EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

The following information, together with the information provided by the insurance company administering the benefits, comprise the Summary Plan Description under the Employee Retirement Income Security Act of 1974 only for the benefits described herein:

(1). The name of the Plan is **Marion County Medical Society, Inc. Insurance Trust Fund**
More commonly referred to as: **MCMS, Inc. – Insurance Trust (Lee Members)**

(2). The name, address and telephone number of the Plan Sponsor and Plan Administrator:

(a) **Marion County Medical Society, Inc. (MCMS)**
P.O. Box 3655
Ocala, FL. 34478
Phone (352)732-8883
FED ID# 23-7026266

(b) A complete list of those employers participating in the Plan is included in our annual IRS Form 5500 filing. You may contact the Agent for legal services for a copy.

(c) The Plan is a fully insured group insurance welfare program. The name and address of the Claims Administrator is:

Blue Cross Blue Shield of Florida. Inc. Post Office Box 1798. Jacksonville. Florida 32231-0014

(d) All Employees may access the current booklet of benefits and applicable endorsements / Notices at www.floridablue.com – Member Login

(e) Federal Required Summary of Benefit Comparison (SBC's) and other policy comparisons are available at www.trustlcms.com

(f) All employees working for an office that is not eligible for Federal COBRA, there is a provision to extend coverage sixty (60) days past the end of the month following termination of employment, so long as each month's premium is paid timely. Therefore, an employee should seek Individual coverage immediately upon termination of employment.

(g) The Agent for legal services is indicated below. Please note that service of legal process may be made upon a Plan Trustee or Plan Administrator, as well as the Agent.
Barrett, Liner & Buss, LLC
104 SE 1st Avenue, Suite A
Ocala, FL 34470
(352) 622-9124

(h) A list of current Trustees and their addresses are indicated on page 4

(3). The Plan Identification Number is **501** and the Plan's records are maintained on a Plan Year basis ending February 28th each year. Plan's original effective date was 04/01/1981. Plan has been amended several times since. Effective date of this document is March 1, 2014.

(4). If employees must contribute to cost, they must contribute at a fixed rate per month toward the cost of the Plan through payroll deductions on a non-discriminatory basis. The remainder of the cost of the Plan is borne by an employer participating in the Trust. Employee contributions vary by employer and are subject to change. Physician-partners and their dependents are considered "Highly Compensated" and not eligible for coverage rates as employees, even if employed full time by employer.

(5). Benefits are administered by the insurance companies in accordance with the provisions of group policies issued by Blue Cross Blue Shield of Florida, Jacksonville, FL. Mailing address is provided in 2(c) above.

(6). Eligibility for participation is described in detail in the Certificate of Coverage booklets issued by the insurance company, the Trust document and rules established by the Trustees.

(7). The details of how a covered person(s) could lose coverage is detailed in the Certificate of Coverage issued by the insurance company, the Trust document or rules established by the Trustees. Only full time employees are eligible after 30 days of employment. Each employer determines any orientation and/or waiting period; however, the waiting period may be no longer than the first of the month following 60 days of permanent, full time employment.

(8). The benefits are fully insured by the insurance company as well as the benefits are administered by the insurance company (i.e. payment of claims). The Certificate of Coverage issued by the insurance company, the Trust document, rules established by the Trustees as well as state law dictates the conditions when the policy and coverage may be terminated.

(9). Claim Procedures:

Claims for benefits under the plan are to be submitted to the insurance carrier as provided herein. Payment of claims under the Plan will be made by the insurance carrier. If an employee's claim for benefits under the Plan is denied, the employee will receive a written explanation giving detailed reasons for the denial, specific reference to policy provisions on which the denial is based, a description of an additional material of information necessary for the employee to perfect the claim and an explanation of why such material or information is necessary as well as an explanation of the claim appeal procedure.

If the employee is not satisfied, or does not agree with the reasons for the denial of the claim, the employee may appeal the decision to the Claims Administrator named above. It is the intent of the Plan Sponsor that the Claims Administrator shall have the sole and exclusive discretion and authority to carry out all actions involving claims procedures explained therein. The Claims Administrator shall have the sole and exclusive discretion and power to grant and/or deny any and all claims for benefits and construe any and all issues relating to eligibility for benefits. All findings, decisions and/or determinations of any type made by the Claims Administrator shall not be disturbed unless the Claims Administrator has acted in an arbitrary and/or capricious manner, subject to the requirements of law, the Claims Administrator shall be the sole judge of the standard of proof required in any claims for benefits and/or in any question of eligibility for benefits. All decisions on a claim is involved, the Claims Administrator is given broad discretionary powers, and the Claims Administrator shall exercise said powers in a uniform and non-discriminatory manner, in accordance with the Plan's terms.

This appeal must be in writing, and can be made by the employee or a duly authorized representative. It must set out the reasons for the appeal and the employee's dissatisfaction or disagreement. Any evidence or documentation to support the employee's position should be submitted with the employee's written appeal. Upon written request, the employee may review pertinent documents that pertain to the employee's claim and its denial.

The employee's appeal must be made within 60 days of the date of receipt of the letter denying the claim.

The Claims Administrator will promptly review the claim and appeal. The Claims Administrator will advise the employee of his/her decision with specific references to pertinent policy provisions on which the decision was based. This written decision will be sent to the employee no later than 60 days after receipt of the employee's written appeal, unless special circumstances require an extension of time for processing the appeal, or obtaining more information, or conducting an investigation of the facts. In no event will the written decision be sent later than 120 days after the employee's written appeal is received.

(10). Regarding maternity Claims: "Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers 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 normal vaginal delivery or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods."

(11). 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:

(a) Examine, without charge, at the plan administrator's office and at other locations, such as work sites, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U. S. Department of Labor, such as detailed Annual Reports and Plan Descriptions

(b) Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The Administrator may make a reasonable charge for the copies: and

(c) 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.

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

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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 (pension, welfare) benefit or exercising your rights under ERISA. If your claim for a (pension, welfare) benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part you may file suite in a state of Federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous, 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 (EBSA). U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, Public Disclosure Rm N – 1513, U. S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

(12). As described in the certificate of coverage booklet, the Plan exceeds benefits to an employee's non-custodial child as required by any qualifying medical child support order ("QUCSO") under ERISA code 609(a). The Plan has procedures for determining whether an order qualifies as a QUCSO. Participants and beneficiaries can obtain a copy of such procedures from their Human Resources Department of the company.

(13). The right is reserved in the plan for the plan sponsor to terminate, suspend, withdraw, amend or modify the plan, covering any active employee or current or future retiree, in whole or in part at any time. Any such change or termination in benefits (a) will be based solely on the decision of the plan sponsor and (b) may apply to all active employees, current retirees or future retirees, as either separate groups or a one group. This is subject to the applicable provisions of the Plan.

The plan sponsor expects and intends to continue the plan indefinitely. However, the plan sponsor reserves the right to amend or terminate the Plan at any time and for any reason. If the plan is amended or terminated, you and other active employees may not receive benefits as described in other sections of this booklet You may be entitled to receive different benefits, or benefits under different conditions. However, it is possible that you will lose all benefit coverage. This may happen at any time, if the plan sponsor decides to terminate the plan or your coverage under the plan. In no event will you become entitled to any vested rights under this Plan. The procedure to amend or terminate the plan is described in the plan documents main maintained by the plan sponsor. You may examine plan documents during regular business hours at the office of the Plan Sponsor (Plan Administrator) at the address shown on the front page of this document.

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