  
423-294-1011  
www.unum.com

**Long Term Disability Benefits**

UNUM  
2211 Congress Street  
Portland, ME 04122  
423-294-1011  
www.unum.com

**Employee Assistance Program**

MKS Performance Solutions, LLC  
18 N. Main Street  
Concord, NH 03301  
888-657-7373  
www.mksp performancesolutions.com

**Voluntary Life and Accidental Death & Dismemberment Coverage**

UNUM  
2211 Congress Street  
Portland, ME 04122  
423-294-1011  
www.unum.com

**Agent for Service of Legal Process**

For disputes arising under any fully insured Benefit Program, Service of Legal Process may be made upon the Insurer listed above. Service of Legal Process may also be served upon:

**HUMAN RESOURCE MANAGER**

Creare Inc.  
P.O. Box 71  
16 Great Hollow Road  
Hanover, NH 03755  
603-643-3800

Service of Legal Process may also be served on the Plan Administrator.

**No Obligation to Continue Employment**

The Plan does not create an obligation for the Employer to continue your employment or interfere with the Employer's right to terminate your employment, with or without cause.

## **Non-Alienation of Benefits**

With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator or, where applicable, the Insurer, has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator or Insurer.

## **Severability**

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

## **Payment of Benefits to Others**

The Insurer/Claims Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

## **Expenses**

All expenses incurred in connection with the administration of the Plan, will be paid by the Plan except to the extent that the Employer elects or is required by law to pay such expenses.

## **Fraud**

No payments under the Plan will be made if you or a provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Insurer/Claims Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. If you or a covered dependent attempts or commits fraud upon the Plan, your coverage may be terminated and you may be subject to disciplinary action by the Employer, up to and including termination of employment.

## **Indemnity**

To the full extent permitted by law, the Employer will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

## **Compliance with State and Federal Mandates**

Each Benefit Program will comply to the extent possible with the requirement of all applicable laws, including but not limited to: ERISA, COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Women's Health and Cancer Rights Act of 1998, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle's Law (if applicable), and Title I of GINA (prohibiting the use of genetic information to

discriminate with respect to health insurance premiums, contributions or other restricted purposes).

### **Refund of Premium Contributions**

For fully insured Benefit Programs, the Plan will comply with DOL guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) of insurance premiums. Where any refund is determined to be a plan asset to the extent amounts are attributable to participant contributions, such assets will be: 1) distributed to current plan participants within 90 days of receipt, 2) used to reduce participants' portion of future premiums under the Plan (e.g., premium holiday); or 3) used to enhance future benefits under the Plan. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

### **Non-discrimination**

In accordance with IRC Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416) or Highly Compensated Individuals as to eligibility to participate; or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. The Plan Administrator will take such actions necessary to ensure that the Plan does not discriminate in favor of Key Employees, Highly Compensated Individuals, or Highly Compensated Participants.

### **Future of the Plan**

The Employer expects that the Plan will continue indefinitely. However, the Employer has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Employer may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.



## **Claims Procedures/Coordination of Benefits**

This section describes what you must do to file or appeal a claim for services. It also describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

### **Claims and Appeals**

For fully insured Benefit Programs, the claims procedures, including issues related to payment, preauthorization approval, or utilization review, as well as the time frames for submitting claims, are set forth in the insurance certificates.

If your claim is denied and you disagree and want to pursue the matter, you must file a First Level Appeal with the respective Insurer. You or your authorized representative may appeal a denied claim within the time frame provided in the insurance certificates for that Benefit Program. Different time frames apply to healthcare claims and disability-related claims. You will have the right to submit for review, written comments, documents, records, and other information related to the claim; and to request, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

The Insurer, acting on behalf of the Plan, has full and exclusive authority and discretion to construe and interpret the provisions of the Program, to determine questions of coverage, and entitlement to and termination of benefits, and to make factual findings. If the Insurer denies your claim (in whole or in part) during a First Level Appeal, you may file a Second Level Appeal. If after such review, the Insurer continues to deny the claim in full or in part, you will be notified of the decision in writing.

The Insurer's decision will include specific reasons for the decision, written in a manner calculated to be easily understood, with specific references to the Benefit Program's provision or provisions, including any internal rules, guidelines, protocol, or other similar criterion relied upon, on which the appeal decision is based. It will also include a statement of your right to access and receive copies of all documents, records, and other information relevant to your appeal. You will also be provided a statement advising that you are entitled to bring civil action in Federal court under Section 502(a) of ERISA.

### **Exhaustion Required**

The decision of the Insurer for fully insured Benefit Programs shall be final and conclusive on all persons claiming benefits under the Benefit Program, subject to applicable law. No other actions may be brought by any person until an appeal for denied benefits has been brought and been denied (or deemed denied) as described above under the respective claims procedure. You must exhaust all remedies available to you before bringing legal action. You cannot take any other steps unless and until you have exhausted all appeals. For example, if your claim is denied and you do not use the appeals procedures, the denial of your claim will be conclusive and cannot be challenged, even in court.

## **Non-Duplication of Benefits / Coordination of Benefits**

If you (or an eligible dependent) are covered by another employer's plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits. The Insurer is responsible for ensuring that eligible expenses are coordinated with benefits from:

- other employers' plans;
- certain government plans; and
- motor vehicle plans when required by law.

The Insurer may request information about other coverage you may have. You are required to provide this information to ensure that claims are properly paid.

## **Health Care Coverage Coordination with Medicare**

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will be coordinated with Medicare. Which plan pays first ("primary") is determined by whether your Employer is considered a small or large group employer. Generally, for large group employer plans, Medicare requires the employer's plan to pay first and Medicare pays second ("secondary"). You should check with your Employer if you become eligible for Medicare while employed to determine if your Employer's coverage will be primary or secondary.

The Plan also coordinates with Medicare as follows.

- **End-stage renal disease**—If you or a covered dependent is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.
- **Mandated coverage under another group plan**—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

## **Subrogation and Reimbursement**

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Insurer has a right to subrogation and reimbursement. Subrogation applies when the Insurer has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan Administrator has delegated all subrogation rights and third party recovery rights to the Insurer of each fully insured Benefit Program. The Insurer shall undertake reasonable steps to identify claims in which the Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. You are required to cooperate with the Insurer to facilitate enforcement of its rights and interests.

These provisions shall not apply where subrogation is specifically prohibited by enforceable law.

## **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 will be entitled to the following.

### **Receive Information about Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, 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 the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Continue 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your 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 previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) or the latest annual report from the Plan and do not receive it 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

administrator. If, after you exhaust your appeals, 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. Such suit must be filed within 180 days from the date of an adverse appeal determination notice. 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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

### **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 also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.

## **Your HIPAA Rights**

### **Health Insurance Portability and Accountability Act (HIPAA)**

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights as they pertain to your health insurance benefits. You will receive a separate "Notice of Privacy Provisions" from the Insurer which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

HIPAA applies to group health plans. These plans are commonly referred to as "HIPAA Plans" and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual's physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan Sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan Sponsor performs on behalf of the HIPAA Plans. Such functions include:

- enrollment of eligible individuals;
- eligibility determinations;
- payment for coverage;
- claim payment activities;
- coordination of benefits; and
- claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Insurer involved with the PHI in question. The Insurer will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Employer or Plan Sponsor with respect to such information. The Employer or Plan Sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan's use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to

the previously listed positions/departments and only for the functions listed previously. The HIPAA Plan's policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan Sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan Sponsor or any Business Associate of the Plan Sponsor becomes aware.

## **Your COBRA Continuation Coverage Rights**

### **Continuing Health Care Coverage through COBRA**

This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Employer is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same healthcare coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

### **COBRA Qualifying Events and Length of Coverage**

Each person enrolled in benefits will have the right to elect to continue healthcare benefits upon the occurrence of a qualifying event that would otherwise result in such person losing healthcare benefits. Qualifying events and the length of COBRA continuation are as follows:

#### **18-Month Continuation**

Healthcare coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of COBRA coverage in addition to the 18-month continuation period (for a total of 29 months of coverage from the date of the qualifying event). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period (including a child born or placed for adoption with you); and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

### **36-Month Continuation**

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus 11 month extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

### **COBRA Notifications**

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation, or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Employer within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage by completing and returning your COBRA enrollment form.



*NOTE: If you have a new child during the COBRA continuation period by birth, adoption or placement for adoption, your new child is entitled to the status of a qualified beneficiary. As such, your new child is entitled to receive coverage upon his or her date of birth, date of adoption or date placement for adoption is made and you become legally obligated to provide support for the child, provided you enroll the child within thirty (30) days of the child's birth/adoption/placement.*

### **Cost of COBRA Coverage**

You or your eligible dependent pay the full cost for healthcare coverage under COBRA, plus an administrative fee of two percent, or 102 percent of the full premium cost, except in the case of an 11-month disability extension where you must pay 150 percent of the full premium cost for coverage.

### **COBRA Continuation Coverage Payments**

Each qualified beneficiary may make an independent COBRA coverage election. You elect coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

### **How Benefit Extensions Impact COBRA**

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage.

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or

- on the date of termination if you decide to terminate your employment during the leave.

### **When COBRA Coverage Ends**

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan, even though the subsequent plan has a pre-existing condition exclusion, so long as the individual has enough creditable coverage to satisfy the subsequent plan's pre-existing condition exclusion. If the individual does not have enough creditable coverage to meet the new plan's requirement, he or she may continue to purchase COBRA coverage until the earlier of the day he or she is eligible for the new coverage, or 36 months.
- The individual becomes entitled to Medicare.
- The Employer terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

***Additional COBRA Election Period.*** The Trade Act of 2002 provides an additional COBRA election period for certain eligible Trade Adjustment Assistance ("TAA") recipients. If you did not elect continuation coverage under the regular COBRA election period, described above, you may elect continuation coverage within the 60-day period that starts on the first day of the month when you are determined to have met the definition of an eligible TAA recipient. However, such election may not be made later than six (6) months after the date you lost coverage as a result of your separation from employment that resulted in you becoming an eligible TAA recipient.

## **Definitions**

### **COBRA**

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of healthcare coverage in certain circumstances for Employers with 20 or more employees. Small Employers may be subject to individual state COBRA provisions.

### **Dependent**

The definition of a dependent is defined in the insurance certificate and other materials provided by the Insurer. Under the PPACA, your dependent for health insurance coverage includes your child under age 26, regardless of financial dependency, residency with you, marital status, or student status.

Your "child" includes:

- Your biological child;
- Your legally adopted child (including any child under age 18 placed in the home during a probationary periods in anticipation of the adoption where there is a legal obligation for support;
- A child for whom you are the court-appointed legal guardian; or
- An eligible child for whom you are required to provide coverage under the terms of a QMCSO or NMSN, as defined below.

Certain states may impose a different definition of dependent that extends coverage beyond age 26. Your employer also may elect a more generous definition of dependent or apply the above definition to other Benefit Programs. For questions regarding dependent eligibility, refer to your insurance certificate.

### **Employee**

A person who is a fulltime employee and who is regularly scheduled to work for the Employer in an employer-employee relationship. The definition of an eligible employee is defined in the Plan Overview.

### **Election Form**

The form used by employees to elect to participate in a Benefit Program and to authorize payment of premiums for such Benefit Program, where applicable.

### **ERISA**

The Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

### **Family and Medical Leave Act**

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or

- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Employer for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Employer has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Employer. Various states also have enacted similar legislation for their residents. Covered employers must comply with the Federal or state provision that provides the greater benefit to their employees. If you have questions regarding your eligibility for FMLA coverage or your state's family medical leave provisions, if applicable, contact your Employer.

### **GINA**

The Genetic Information Nondiscrimination Act of 2008, as amended.

### **HIPAA**

Health Insurance Portability and Accountability Act of 1996, as amended.

### **HITECH**

The Health Information Technology for Economic and Clinical Health Act, as amended.

### **Insurer**

Any insurance company that fully insures (or partially insures) any benefit provided by this Plan or any Benefit Program.

### **Leased Employee**

Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

### **Medicare**

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

### **NMHPA**

The Newborns' and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers 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 cesarean 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).

### **Participant**

An eligible employee who elects to participate in the Plan by completing the necessary Election Form on a timely basis, as provided by the Plan Administrator.

**PPACA**

The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

**Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)**

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

**USERRA**

The Uniformed Services Employment and Reemployment Rights Act of 1994; a Federal law covering the rights of participants who have a qualified uniformed services leave.

**WHCRA**

The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.

## Adoption of the Plan

The Creare Inc. Flexible Benefits Plan, effective 02/01/1989, as amended and restated herein, is hereby adopted as of 01/01/2014. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this 16<sup>th</sup> day of December, 2013.

BY: *Mark W. Min*

TITLE: President

## APPENDIX A

BENEFIT PROGRAMS OFFERED: MEDICAL/PRESCRIPTION DRUG, SHORT-TERM DISABILITY INSURANCE COVERAGE, LONG-TERM DISABILITY INSURANCE COVERAGE, GROUP TERM LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE COVERAGE, EMPLOYEE ASSISTANCE PROGRAM AND VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT COVERAGE.

<b>BENEFIT PROGRAM/ EFFECTIVE DATE OF COVERAGE</b>	<b>NAME OF INSURER/ CLAIMS ADMINISTRATOR</b>	<b>POLICY OR CONTRACT NUMBER(S)</b>	<b>BENEFITS PROVIDED</b>	<b>ELIGIBILITY</b>	<b>CLAIMS PROCEDURE &amp; BENEFITS</b>
GROUP MEDICAL INSURANCE  HMO  01/01/2014	HARVARD PILGRIM HEALTH CARE OF NEW ENGLAND  INSURER/CLAIMS ADMINISTRATOR	027626	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP MEDICAL INSURANCE  PPO  01/01/2014	HARVARD PILGRIM HEALTH CARE OF NEW ENGLAND  INSURER/CLAIMS ADMINISTRATOR	027627	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
SHORT-TERM DISABILITY BENEFITS  01/01/2014	UNUM  INSURER/CLAIMS ADMINISTRATOR	501407	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
LONG-TERM DISABILITY BENEFITS  01/01/2014	UNUM  INSURER/CLAIMS ADMINISTRATOR	501407	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP TERM LIFE INSURANCE BENEFITS  01/01/2014	UNUM  INSURER/CLAIMS ADMINISTRATOR	501407	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.

<b>BENEFIT PROGRAM/ EFFECTIVE DATE OF COVERAGE</b>	<b>NAME OF INSURER/ CLAIMS ADMINISTRATOR</b>	<b>POLICY OR CONTRACT NUMBER(S)</b>	<b>BENEFITS PROVIDED</b>	<b>ELIGIBILITY</b>	<b>CLAIMS PROCEDURE &amp; BENEFITS</b>
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE COVERAGE  01/01/2014	UNUM  INSURER/CLAIMS ADMINISTRATOR	501407	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
EMPLOYEE ASSISTANCE PROGRAM  01/01/2014	MKS PERFORMANCE SOLUTIONS, LLC  INSURER/CLAIMS ADMINISTRATOR		See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
OTHER INSURANCE (Voluntary Life and Accidental Death & Dismemberment Coverage)  01/01/2014	UNUM  INSURER/CLAIMS ADMINISTRATOR	572918	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.



## Amendment #1 to the Creare Inc. Flexible Benefits Plan

This is a summary of material modifications that reflects an amendment made to the **Creare Inc. Flexible Benefits Plan** (Plan). You should read it carefully and keep it with your summary plan description (SPD) for future reference.

Effective January 1, 2015, the Creare Inc. Flexible Benefits Plan SPD has been revised as described below. If you have any questions about this amendment, or how it applies to you, please contact the Plan Administrator.

### Company (Plan Sponsor) and Plan Name Change

Effective February 10, 2014, the company/plan sponsor's name has changed to Creare LLC and the Plan name has changed to the Creare LLC Flexible Benefits Plan.

**In Witness Whereof**, Creare LLC has caused this Amendment to be signed on its behalf and attested by its duly authorized officer this 26<sup>th</sup> day of January, 2015.

**Creare LLC**

By 

Its President

This summary of material modifications is for informational purposes only. No action is required on your part. It is provided in compliance with the Employee Retirement Income Security Act of 1974, as amended (ERISA).

## Amendment #2 to the Creare LLC Flexible Benefits Plan

This is a summary of material modifications that reflects an amendment made to the **Creare LLC Flexible Benefits Plan** (Plan). You should read it carefully and keep it with your summary plan description (SPD) for future reference.

Effective January 1, 2015, the "Qualifying Change in Status" section of your SPD has been revised to include the following paragraph. If you have any questions about this amendment, or how it applies to you, please contact the Plan Administrator.

### Qualifying Change in Status

Effective January 1, 2015, you may prospectively revoke an election of coverage under a group health plan that provides minimum essential coverage (that is not a health FSA) if the following conditions are met:

- You have been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in you ceasing to be eligible for coverage under the Plan; and
- You represent that the revocation of the election of coverage under the Plan corresponds to your intended enrollment, and the intended enrollment of any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

**In Witness Whereof**, Creare LLC has caused this Amendment to be signed on its behalf and attested by its duly authorized officer this 26<sup>th</sup> day of January, 2015.

**Creare LLC**

By *Mark W. Smith*

Its *President*

This summary of material modifications is for informational purposes only. No action is required on your part. It is provided in compliance with the Employee Retirement Income Security Act of 1974, as amended (ERISA).

## Amendment #3 to the Creare LLC Flexible Benefits Plan

This is a summary of material modifications that reflects an amendment made to the **Creare LLC Flexible Benefits Plan (Plan)**. You should read it carefully and keep it with your summary plan description (SPD) for future reference.

Effective January 1, 2015, the "Plan Overview" section of your SPD has been revised to include an additional section on the look-back measurement method for determining employees' full-time status for purposes of eligibility for the Plan's health care benefits. Other than this change for health care benefits, the Plan's eligibility rules for you and your dependents remain the same.

If you have any questions about this amendment, or how it applies to you, please contact the Plan Administrator.

### Look-Back Measurement Method for Determining Full-time Employee Status:

The Company uses the look-back measurement method to determine who is a full-time employee for purposes of the Plan's health care benefits. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations.

The look-back measurement method applies to:

- All employees;
- Salaried employees;
- Hourly employees;
- Employees in the following state(s): \_\_\_\_\_;
- All collectively bargained employees;
- All non-collectively bargained employees;
- All collectively bargained employees covered by the following bargaining agreement(s): \_\_\_\_\_.

The look-back measurement method involves three different periods:

- A **measurement period** is a period for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full time.

If you are an ongoing employee, this measurement period is called the "standard measurement period." Your hours of service during the standard measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the standard measurement period and any administrative period.

For purposes of determining your eligibility for health care benefits for the stability period beginning in 2015, the Company may use a shorter standard measurement period than is used in subsequent years.

If you are a new employee who is variable hour, seasonal or part-time, this measurement period is called the "initial measurement period." Your hours of service during the initial measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the initial measurement period and any administrative period.

If you are a new non-seasonal employee who is expected to work full time, the Company will determine your status as a full-time employee who is eligible for the Plan's health care benefits based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

- The **stability period** is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are considered a full-time employee who is eligible for health care benefits during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the Company. There are exceptions to this general rule for employees who experience certain changes in employment status.
- An **administrative period** is a short period between the measurement period and the stability period when the Company performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period may last up to 90 days. However, the initial measurement period for new employees and the administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date (totaling, at most, 13 months and a fraction of a month).

The **standard measurement period** starts and ends on the following dates each year:

October 1 through September 30.

The **initial measurement period** begins on your first date of employment and lasts for 12 consecutive months.

The **stability period** lasts for 12 consecutive calendar months.

The **administrative period** lasts three months for ongoing employees and up to two months for new hires once their initial measurement period ends.

Special rules may apply in certain circumstances, such as when employees are rehired by the Company or return from an unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is a summary of how the rules work. More complex rules may apply to your situation. The Company intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

**In Witness Whereof**, Creare LLC has caused this Amendment to be signed on its behalf and attested by its duly authorized officer this 26<sup>th</sup> day of January, 2015.

**Creare LLC**

By 

Its President

This summary of material modifications is for informational purposes only. No action is required on your part. It is provided in compliance with the Employee Retirement Income Security Act of 1974, as amended (ERISA).

## Amendment to the Creare LLC Flexible Benefits Plan

This is a summary of material modifications that reflects an amendment made to the **Creare LLC Flexible Benefits Plan** (Plan). You should read it carefully and keep it with your summary plan description (SPD) for future reference.

Effective January 1, 2017, the Creare LLC Flexible Benefits Plan SPD has been revised as described below and attached. If you have any questions about this amendment, or how it applies to you, please contact the Plan Administrator.

### Plan Sponsor/Administrator address and address for service of legal process

16 Great Hollow Road  
Hanover, NH 03755

### Employee Eligibility

You are eligible for the Benefit Program(s) shown in Appendix A if you are a full-time active employee who is normally scheduled to work 30 or more hours per week. One exception, eligibility for the EAP is only contingent upon being an active employee of Creare or one of its affiliates, regardless of hours worked each week.

**In Witness Whereof**, Creare LLC has caused this Amendment to be signed on its behalf and attested by its duly authorized officer this 24<sup>th</sup> day of January, 2017.

**Creare LLC**

By 

Its President

This summary of material modifications is for informational purposes only. No action is required on your part. It is provided in compliance with the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Amended effective 1/1/2017

## APPENDIX A

BENEFIT PROGRAMS OFFERED: MEDICAL/PRESCRIPTION DRUG, SHORT-TERM DISABILITY INSURANCE COVERAGE, LONG-TERM DISABILITY INSURANCE COVERAGE, GROUP TERM LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE COVERAGE, EMPLOYEE ASSISTANCE PROGRAM AND VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT COVERAGE.

BENEFIT PROGRAM/ EFFECTIVE DATE OF COVERAGE	NAME OF INSURER/ CLAIMS ADMINISTRATOR	POLICY OR CONTRACT NUMBER(S)	BENEFITS PROVIDED	ELIGIBILITY	CLAIMS PROCEDURE & BENEFITS
GROUP MEDICAL INSURANCE  HMO 1  01/01/2014	HARVARD PILGRIM HEALTH CARE OF NEW ENGLAND  INSURER/CLAIMS ADMINISTRATOR	086087	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP MEDICAL INSURANCE  HMO 2  01/01/2015	HARVARD PILGRIM HEALTH CARE OF NEW ENGLAND  INSURER/CLAIMS ADMINISTRATOR	042120	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP MEDICAL INSURANCE  PPO/HSA  01/01/2017	HARVARD PILGRIM HEALTH CARE OF NEW ENGLAND  INSURER/CLAIMS ADMINISTRATOR	017526	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
SHORT-TERM DISABILITY BENEFITS  01/01/2017	UNUM  INSURER/CLAIMS ADMINISTRATOR	501407	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.

<b>BENEFIT PROGRAM/ EFFECTIVE DATE OF COVERAGE</b>	<b>NAME OF INSURER/ CLAIMS ADMINISTRATOR</b>	<b>POLICY OR CONTRACT NUMBER(S)</b>	<b>BENEFITS PROVIDED</b>	<b>ELIGIBILITY</b>	<b>CLAIMS PROCEDURE &amp; BENEFITS</b>
LONG-TERM DISABILITY BENEFITS  01/01/2017	UNUM  INSURER/CLAIMS ADMINISTRATOR	501407	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP TERM LIFE INSURANCE BENEFITS  01/01/2014	UNUM  INSURER/CLAIMS ADMINISTRATOR	501407	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE COVERAGE  01/01/2014	UNUM  INSURER/CLAIMS ADMINISTRATOR	501407	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
EMPLOYEE ASSISTANCE PROGRAM  01/01/2014	MKS PERFORMANCE SOLUTIONS, LLC  INSURER/CLAIMS ADMINISTRATOR		See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
OTHER INSURANCE (Voluntary Life and Accidental Death & Dismemberment Coverage)  01/01/2014	UNUM  INSURER/CLAIMS ADMINISTRATOR	572918	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.