Summary Plan Description

PREPARED BY:

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ADOPTION AGREEMENT

WRAP SPD

ADOPTION AGREEMENT

Article I. General Information

Name of the Plan:

LCJ Inc Employee Benefit Plan

Sponsoring Employer:

LCJ Inc.

Sponsoring Employer's Primary Contact:

Colleen McDonald
President
(734) 525-5000
30777 Plymouth Rd, Livonia, Michigan, 48150

Sponsoring Employer's Federal Employer Identification Number:

38-2245869

Agent for Service of Legal Processing:

Colleen McDonald
President
(734) 525-5000
30777 Plymouth Rd, Livonia, Michigan, 48150

Effective Date of the Amendment and Restatement of the Plan:

January 1, 2018

Plan Number:

501

Plan Year:

01/01 - 12/31

Article II. FMLA Application

Is the Employer subject to FMLA:

eg. is an employer who employs 50 or more employees for each working day during each of 20 or more calendar workweek in the current or preceding calendar year

No

Article III. Participating Employers

The following participating employers (and its eligible employees) are authorized by the sponsoring employer to participate in the Plan:

Only employers who are related entities of the sponsoring employer (in accordance with Internal Revenue Code Sections 414(b), 414(e) and/or 414(m)) can participate in the plan.

Article IV. Available Welfare Benefit Programs

The following chart identifies welfare benefit plans available to eligible employees:

Plan Name	Category / Package Name with Included Benefits	ER offers to employees	Funding Medium	Name, address and telephone of Insurer/Claims Administrator	Required employee contribution towards employee coverage	Required employee contribution towards spouse/dependent coverage	Grandfathered status
LCJ Inc. Employee Benefit Plan	Medical Rx Voluntary Benefits	Employees	Fully-insured	BCBS of Michigan Blue Care Network Detroit, Michigan	Portion	Entire	No

Article V. Employee Eligibility

The following chart identifies welfare benefit plans available to employee classes:

Plan Name	Plan is Offered to Class 1 Employees
LCJ Inc. Employee Benefit Plan	Yes

Except as otherwise provided in the Benefits Guide for a particular welfare benefit program, the Employees eligible to participate in the Plan include the following

- Except as otherwise provided below, all full-time Employees of the Employer. For this purpose, a full-time Employee is an individual who is regularly scheduled to work _____ or more hours/work week.

Minimum number of hours for full time consideration

30

Notwithstanding the foregoing, the following categories of Employees are not eligible to participate in the Plan

Note: the Basic SPD and Plan document automatically excludes independent contractors, leased employees, and union employees (unless the terms of the collective bargaining agreement expressly requires participation), and thus you do not need to specify such categories as excluded below

Article VI. Dependent Eligibility

The definition of "Eligible Dependent" shall have the meaning ascribed to it under the accompanying Benefit Guide for the applicable welfare benefit programs, but to the extent it is not defined or is not consistent with the Basic Plan document, Eligible Dependent shall have the meaning set forth below.

Plan Name	Spousal Coverage	Domestic Partner Coverage	Child Coverage
LCJ Inc. Employee Benefit Plan	This plan is offered to spouses even if they have other coverage	This plan is offered to domestic partners only if they do not have other coverage	An Employee's child can be enrolled in this plan

If spouses are eligible for coverage under the Plan, the term "Spouse" shall mean an Employee's legal spouse by marriage.

The term "Domestic Partner" shall have the meaning ascribed to it under the Basic SPD and Plan document, except as altered below

The Eligible Employee and Domestic Partner must be the same sex

The definition of Child shall have the meaning ascribed to it under the Basic Plan document, in addition the following categories of children are also included in the definition of Child under the Plan, where applicable:

- The Employee's step-children
- The natural child, adopted child or step-child of the Employee's Domestic Partner
- A foster child who is placed with the Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction (automatically included in definition for medical plan purposes and for any benefits

integrated with the medical plan)
- A child for whom legal guardianship has been awarded to the Employee (automatically included in definition for medical plan purposes and for any benefits integrated with the medical plan);

Article VII. Effective Date Of Coverage

Except as otherwise provided in the Benefits Guide for a particular welfare benefit program, an Eligible Employee's initial participation in the Plan will become effective on the date set forth below, provided he or she timely enrolls by the deadline established by the Plan Administrator:

On the first day of the calendar month following his or her employment commencement date

Article VIII. Rehired Employees

Except as otherwise provided in the Benefits Guide for a particular welfare benefit program, if an Employee terminates employment and is rehired, his or her participation in the Plan will become effective on the date set forth below:

As of the date specified in the Effective Date of Coverage Section above treating such Employee as a newly hired employee.

Article IX. Special Enrollment Deadline

If an Employee desires to enroll himself (and his Dependents) in the Medical Program upon loss of other coverage, marriage, birth, adoption, or placement for adoption or placement for adoption of a child, he must enroll in the Medical Plan during the Special Enrollment Period within this timeframe in days:

30

Article X. Employer-Approved Leave Of Absence

The term "Employer-Approved Leave of Absence" shall have the meaning ascribed to it:

Subject to the accompanying Adoption Agreement and Benefits Guide, an Employer-Approved Leave shall mean any leave of absence of the Eligible Employee that is qualified by the Employer as an FMLA leave, or the Employer has approved in writing and has specifically agreed in writing to continue the coverage of such Employee under a particular Plan during such leave period (pursuant to an individual agreement with an Employee or pursuant to the Employer's written Leave Policies, if any). Except as otherwise provided in the Adoption Agreement, 'Employer-Approved Leave' will not include any period of time during which the Eligible Employee is entitled to receive long-term disability benefits under the Employer's Long- Term Disability Plan or any period after the Eligible Employee fails to return to work following the expiration of his or her Employer-Approved Leave.

An Eligible Employee's cost of coverage during such Employer-Approved Leave of Absence shall equal:

The same cost to the Eligible Employee as if he or she had been continuously employed during the Employer-Approve Leave of Absence.

Article XI. Effective Date Of Termination Of Coverage

Except as otherwise provided in the Benefits Guide for a particular welfare benefit program, if an Eligible Employee's and Dependent's coverage is terminated by reason of employment termination or job classification change, the coverage will be terminated effective:

Plan Name	Coverage Ends
LCJ Inc. Employee Benefit Plan	At 11:59 p.m. on the last day worked for the Employer or in the benefit eligible job classification

Except as otherwise provided in the Benefits Guide for a particular welfare benefit program and subject to above regarding Spousal, Domestic Partner and Child eligibility criteria, for an Eligible Dependent who no longer satisfies the dependent eligibility criteria (e.g. no longer the Employee's Spouse, or attain the limiting age, etc.), his/her coverage under the programs will be terminated effective:

Plan Name	Coverage Ends
LCJ Inc. Employee Benefit Plan	At 11:59 p.m. on the last of eligibility

Article XII. Applicable State Law

To the extent not preempted by ERISA, the laws of the following state(s) shall apply:

- Michigan

Article XIII. Cafeteria Plan

Has the Employer adopted a written Code Section 125 Cafeteria Plan allowing Employees to pay their share of premium cost on a pre-tax basis

Yes, Employer has adopted a Cafeteria Plan.

Article XIV. HIPAA Privacy And Security Officers

The name, address and phone number of the appointed HIPAA Privacy and Security Officers are:

Privacy Officer	Security Officer
Colleen McDonald President (734) 525-5000 30777 Plymouth Rd, Livonia, Michigan, 48150	Colleen McDonald President (734) 525-5000 30777 Plymouth Rd, Livonia, Michigan, 48150

Article XV. Authorization

This Employer hereby executes this Adoption Agreement, which is incorporated by reference and is made part of the Basic Plan and SPD Document attached hereto.

Completed By:

Colleen McDonald President LCJ Inc.	(date)

Article XVI. Consent Resolutions of the Board of Directors

WHEREAS, the Company desires to adopt the Basic Plan and SPD Document for the Welfare Benefit Plan and accompanying Adoption Agreement (the "Plan").

NOW THEREFORE, BE IT RESOLVED, that the Plan is approved and adopted effective as of January 1, 2018.

RESOLVED FURTHER, that the President of the Company is authorized and directed to execute the Adoption Agreement for the Plan, and to take such other action as may be necessary or appropriate to implement these resolutions.

Colleen McDonald, President	Date

WRAP SPD

Article XVII. Introduction

The Employer has established various welfare benefit programs for eligible Employees. This document is the Summary Plan Description for such welfare benefit programs and has been prepared to comply with various disclosure requirements mandated by law, to clarify administrative procedures for and establish eligibility conditions under the Plan and to join the welfare benefit programs together into one legal wrap plan document for annual reporting purposes (collectively referred to as the "Plan"). (The Plan is required to file an annual return - Form 5500 with the Department of Labor by the last day of the 7th calendar month following the end of the Plan Year, unless the Plan covers fewer than 100 participants as of the beginning of the Plan Year and is fully-insured or self-funded through the employer's general assets).

A specific description of the welfare benefit programs under the Plan as well as a description of the terms and conditions to receive such benefits are contained in the Adoption Agreement, as well as in the insurance certificates, contracts, administrative agreements, booklets and formal plan documents (collectively referred to as "Benefits Guide") for each of the welfare benefit programs under the Plan, all of which are incorporated by reference into this document and together these documents constitute the Summary Plan Description and Legal Plan document for such welfare benefit programs. Various employee groups (e.g. salaried, hourly or union) may receive coverage under different welfare benefit programs, so their Benefit Guides may differ from one another. To the extent not specifically set forth in this Basic SPD and Plan document and Adoption Agreement, the Benefit Guide may contain additional eligibility conditions to participate, and will contain a specific explanation of covered and excluded benefits (e.g. schedules of benefits), cost-sharing requirements, network requirements, other terms and conditions for receipt of benefits and the name and contact information for the insurance carrier and/or any other third party administrator.

You should not rely on any oral explanation, description, or interpretation of the plan by any employee of the employer or the employer because the written terms of the plan always will govern. Also, if the terms of an underlying benefits guide conflicts with the terms of this summary plan description and legal plan document, the terms of the underlying benefits guide will control.

The Plan Administrator (identified in the Adoption Agreement) will furnish you with a copy of the Adoption Agreement and the summary portions of the Benefits Guide for a particular welfare benefit program when you first become a Participant in such program. You also may examine all of the documents that make up the Benefits Guide in the Plan Administrator's office, and may request a copy of such documents, but may be asked to pay for copying costs in some circumstances. If you have any questions about this document or about the welfare benefit programs, you should contact the Plan Administrator.

The Employer expressly reserves the right to amend or revise any term or provision of the Plan or to terminate the Plan at any time in its sole discretion by action of the Employer's governing board.

Article XVIII. Important Information

Section 1. Type of Plan, Type of Plan Administration and Source of Contributions

The Adoption Agreement provides a description of each type of welfare benefit program maintained and sponsored by the Employer and covered by this Summary Plan Description and Legal Plan Document. The type of administration and the source of contributions for each of these welfare benefit programs also are described in the Adoption Agreement.

Section 2. Plan Sponsor, Named Fiduciary, Plan Administrator and Agent for Service of Process

The Plan Sponsor, ERISA Named Fiduciary and Plan Administrator are the Employer identified in the Adoption Agreement. The Agent for Service of Process is identified in the Adoption Agreement, and process may also be made upon the Plan Administrator The Adoption Agreement also will identify any related entities that adopt the Plan described in this booklet for the benefit of its Eligible Employees. The Employer and these other Participating Employers are collectively referred to as the "Employer" throughout this document. However, whenever the Plan indicates that the Employer may or shall take any action under the Plan, the Plan Sponsor that is identified in the Adoption Agreement shall have sole authority to take such action for itself and as agent for any such Participating Employers. The Plan Sponsor may delegate some or all of its administrative responsibilities to other persons or organizations, including an outside insurer or third party administrator.

Section 3. Plan Number

The Plan Number assigned to the Plan is identified in the Adoption Agreement.

Section 4. Plan Year

The Plan Year is the period on which the plan records are kept and is the twelve month period beginning and ending on the dates set forth in the Adoption Agreement.

Article XIX. Definitions

Throughout the Plan, various terms are used repeatedly. These terms have specific and definite meanings when capitalized in the text. For convenience, capitalized terms are collected and defined in this Article. Whenever capitalized terms appear in the Plan, they shall have the meanings specified in this Article. Where necessary or appropriate to the context, the masculine shall include the feminine, the singular shall include the plural and vice versa.

Section 1. Act or Health Care Reform Act

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, and its related regulations, rules and guidance promulgated by governmental agencies.

Section 2. Adoption Agreement

The Adoption Agreement is the agreement under which the Employer duly adopts this basic SPD and Plan document and provides specific information about the Employer and types of welfare benefits provisions that shall apply. The Adoption Agreement is incorporated by reference herein.

Section 3. Benefits Guide

The actual plan documents, including insurance contracts, booklets, summaries of coverage or administrative services agreements, that govern each of the welfare benefit programs.

Section 4. Cafeteria Plan

The Code Section 125 - Cafeteria Plan adopted by the Employer as identified in the Adoption Agreement.

Section 5. Child

Except as otherwise provided in the accompanying Adoption Agreement and/or the applicable Benefits Guide, the term "Child" shall mean:

- For purposes of the medical and prescription welfare benefit program , or any other benefit program that is integrated with the medical welfare benefit program , the term "Child" as used in definitions eligible dependents below shall only include your natural or adopted child for whom you have not relinquished your parental rights; a child lawfully placed with you for adoption; your step-child who is the natural or adopted child of your current Spouse for whom your Spouse has not relinquished parental rights if elected in Section 15 of the Adoption Agreement; a foster child who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction, or a child for whom legal guardianship has been awarded to you. To the extent Domestic Partner coverage is selected under the Adoption Agreement, the term "Child" generally will include the natural, adopted or step-child of your Domestic Partner unless otherwise specified in the Adoption Agreement.
- For purposes of a stand-alone dental or vision welfare benefit program , except as otherwise provided in the applicable Benefits Guide, the term "Child" as used in definitions eligible dependents below shall only include your ***unmarried*** natural child, adopted child, child lawfully placed with you for adoption, stepchild who are in the custody of and legally dependent on your Spouse, or child for whom legal guardianship has been awarded to you or a foster child who is placed with the Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. To the extent Domestic Partner coverage is selected under the Adoption Agreement, the term "Child" generally will include the ***unmarried*** natural, adopted or step-child of your Domestic

Partner unless otherwise specified in the Adoption Agreement.

The spouse of an enrolled Child under the Plan or the child of an enrolled Child under the Plan does NOT qualify as an eligible "Child" under this definition and thus is not eligible for coverage under the Plan (except as otherwise permitted under the Benefits Guide for a particular welfare benefit program).

Section 6. **Claims Administrator**

The organization that has been engaged by the Plan Administrator or the insurer that is responsible to perform enrollment, disenrollment and/or benefit claims processing services for the Plan. The Adoption Agreement and/or Benefits Guide will identify the name, address and telephone number of the Claims Administrator.

Section 7. **COBRA**

The federal Consolidated Omnibus Budget Reconciliation Act of 1985, and the related regulations.

Section 8. **Code**

The Internal Revenue Code of 1986, as amended, together with its related regulations and rules. References to any Code provisions shall include successor provisions.

Section 9. **Domestic Partner**

Except as otherwise provided in the Adoption Agreement, an individual will be considered your Domestic Partner if each of the following criteria are satisfied:

- You and your Domestic Partner are both over age 18 and mentally competent to consent to a civil contract;
- You and your Domestic Partner are not legally married to or legally separated from any other person;
- You and your Domestic Partner are not engaged in another domestic partner relationship;
- You are not related to your Domestic Partner by blood or marriage to a degree of closeness that would prohibit legal marriage in the state in which you reside;
- You and your Domestic Partner are engaged in a continuous committed relationship with your Domestic Partner of mutual caring and support and are jointly responsible for each other's common welfare;
- You and your Domestic Partner are jointly responsible for each other's assets and debts as provided by applicable law;
- You and your Domestic Partner reside in the same household and have done so for at least one (1) year;
- Upon request, you provide evidence of the Domestic Partner relationship and shared living arrangements in a manner acceptable to the Plan Administrator and its domestic partner policies; and
- You and your Domestic Partner complete an annual affidavit attesting that you meet all of the above eligibility requirements.

Note that you are eligible to enroll a Domestic Partner in coverage under the Plan only if the Adoption Agreement specifically includes Domestic Partners as "Eligible Dependents" and only to the extent otherwise permitted by the Benefits Guide for each applicable welfare benefit program.

Section 10. **Eligible Dependent**

This portion sets forth the categories of Eligible Dependents that an Eligible Employee may enroll under the Employer's various welfare benefit programs. Notwithstanding this definition, the Adoption Agreement must specifically indicate that coverage is available for such categories of dependents listed below and such Adoption Agreement and the Benefits Guide for each applicable welfare benefit program may set forth additional eligible conditions for such dependent coverage:

A. Your Spouse.
B. Your Domestic Partner.
C. For purposes of the medical or prescription welfare program benefits, or for a dental or vision Plan that is integrated with the medical welfare program benefits, your Child until the end of the month in which such Child turns age 26 (For purposes of a stand-alone dental or vision welfare program benefits , (i) your Child while he or she is in your custody and legally dependent on you until the date on which the Child turns 19, and (ii) your Child between the age of 19 and 25, if he or she is a full-time student; he or she is dependent on you for more than half of his or her support; he or she is a member of your household (unless they temporarily reside elsewhere as in the case of college students); and you apply for continued coverage for such a dependent before the child turns age 19. This coverage will continue until the date on which such Child

turns age 25, if he or she otherwise remains eligible. A full-time student means a person who is enrolled in and attending, full-time, a recognized course of study or training at an accredited secondary school, vocational or technical school, college or university. Full-time student status is determined in accordance with the standards set forth by the educational institution. A person is no longer a full-time student on the last day of a calendar month after he or she graduates or otherwise ceases to be enrolled and in attendance at the institution on a full-time basis. A person will continue to be a full-time student during periods of regular vacation established by the institution. If a person does not continue as a full-time student immediately following the period of vacation, the full-time student designation will end as described above. The Employer may require you to confirm throughout the Plan Year that the dependent is a full-time student. You will be notified of any verification requirements.

D. Your Child who becomes (i) mentally or physically disabled before age, 19 (ii) qualifies as your dependent for federal tax purposes under Code Section 152 ((without regard to the earnings limit under Section152(d)(1)(B) or the special exclusions under Section152(b)(1) or (2)), **and** (iii) you notify the Employer in writing of the condition by the end of the calendar month in which the child attains the age of 26. A child is considered mentally or physically disabled if the Claims Administrator determines that the child is not able to earn his or her own living because of a mental or physical condition, which started prior to the date he or she reached age 19 and the child depends primarily on you for support and maintenance. You will be required to provide initial and periodic verification from a physician of a Dependent's mental or physical condition.
E. Your Child or other alternate recipient for whom you or your current Spouse are financially responsible for health care coverage under the terms of a Qualified Medical Child Support Order.
F. For purposes of the Cafeteria Plan, a Participant can pay premiums on a pre-tax basis only for the Participant's Spouse (as defined consistent with federal law) or for the Participant's Eligible Dependents who meet the Code Section 152 definition of "dependent" (without regard to the earnings limit under Section152(d)(1)(B); the special exclusions under Section152(b)(1) or (2); or the age or student status requirements under Section152(c)(3), provided that such qualifying child is age 26 or under.).
G. Notwithstanding anything in this Plan to the contrary, this definition of Eligible Dependent shall control for the Plan; provided, however, if the Adoption Agreement or the applicable Benefits Guide has a more restrictive definition of Eligible Dependent (e.g. contains additional dependent eligibility conditions), then the more restrictive conditions under the Adoption Agreement and/or Benefits Guide will apply, but only to the extent they are consistent with applicable federal law.

Please note that you are solely responsible to notify the Plan when your Child, Spouse or Domestic Partner no longer qualifies as an Eligible Dependent as defined above. You should notify the Plan within 31 days of any change in eligibility. Failure to timely notify the Plan may result in such dependent's coverage being retroactively terminated and a loss of your dependent's right to elect COBRA continuation coverage. Please review dependent eligibility for benefits and COBRA continuation coverage carefully to more fully understand your responsibility and the consequences of failing to timely notify the Plan.

Section 11. Eligible Employee

An Employee who is hired and designated by the Employer and who satisfies the applicable criteria in the Adoption Agreement. All other Employees of the Employer are not eligible to participate in the Plan.

Section 12. Employee

Any individual who is a common-law employee on the Employer's payroll. However, the term "Employee" will not include:

- any individual whose employment is covered under and subject to a collective bargaining agreement, **unless** such agreement expressly requires and provides for coverage under one or more of the welfare benefit programs described in this document; or
- any individual for whom the Employer designates as an independent contractor or leased or contract employee (regardless of the finding by the Employer or any third party as to the common law employment status or reclassification of any such person).

Section 13. Employer

The Employer identified in the Adoption Agreement or any of its related entities (as defined under Code Section 414(t)) who are authorized in writing to participate in the Plan by the Plan Sponsor (collectively referred to as "Employer" throughout this document); provided, however, that whenever the Plan indicates that the Employer may or shall take any action under the Plan, the Plan Sponsor that is identified in the Adoption Agreement shall have sole authority to take such action for itself and as agent for any such related entity. The Adoption Agreement contains a current listing of Participating Employers.

Section 14. **Employer-Approved Leave**

Subject to the accompanying Adoption Agreement and Benefits Guide, an Employer-Approved Leave shall mean any leave of absence of the Eligible Employee that is qualified by the Employer as an FMLA leave, or the Employer has approved in writing and has specifically agreed in writing to continue the coverage of such Employee under a particular Plan during such leave period (pursuant to an individual agreement with an Employee or pursuant to the Employer's written Leave Policies, if any). Except as otherwise provided in the Adoption Agreement, "Employer-Approved Leave" will not include any period of time during which the Eligible Employee is entitled to receive long-term disability benefits under the Employer's Long-Term Disability Plan or any period after the Eligible Employee fails to return to work following the expiration of his or her Employer-Approved Leave.

Section 15. **ERISA**

The Employee Retirement Income Security Act of 1974, as amended, and its related regulations.

Section 16. **FMLA**

The Family and Medical Leave Act of 1993, and its related regulations.

Section 17. **Grandfathered Status**

A group health benefit option under this Plan shall have Grandfathered Status only to the extent elected in the Adoption Agreement and permitted under the Act and related regulations. Generally, a group health benefit option offered under this Plan qualifies for Grandfathered Status only if it was in existence and covered Eligible Employees as of March 23, 2010. Grandfathered Status continues applying to a group health benefit option even when newly eligible employees and/or their family members are enrolled after March 23, 2010. In order to maintain Grandfathered Status, the Employer shall maintain records documenting the terms of each group health benefit option under the Plan with Grandfathered Status in connection with the coverage in effect as of March 23, 2010, and any other documents necessary to verify, explain or clarify a group health benefit option's Grandfathered Status.

However, a group health benefit option under this Plan will lose its Grandfathered Status upon the occurrence of any of the events set forth in the related regulations under the Act. For example, Grandfathered Status will be lost under the circumstances described below:

- Elimination of benefits. Grandfathered Status will be lost if the group health benefit option eliminates all or substantially all benefits to diagnose or treat a particular condition.
- Increase in Percentage of Cost-Sharing Requirement. Grandfathered Status will be lost if the group health benefit option increases the percentage, measured from March 23, 2010, that an Eligible Employee is required to pay towards a covered benefit (e.g. the Eligible Employee's coinsurance percentage for treatment is increased).
- Deductibles and out-of-pocket maximums. Grandfathered Status will be lost if the group health benefit option increases the fixed-amount deductible and/or out-of-pocket maximum, determined as of the effective date of the increase, and such increase causes the total percentage increase in such fixed-amount deductible and/or out-of-pocket maximum (measured from March 23, 2010) to exceed medical inflation (as defined in related regulations) plus 15%.
- Copayments. Grandfathered Status will be lost if the group health benefit option increases a fixed-amount copayment, determined as of the effective date of the increase, and such increase causes the total percentage increase in the fixed-amount copayment (measured from March 23, 2010) to exceed the greater of: (i) an amount equal to $5 increased by medical inflation (as defined in related regulations) or (ii) a total percentage that is more than the sum of the medical inflation rate plus 15%.
- Decrease in contribution rate by employers and employee organizations. Grandfathered Status will be lost if the Employer decreases its contribution rate based on cost of coverage towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5% below the contribution rate for the coverage period that includes March 23, 2010.
- Changes in annual limits. Grandfathered Status will be lost if the group health benefit option did not impose an overall annual or lifetime limit on the dollar value of benefits on March 23, 2010, and then subsequently imposes an overall annual limit on the dollar value of benefits. Grandfathered Status also is lost if the group health benefit option, that imposed an overall lifetime limit on the dollar value of all benefits but no annual limit on the dollar value of all benefits on March 23, 2010, subsequently adopts an overall limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010. Finally, Grandfathered Status will be lost if an overall annual limit on the dollar value of all benefits on March 23, 2010, is subsequently decreased (regardless of whether the group health benefit option also imposed an overall lifetime limit on March 23, 2010, on the dollar value of all benefits).

Notwithstanding anything to the contrary, changes in premiums, changes to comply with federal and state legal requirements,

changes to voluntarily comply with the Health Care Reform Act, and changing third-party administrators will not cause a group health benefit option to lose its Grandfathered Status, provided these changes are made without exceeding the standards described in sub-paragraphs (a) through (g) above.

Section 18. Open Enrollment Period

A period during which you may enroll in or change your coverage under the Plan. The Open Enrollment Period will begin and end on dates determined by the Plan Administrator, which will be prior to the beginning of the next Plan Year.

Section 19. Participating Employers

Any related entity (as defined by Code Section 414(t)) of the Plan Sponsor that, with the approval of the Plan Sponsor, adopts the Plan (see the Adoption Agreement for a current listing of Participating Employers).

Section 20. Plan

The Welfare Benefit Plan described in this basic SPD and Plan document and the Adoption Agreement.

Section 21. Plan Administrator

The Plan Administrator is the Employer identified in the Adoption Agreement and is charged with the responsibility to administer the Plan.

Section 22. Plan Year

The Plan Year is the period on which the plan records are kept and is the twelve month period beginning and ending on the dates set forth in the Adoption Agreement.

Section 23. Spouse

Notwithstanding any contrary provision in a Benefits Guide, the term "Spouse" shall have the meaning ascribed to it under the Adoption Agreement.

Section 24. USERRA

Uniformed Services Employment and Re-employment Rights Act of 1994, and its related regulations.

Article XX. Medical Plan, Dental Plan, and Vision Plan

Section 1. Introduction

This portion of the summary describes your rights and benefits under the group health plans identified in the Adoption Agreement (e.g. medical, prescription drug, dental and vision benefit programs). Each reference to the Plan throughout this Article IV will be a reference to such group health benefit programs collectively, unless otherwise noted. This portion of the summary is to be used in conjunction with the Benefits Guide for each of these Plans (noting that employee groups at various locations or in different classifications of the Employer may be insured under different plans or insurance contracts - you will receive the Benefits Guide that pertains to your employee group). You may obtain additional copies of the applicable Benefits Guides by contacting the Plan Administrator.

Section 2. Eligibility for Benefits

You may enroll in the Plan if:

- You are an Eligible Employee who has completed the applicable waiting period set forth in the Adoption Agreement; and
- You properly complete the enrollment process by the deadline established by the Plan Administrator. The Plan Administrator will provide you with the necessary instructions and deadlines at the time you are initially eligible to

participate in the Plan (please review Cafeteria Plan, Enrollment Section regarding the enrollment process).

If you initially are not considered by the Employer to be an Eligible Employee, but are later determined to be an Eligible Employee, you only will be an Eligible Employee prospectively from the date of that determination.

Section 3. Dependent's Eligibility for Benefits

A covered Eligible Employee also may enroll his or her Eligible Dependents for coverage under the Plan if dependent coverage is offered for that particular Plan **and** such dependents qualify as "Eligible Dependents" as defined in the Adoption Agreement and under the provisions of the applicable Benefits Guide.

Generally, you must be covered by the applicable Plan, as an Eligible Employee, before an Eligible Dependent's coverage will take effect. If you timely elect dependent coverage, their coverage generally begins on the same date your coverage begins as specified in the Adoption Agreement.

No person may be covered as both an Eligible Employee and an Eligible Dependent and no person may be covered as an Eligible Dependent by more than one Eligible Employee.

Please read the Adoption Agreement and the applicable Benefits Guide carefully to determine whether your dependent is eligible for coverage under the Plan. The Adoption Agreement or Benefits Guide may provide that your dependent (e.g. Spouse) may only be covered under this Plan if he or she does not otherwise have coverage available through another group health plan. Notwithstanding anything to the contrary in the Adoption Agreement or Benefits Guide, the continued eligibility of children until age 26 pursuant to the Health Care Reform Act shall apply.

The Plan Administrator has full and final discretion to determine if, and require you to verify that, a dependent satisfies the eligibility requirements of the Plan, and to determine whether a dependent has been timely enrolled in the manner which satisfies Plan requirements. In this regard, the Plan Administrator may require that you submit documentation to verify the relationships of the dependents whom you wish to enroll. The Plan Administrator will notify you of any dependent verification procedures. You also must notify the Plan Administrator within 30 days of any change to dependent's qualification (e.g. attainment of limiting age, disabled status, etc). Failure to timely notify the Plan Administrator within 30 days of a change may result in disciplinary action up to and including termination of employment and loss of your benefit coverage under the Plan.

To the extent permitted under the Health Care Reform Act's restrictions on rescinding group health coverage, the Plan Administrator retains the right to retroactively or prospectively terminate coverage of a dependent as of the date that he or she no longer satisfies each of the Plan's eligibility requirements and receive reimbursement from you or a dependent for any benefits that the Plan pays for a dependent who does not satisfy the Plan's eligibility requirements.

Please review the portion regarding Michelle's law which creates special coverage rules for college aged dependents during medical leave.

Note Regarding Tax Rules for Dependents: In order for coverage to be provided on a tax-free basis, your Eligible Dependent must be your Spouse as defined under federal law or tax dependent as defined by the Internal Revenue Code Section 152 ((without regard to the earnings limit under Section152(d)(1)(B); the special exclusions under Section152(b)(1) or (2); or the age or student status requirements under Section152(c)(3), provided that such dependent is age 26 or under during the entire Plan Year). If a covered Eligible Dependent (as defined in Definition of Eligible Dependent) does not qualify as your tax dependent or Spouse (as defined under federal law), you cannot pay any required contributions for such dependent's coverage on a pre-tax basis. Further, the value of the Employer-paid portion for such dependent's coverage must be added to your taxable income. For example, you typically will be subject to imputed income tax for a Domestic Partner's coverage under this Plan.

Section 4. Initial Enrollment

If you timely and properly complete the enrollment or deemed enrollment process as established by the Plan Administrator (see Cafeteria Plan Enrollment), coverage (for you and your Eligible Dependents) will become effective on the date specified in the Adoption Agreement. If the Adoption Agreement or Benefits Guide requires you to complete a period of service before your participation under a group health benefit program becomes effective, to the extent required by HIPAA, you will receive credit for any period of absence from work due to a health related factor and participation will begin even if you are not actively at work on the date coverage otherwise would begin due to a medical condition or because you are confined to a hospital.

The Plan Administrator will inform you of how to enroll and the deadline by which you must enroll (which generally will be no later than the date on which your coverage would first become effective as stated above).

Section 5. **Special Enrollment**

If you do not timely or properly complete the enrollment process (or deemed enrollment process established in see Cafeteria Plan Enrollment), you and your Eligible Dependents generally will not be covered under the applicable Plan, except as described below, or in see Cafeteria Plan Enrollment. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan, except as otherwise provided below.

- If you decline enrollment because you or your dependent had other group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Medical Program within **30 days** of the loss of that coverage (or such later date identified in the Adoption Agreement). Your enrollment will become effective on the date you enroll in the Medical Program. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage. However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other medical plan that you no longer have that coverage.
- You are eligible to enroll yourself and your Eligible Dependent in the Medical Program within **30 days** of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption (or such later date identified in the Adoption Agreement). Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption.
- You are eligible to enroll yourself and your Eligible Dependent in the Plan within **60 days** after either:
    A. Your or your Eligible Dependent's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or
    B. You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.
- You are eligible to enroll yourself and your Eligible Dependents in the Plan during an Open Enrollment Period. Your enrollment will become effective on the 1st day of the Plan Year following the Open Enrollment Period.
- You may enroll in the Plan an Eligible Dependent child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (as defined under ERISA Section 609 and described in Appendix B). This enrollment of an Eligible Dependent will become effective as of the Plan Administrator's qualification and acceptance of the Qualified Medical Child Support Order.
- You are eligible to enroll yourself and your Eligible Dependents in the Plan under any other special circumstances set forth in the applicable Benefits Guide (but only to the extent permitted by and consistent with the terms of the Cafeteria Plan).

NOTE: You will not be allowed to enroll yourself and/or Eligible Dependents for coverage in the Plan for a Plan Year unless you timely and affirmatively complete (or, under Section 6.5, are deemed to have completed) the enrollment process by the deadlines set forth above (i.e. within 30 days for loss of coverage or new dependents; within 60 days for Medicaid or CHIP circumstances; or within the deadline established by the Plan Administrator for Open Enrollment Period).

Section 6. **Contributions**

You are required to share in the cost of coverage through deductibles, co-payments and other limitations specified in the Benefits Guide. You also may be required to pay a portion or the entire share of the premium or cost for you and your Eligible Dependents' coverage under the Plan, as indicated in the Adoption Agreement.

The Employer may have established a Cafeteria Plan (as described in Article VI) under which you would be able to pay your share of the premiums on a pre-tax basis. When you enroll in the Plan, you will be required to complete a compensation reduction agreement. The Plan Administrator will advise you in writing of the cost of coverage under the Plan each Plan Year.

Section 7. **Termination of Coverage**

You and/or your Eligible Dependents' coverage under the Plans generally will terminate under the circumstances and on the dates described in this section. However, you may have the opportunity to temporarily continue health coverage under circumstances described below regarding COBRA Continuation Coverage, Continuation During FMLA Leave and other Leaves of Absence (the Adoption Agreement), Continuation During Military Leave of Absence and other events described in the Adoption Agreement.

- *Termination of Employment.* If your employment terminates, voluntarily or involuntarily, or you otherwise stop active work,

then your coverage and your covered Eligible Dependents' coverage under the Plan generally will terminate at the time specified in the Adoption Agreement, except as otherwise specifically provided in a written severance, layoff or other agreement. Notwithstanding anything to the contrary, your employment or active work status will end as of the date you fail to return to work with the Employer after your FMLA leave, USERRA leave or Employer-Approved Leave has ended, or as of the date you begin receiving long-term disability benefits under the Employer's Long-Term Disability Plan (except as otherwise provided in the Adoption Agreement).

- *Job Classification Change.* If you cease to be an Eligible Employee (e.g. you are transferred to a job position with the Employer that no longer qualifies as a benefit eligible position), then your coverage and your Eligible Dependents' coverage under the Plan generally will terminate at the time specified in the Adoption Agreement, except as otherwise specifically provided in a written severance, layoff or other agreement.
- *Failure to Pay Required Contributions.* If you and/or any covered Eligible Dependent fail to timely make any required contributions to the Plan, your coverage and your Eligible Dependents' coverage will be terminated on the date established by the Plan Administrator.
- *Dependents.* Your Eligible Dependents' coverage under the Plan will terminate on the earliest of:
    - the date your coverage terminates for any reason; or
    - the date your dependent ceases to meet any of the dependent eligibility requirements, as specified in this document, Adoption Agreement or the Benefits Guide (e.g. on the date you cease to be married to your Spouse or the date your dependent-child attains the limiting age, etc.).

  You must notify the Plan Administrator within **30 days** (or such later date specified in the Adoption Agreement) of the date a dependent Spouse no longer is eligible to participate in the Plan as a result of divorce, legal separation or death. You also must notify the Plan Administrator within **30 days** of the date a dependent child no longer is eligible to participate in the Plan as a result of death, attainment of the limiting age or failure to satisfy any other qualifying factor specified under the Benefit Guide.

- *Fraudulent, Falsification or Intentional Material Misrepresentation Activities.* You and your Eligible Dependents may not perform an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact. You and/or your dependents may not permit any other person who is not a qualified member to use any identification card issued by the Plan or Claims Administrator or otherwise fraudulently claim a benefit or falsify information on a benefit claim form. The Plan Administrator or Claims Administrator reserves the right to terminate your and your dependents' coverage under the Plan either retroactively (to the extent permitted the Health Care Reform Act or prospectively.
  Generally, the Plan Administrator will give you written notice that you and/or your dependents are no longer covered persons for benefits under the Plan. In this case, you and your dependents will cease to be eligible for the benefits under the Plan as of the date specified in such written notice, and no benefits will be paid to you and your Eligible Dependent under the Plan after that date. Any action by the Plan Administrator or Claims Administrator under this provision is subject to review in accordance with the Claims and Claims Review Procedures under the Plan.

- *Other Termination.* Your coverage and your Eligible Dependents' coverage under the Plan will terminate on the date of termination of the Plan or termination of the part of the Plan providing benefits to you or your Eligible Dependents. Your coverage and your Eligible Dependents' coverage under the Plan also will terminate as of any other date specified in the Benefits Guide.

Section 8. **Benefit Authorization Procedures, PPO and HMO Information, Wellness Initiatives and Patient Protections**

A. Authorization Procedures. Certain benefits under the Plan may require prior authorization before those benefits will be covered under the Plan. The Benefits Guide lets you know when prior authorization is required. The Benefits Guide also describes the procedures for obtaining this prior authorization.

B. HMO/PPO Information. If the Benefits Guide specifies that a particular benefit program is offered through a Preferred Provider Organization (PPO) or Network system, this means that you are offered a choice to utilize either designated health care providers or non-designated health care providers. If you (and your covered Eligible Dependents) use designated health care providers, you generally will experience a higher level of benefits (i.e. at lower cost to you) than if you use non-designated providers. Benefit levels for in-network and out-of-network services are outlined in the Benefits Guide. A listing of designated health care providers is available at no charge through the Plan Administrator or through the insurance carrier for the applicable PPO (identified in the Appendix B or Benefits Guide that applies to your employee group).

   If the Benefits Guide specifies that a particular benefit program is offered through a Health Maintenance Organization (HMO), this means that you (and your covered Eligible Dependents) must each select a Primary Care Physician (PCP) from the HMO network. Your PCP will be responsible for coordinating all of your health care through other providers and specialists within the HMO network. If you bypass your PCP or use providers outside of the HMO network, there generally will be no coverage (except in the case of emergency). If the Employer decides to offer an HMO option, a listing of PCP and other HMO network providers will be made available at no charge through the Plan Administrator or through the carrier for

the HMO. The Employer will notify you during Open Enrollment if an HMO option becomes available.

In the case of PPO or HMO arrangements, the third party administrator or insurer requires in its contracts with the health care providers that each provider meet all applicable licensure requirements. The Plan, however, does not supervise, select or control the network providers or assume liability for their activity or treatment of you, and, thus, you should carefully select your health care providers. **You also are solely responsible for verifying whether a particular provider is in-network by calling the Third Party or Claims Administrator identified in the Benefits Guide (and Appendix B) for a particular benefit program that is offered through a PPO or HMO (you should not solely rely on a provider's representation for network verification).**

C. Wellness Incentive Programs. The Employer, at its sole discretion, may implement certain wellness initiatives to help Employees and their families achieve better health. The Employer will furnish you with a Benefit Guide that will more fully describe such wellness initiatives, which may include activities such as weight management, smoking cessation, and other lifestyle behavior change initiatives. Participation in some of these programs may make you eligible for a reward or incentive, which could help to pay for some of your health care expenses. If you reasonably believe you are unable to participate in any wellness initiative due to a medical condition, please contact the Plan Administrator. The Plan Administrator, in its sole discretion, may decide to offer you alternative standards or goals to achieve a reward that may be available under the wellness initiative based on your medical condition.
D. Patient Protections. This document incorporates various patient protection rights with respect to selecting providers and emergency room services pursuant to the Health Care Reform Act that may apply to benefit options under the Medical Plan which have lost grandfathered status.

Section 9. Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, the Medical Program may not 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; and
- 96 hours following a delivery by cesarean section.

However, the Medical Program may pay for a shorter stay if the attending provider (e.g., your physician) after consultation with the mother, discharges the mother or newborn earlier. Also, the Plan may not set the level of benefits or out-of-pocket costs so that any portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-approval. For information on pre-approval, refer to the Benefits Guide that applies to the health care option elected.

Section 10. Women's Health and Cancer Rights Act

Consistent with the Women's Health and Cancer Rights Act of 1998, the Medical Program provides the following benefits in connection with a Plan covered mastectomy:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and coverage for physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes).

The manner in which the above services will be performed will be determined after consultation with the physician and patient. Coverage for the above services will be subject to deductibles, co-payments and other limitations that are consistent with those that apply to other benefits under the Medical Program.

Section 11. Rights under Michelle's Law

Effective for the Plan Year beginning on and after October 4, 2009, Michelle's Law prohibits a group health plan from terminating coverage for a dependent student who takes a medically necessary leave of absence. Generally, a group health plan must continue to provide coverage to a dependent who otherwise would lose coverage under the group health plan for failing to maintain full-time enrollment status in a post-secondary institution because the dependent requires a medically necessary leave of absence.

For these purposes, a "medically necessary leave of absence" means a leave of absence of a child from a post-secondary educational institution or any other change in enrollment of such child at such an institution that (i) commences while such child is suffering from a serious illness or injury, (ii) is medically necessary, and (iii) otherwise would cause such child to lose student status for purposes of coverage under the terms of the Plan. The child's treating physician must provide written certification to the Plan Administrator that the child is suffering from a serious illness or injury and that the leave of absence from school is medically necessary.

If these requirements are satisfied, an Eligible Dependent who is on a medically necessary leave of absence as defined under this section may continue to receive coverage under the Plan for one year after the first day of the medically necessary leave or until coverage otherwise would terminate under the Plan (e.g. attainment of the limiting age). At the expiration of this continued coverage leave period under Michelle's Law, the dependent's coverage under the Plan shall be terminated, unless he or she (i) returns to school and otherwise remains eligible for dependent coverage under the terms of the Plan, or (ii) is otherwise eligible for COBRA continuation coverage under Section 4.14), provided however, that, to the extent permitted by law, the maximum period of COBRA coverage will be reduced by the period during which such dependent continued coverage under the Plan while on a medically necessary leave under Michelle's Law.

Section 12. Continuation of Coverage During an FMLA Leave or Employer-Approved Leave of Absence

A. FMLA Leave. The Adoption Agreement indicates whether your Employer is subject to the FMLA. If your Employer is subject to the FMLA and you are absent from work due to an approved medical or family leave of absence which is covered under the FMLA, you will be eligible to continue coverage under the Plan during your leave in accordance with the terms of the FMLA, subject to the following:
    i. During any FMLA leave, the coverage of you and your Eligible Dependents for health care benefits (e.g. medical, prescription or dental) will continue on the same conditions as are provided in the Plan for an Employee who is continuously employed during the entire FMLA leave period.
    ii. During any FMLA leave, you and your Dependents will be provided health care benefits under the Plan at the same cost to you as if you had been continuously employed during the FMLA leave period.
B. Employer-Approved Leave. If you are on a leave which the Plan Administrator determines qualifies as an Employer-Approved Leave of Absence, regular participation in the Plan generally will continue for the duration approved by the Employer during such leave.
C. General Provisions. If you fail to return to work with the Employer after your Leave period is exhausted, you will be indebted to the Employer and the Employer retains the discretion to recover from you the full amount of the cost of health care coverage provided to you and your dependents under the Plan during such Leave period.

    Other rights and payment requirements regarding your coverage during an FMLA Leave or during any other Employer-Approved Leave of Absence are explained in Section 8.6 (A Leave of Absence). To the extent required by FMLA, you also will receive more information regarding your payment obligations during a FMLA leave in the "Rights and Responsibility Notice" provided to you by the Employer.

Section 13. Continuation Coverage during a Military Leave of Absence

If you are on a qualified military leave of absence under the USERRA, you may continue coverage during your military leave, as follows:

A. Short-Term Military Leave of Absence. If you are on a military leave of absence which is less than 31 days, you and your dependents may continue to participate in the Plan for an additional 30 days beyond the date on which your leave begins. After that time, if you do not return to employment, you may elect to continue coverage under COBRA (as discussed below). The maximum period of COBRA coverage may be reduced, however, by the 30-day period during which you were covered under the Plan while on military leave of absence.
B. Long-Term Military Leave of Absence. If you are on a military leave of absence which is 31 days or more, you and your dependents may elect to continue coverage under the Plan for the lesser of:
    - The 24-month period beginning on the date your absence begins.
    - The date after the date you fail to apply for or return to a position of employment, as determined under USERRA.
    - The date you fail to pay the required premium for such coverage. The required premium for this coverage is 102 percent of the premium for coverage under the Plan for active employees.

    Your share of the premium cost of continued coverage under the Plan during your USERRA military leave will be paid in accordance with the rules outlined in Section 8.6 (A Leave of Absence). Note that you also may have rights to continue coverage after your military leave under COBRA, but the maximum period of COBRA coverage will be reduced, and may

be exhausted, by the period during which you were covered under the Plan while on military leave of absence.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA advisor can be viewed at http://www.dol.gov/elaws/userra.htm. If you file a complaint with VETS and VETS is not able to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, depending on the employer for representation. You also may bypass the VETS process and file a claim under the Plan's internal claims procedures or bring a civil action for violations of USERRA.

Section 14. COBRA Continuation Coverage

A. General COBRA Rights Under Federal Law. To the extent that the Employer is subject to COBRA under federal law, if you and your Spouse and Dependent-children cease to be covered by the Plan under the same terms and conditions as in effect following the occurrence of certain "qualifying events" (listed below), you are eligible to elect health continuation coverage under such Plan upon payment of a monthly premium. COBRA continuation rights only apply to a benefit plan if such plan constitutes a group health plan (e.g. the medical, prescription drug, dental, and vision); provided, however, that a small-employer plan is **not** subject to COBRA under federal law. A small-employer plan is a group health plan maintained by an employer that normally employed fewer than 20 employees during the preceding calendar year as more fully described in Treasury Regulation Section54.4980B-2 (Q&A-5). If the Employer maintains a small-employer plan and thus is exempt from COBRA under federal law, the following provisions shall not apply, but you may have continuation rights under State law - which rights will be more fully described in the Benefits Guide or you may contact the insurer of the group health plan for additional information on your rights under State law.

   If the Employer is subject to COBRA under federal law, then the remaining provisions of this shall apply.

B. Qualifying Events. As an Eligible Employee, you will experience a "qualifying event" if you lose your coverage because of a reduction in your hours of employment (for reasons other than an FMLA leave), termination of your employment (for reasons other than gross misconduct on your part) or failure to return to employment following an FMLA leave (a "qualifying event").

   Your Spouse or Dependent-child (including a child born to or placed for adoption with you during a COBRA coverage period) who is covered by the Plan, will be deemed to have a qualifying event if he or she loses group health coverage under the Plan for any of the following reasons:

   i. Your death;
   ii. Your termination of employment (for reasons other than gross misconduct), reduction in your hours of employment (for reasons other than an FMLA leave), or your failure to return to employment following an FMLA or other Employer-Approved leave of absence;
   iii. Divorce or legal separation from you; or
   iv. Your becoming entitled to Medicare.

   Your Dependent-child also will experience a "qualifying event" if group health coverage under the Plan is lost because the Dependent-child ceases to be a "dependent child" under the Plan.

   For purposes of the above, a reduction in hours of employment includes any decrease in the number of hours you work or are required to work, including a leave of absence, disability or layoff. Rights similar to those described above may apply to retirees, spouses and dependents if the Employer commences a bankruptcy proceeding and these individuals' coverage would be substantially eliminated as a result.

   If coverage under the Plan is reduced or eliminated in anticipation of a qualifying event (e.g. your termination of coverage in anticipation of a termination of your employment, or your elimination of the coverage of your Spouse in anticipation of a divorce), such reduction or elimination is disregarded in determining whether the qualifying event causes a loss of coverage.

C. Notice Requirements for Covered Employees and/or Qualified Beneficiaries. You and/or your covered Spouse or Dependent-child (or any representative acting on your behalf) must inform the Plan Administrator of the occurrence of each of the following events within the time described below:
   i. A divorce, legal separation, or a child losing dependent status under the Plan; such notice must be given within 60 days from the date that the qualifying event occurs or the date on which coverage would be lost under the Plan

because of the qualifying event, whichever is later;

ii. A second qualifying event after the individual has become entitled to COBRA continuation coverage with a maximum duration of 18 (or 29) months; such notice must be given within 60 days from the date that the second qualifying event occurs;

iii. A determination that an individual (i.e. you or your covered Spouse or Dependent child) is disabled within the meaning of Title II or XVI of the Social Security Act at any time prior to or during the first 60 days of COBRA continuation coverage; such notice must be given within 60 days after the latest of (i) the date of a disability determination by the Social Security Administration, (ii) the date that the qualifying event occurs or (iii) the date on which coverage would be lost under the Plan because of the qualifying event; provided, however, that the notice must be given before the end of the first 18 months of COBRA coverage under all circumstances;

iv. The Social Security Administration's determination that an individual is no longer disabled; such notice must be given within 30 days of the date of such determination; and

v. Eligibility as a PBGC or TAA eligible individual (as described in paragraph (i) below); such notice must be given before the end of the first 18 months of COBRA coverage.

Any Notice under this paragraph must be sent in writing by U.S. mail to the Plan Administrator and must contain the following information:

- the name of the covered employee and his or her employee identification number or the last four digits of social security number;
- the names of any covered Spouse and/or covered Dependent children;
- the identity of the group health plans in which the covered individual(s) participate (e.g. Medical, Dental, Vision, and/or Health Care Spending Account Programs);
- a description of the event that triggers these notice requirements (e.g. the occurrence of a divorce, a child losing dependent status, a disability determination, a second qualifying event (including a description of the second qualifying event)); and
- the date on which such event occurred.

The Plan Administrator may require that the notice be supplemented with any additional information as it deems necessary to administer these COBRA provisions. **Failure to timely provide written notice to the Plan Administrator under this paragraph will cause you (or your covered Spouse or Dependent Child) to lose the right to receive or extend the period of COBRA coverage.**

D. Notice of COBRA Rights. The Employer will notify you of your right or your Spouse's and/or Dependent child's right to elect continuation coverage (i) after you or your Spouse have notified the Employer of a divorce, legal separation, or a child losing dependent status, (ii) after you die, terminate employment (for reasons other than gross misconduct), have a reduction in hours of employment (for reasons other than an FMLA leave), fail to return to employment following an FMLA leave or become entitled to Medicare, or (iii) in the event the Employer files bankruptcy proceedings and retirees, Spouses and dependents coverage, if any, is substantially eliminated.

E. Election of COBRA Coverage. You, your Spouse, or your dependent child(ren) have 60 days from the date your coverage would terminate under the Plan by reason of a qualifying event or 60 days from the date of notice from the Employer, whichever is later, to inform the Employer that you, your Spouse, and/or your Dependents want continuation coverage. Each Qualified Beneficiary has independent election rights, regardless of his/her original status under the Plan; i.e., as an Employee, a Spouse or a Dependent-child. For example, both you and your Spouse may elect COBRA continuation coverage, or only one of you. Parents may elect COBRA coverage on behalf of their Dependent children only. Each qualified beneficiary may elect COBRA coverage on behalf of all other qualified beneficiaries, including on behalf of a minor child.

If you do not timely elect to purchase COBRA continuation coverage, your group health plan coverage will end. In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having a pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you otherwise are eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You also will have the same special enrollment right at the end of COBRA continuation coverage if you get continuation coverage for the maximum time available to you.

F. Cost of COBRA. Under the law, you are required to pay the cost of COBRA continuation coverage, which can be up to 102% of the full cost of coverage. If you qualify for extended benefits because of disability, and elect the additional 11

months of coverage, you will be required to pay up to 150% of the full cost of coverage for the additional period.

G. COBRA Coverage. If continuation coverage is chosen, the Employer is required to give you coverage which, at the time coverage is provided, is identical to the coverage provided under the Plan to similarly situated non-COBRA employees or family members.

H. General Duration of COBRA Coverage. The law generally requires that you be afforded the opportunity to maintain continuation coverage for:

- 18 months after the date of the qualifying event that caused you, your Spouse or dependent child to lose coverage because of a termination of employment (for reasons other than gross misconduct), reduction in hours (for reasons other than an FMLA leave) or failure to return to employment following an FMLA leave; or
- 36 months after the date of all other qualifying events that caused your Spouse or dependent child to lose coverage under the Plan.

The coverage period of a child who is born to or placed for adoption with you during a period of continuation coverage is measured from the date of the qualifying event which caused you to lose coverage under the Plan (and not from the date of the birth or placement for adoption).

I. Extended Period of COBRA Coverage. If you elect continuation coverage, an extension of the maximum 18-month period of coverage may be available if a qualified beneficiary is disabled, a second qualifying event occurs or you are a PBGC or TAA eligible individual, as described below. You must notify the Plan Administrator of a disability, a second qualifying event or your status as a PBGC or TAA eligible individual in accordance with paragraph (c) above.

i. *Second Qualifying Event.* The 18-month period (for Spouse and dependents) may be extended to 36 months if other events (e.g., divorce, legal separation, death, Medicare entitlement, or loss of dependent child status) occur during the initial 18-month period.

   If you become entitled to Medicare and within 18 months thereafter lose coverage due to a termination of employment, reduction in hours or failure to return to work after the end of an FMLA Leave period, your Spouse and/or dependent children will be entitled to continuation coverage for a total of 36 months from the date you become entitled to Medicare.

   The Qualified Beneficiary must notify the Plan Administrator of a second qualifying event in the manner and by the time set forth in paragraph (c) above.

ii. *Disability.* The 18-month period also may be extended to 29 months by an individual (i.e. by you or your Spouse, or Dependent child) who is determined to be disabled within the meaning of Title II or XVI of the Social Security Act at any time prior to or during the first 60 days of COBRA continuation coverage, and by any individual who became eligible for continuation coverage under this Section with respect to the same qualifying event as the disabled individual (i.e., a non-disabled family member). A disabled individual (and his or her non-disabled family members who are entitled to continuation coverage) must notify the Plan Administrator in the manner and by the time set forth in paragraph (c) above. In addition, the Plan Administrator must be notified within 30 days of any final determination that the individual is no longer disabled. For the additional 11-month period, the cost of coverage will be not greater than 150% of the applicable premium, provided that the disabled individual is included in that coverage. If the disabled individual does not elect continuation coverage, but his/her non-disabled family members elect COBRA, the cost of coverage will not be greater than 102% of the applicable premium.

   The 29-month period may be further extended to 36-months for a Spouse or Dependent child if another qualifying event (e.g., divorce, legal separation, death, loss of dependent child status) occurs during the 29-month period. If such other qualifying event occurs during the first 18 months of continuation coverage, the cost of coverage will not be greater than 102% of the applicable premium. If such other qualifying event occurs after the first 18 months of continuation coverage (and before the expiration of the 29-month period), the cost of coverage will not be greater than 150% of the applicable premium, provided that the disabled individual is included in that coverage. The Qualified Beneficiary must notify the Plan Administrator of a second qualifying event in the manner and by the time set forth in paragraph (c) above.

iii. *PBGC or TAA Eligible Individuals -- Effective Only for Periods of COBRA Coverage That Would End On or After November 20, 2011.* If, as of the qualifying event date of termination of employment, you have a nonforfeitable right to receive any pension benefits directly from the Pension Benefit Guaranty Corporation, your maximum COBRA coverage period will be extended until the earlier of your date of death or January 1, 2014 (or such later date as extended by law). The maximum COBRA coverage period for your covered surviving spouse or dependent children will be extended until the earlier of 24 months after your date of death, or January 1, 2014 (or such later date as extended by law).

If you are an eligible individual under the Trade Adjustment Assistance Program as of the date your COBRA coverage would otherwise end (see paragraph (k) below), your maximum COBRA coverage period will be extended until the earlier of the date you cease to be an eligible individual under the Trade Adjustment Program, or January 1, 2014 (or such later date as extended by law).

You must notify the Plan Administrator in writing that you qualify as a PBGC or TAA eligible individual prior to the expiration of your initial 18-month COBRA period in accordance with paragraph (c) above.

J. Termination of COBRA Coverage. Notwithstanding anything herein to the contrary, continuation coverage will terminate on the earliest of:
   i. the date the maximum period of continuation coverage is completed (i.e. the expiration of the 18-, 29- or 36-month period as described above);
   ii. the date the COBRA continuee is covered under another group plan (other than a group health plan under which the person was covered prior to electing COBRA continuation coverage), if that plan does not contain an exclusion or limitation for a pre-existing condition of such individual or which does contain an exclusion or limitation as to any preexisting condition, but such exclusion or limitation does not apply to or is satisfied by the employee, Spouse or dependent child, as applicable, by reason of applicable law or otherwise;
   iii. the date the COBRA continuee's applicable premium for continuation coverage is not timely paid;
   iv. the date the COBRA continuee becomes entitled to and actually enrolled in Part A or B of Medicare (provided the entitlement to Medicare first arises after COBRA continuation coverage has been elected);
   v. if there has been an 11-month extension of coverage due to a COBRA continuee's disability, coverage during the 11-month extension period shall terminate following the date there has been a final determination that such individual is no longer disabled (in such case, coverage shall terminate for all individuals who were entitled to the 11-month extension as a result of the disability); or
   vi. the date the Employer ceases to provide any health plan coverage to any of its Employees.

K. Keep the Employer Informed of Address Changes. To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You also should keep a copy of any notices, election or payments you send to the Employer or Plan Administrator regarding your COBRA continuation coverage.

L. TAA-Related Loss of Coverage. . The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (TAA eligible individuals). For coverage months beginning after February 12, 2011 and through December 31, 2013 (or as otherwise extended by law), TAA eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you are a TAA eligible individual and you did not elect COBRA continuation coverage during the 60-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, you may elect COBRA continuation coverage during a 60-day period that begins on the first day of the month in which you are determined to be a TAA-eligible individual (the "TAA election period"); provided, however, that your election is made not later than 6 months after the date of the TAA-related loss of coverage. You may elect COBRA coverage for both yourself and your family members. Any COBRA coverage elected during this TAA election period will begin on the first day of the TAA election period, and not on the date on which coverage originally ended. However, the time between the original TAA-related loss of coverage and the start of the TAA election period (i) will be counted toward the maximum COBRA duration period, but (ii) will not be counted for purposes of determining whether you had a 63-day break in coverage under ERISA Section 701(c)(2). If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act also is available at www.doleta.gov/tradeact/2002act_index.asp.

Section 15. Conversion Rights

Please refer to the Benefits Guide that applies to the health care option you elected to determine if you are eligible to convert your health care coverage to an individual health insurance policy after your Plan coverage terminates. If available, conversion coverage may be provided to you either (i) as an alternative to COBRA coverage or (ii) at the end of the maximum period of COBRA coverage, if you made all required payments during that period. It is your responsibility to timely contact the Claims Administrator for information about the availability of this conversion coverage and the rules concerning your eligibility for conversion coverage when your group coverage ends under this Plan.

Section 16. Preexisting Condition Exclusions and Certificates of Creditable Coverage

Effective January 1, 2014 group medical plans and non-standalone dental and vision plans are prohibited from imposing preexisting condition exclusions with respect to any covered individual.

Section 17. Qualified Medical Child Support Order

The Plan Administrator has established procedures that are to be followed if the Plan receives a medical child support order that requires you to provide health care coverage for your child under the Plan. These procedures are set forth in **Claims for Benefits** to this summary.

Section 18. Coordination of Benefits

Coordination of Benefits" is the procedure used to pay health care expenses when a person has coverage under this Plan as well as coverage under another plan, program, or policy providing health care benefits, including but not limited to an automobile insurance policy. The plan, program or policy that is deemed to be the "primary plan" must pay its full benefits as if no other coverage existed. The remaining plan, program or policy is deemed the "secondary plan" and is only required to pay its benefits that are in excess of those paid by the primary plan.

The following rules shall govern the coordination of benefits, except as otherwise provided in the applicable Benefits Guide:

- The plan that covers the patient as the employee is primary and pays before the plan that covers the patient as a dependent.
- The plan that covers the patient as an active member (e.g., employee) is primary and pays before the plan that covers the patient as an inactive member (e.g., retiree, COBRA continue, etc.).
- If a child is covered under both the mother' s and father's plan, the plan of the parent whose birthday is earlier in the year is primary.
- For children of divorced parents or separated Spouses, benefits are determined in the following order unless a Qualified Medical Child Support Order (as defined above) places financial responsibility on one parent:
    A. The plan of the custodial parent.
    B. The plan of the custodial parent's new Spouse (if remarried).
    C. The Plan of the non-custodial parent.
    D. The plan of the non-custodial parent's new Spouse.

  If the primary plan cannot be determined for the children of divorced or separated parents under these rules, then the "birthday rule" under the third bullet above will be used to determine the primary plan.

- Any situations not addressed in the Plan will be handled in accordance with the guidelines established for coordination of benefits by the National Association of Insurance Commissioners.

You must notify the Plan Administrator of any other health care plans in which you and/or your dependents participate.

To the extent required under the Medicare Secondary Payer Act (e.g. the Employer has 20 or more employees), if you are age 65 and eligible for Medicare while still working for the Employer, the Plan automatically will remain the primary plan and Medicare will be the secondary plan. However, you still should apply for Medicare benefits, especially Part A, because it may provide additional health care benefits to you, even as the secondary plan.

If the Employer qualifies for the small employer exception under the Medicare Secondary Payer rules (e.g. has less than 20 employees), Medicare will be the primary payer and the Employer's medical program will become the secondary payer on all covered expenses under the Plan with respect to the person entitled to Medicare. You generally must enroll for Medicare within the three months prior to your 65th birthday to be assured of coverage. If you do not timely enroll, Medicare may not approve your application either for some period or not at all. It is your responsibility to consult with your local Social Security office and obtain details regarding Medicare. For these purposes, the Employer's medical program will assume that all individuals who are eligible for Medicare are actually enrolled in Parts A and B. As a result, your failure to apply for Medicare when eligible could leave you without primary coverage for certain medical expenses. The Employer will **not** reimburse or otherwise subsidize you for the cost of Medicare.

Section 19. Subrogation

The Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a covered individual in a time of need, the Plan may pay covered expenses that may be or become the responsibility of another person, contingent on the individual's agreement that the Plan later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

- *Assignment of Rights (Subrogation).* The covered person automatically assigns to the Plan any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. By this assignment, the Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.
- *Equitable Lien and other Equitable Remedies.* The Plan shall have an equitable lien against any rights the covered person may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien also shall attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person' s attorney, and/or a trust) as a result of an exercise of the covered person's rights of recovery (sometimes referred to as "proceeds"). The Plan also shall be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Plan Administrator, the Plan may reduce any future covered expenses otherwise available to the covered person under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien.

This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court' s decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 U.S. 204 (1/8/2002). The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies also are intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

- *Assisting in Plan's Reimbursement Activities.* The covered person has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the Plan with any information concerning the covered person's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (a) cooperate fully in the Plan's exercise of its right to subrogation and reimbursement, (b) not do anything to prejudice those rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan), (c) sign any document deemed by the Plan Administrator to be relevant to protecting the Plan's subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the Plan Administrator to enforce the Plan's rights.
- *Overpayments.* This Plan will have the right to recover any payments that were made to, or on behalf of, a covered individual and which causes an overpayment to be made.
- *Interpretation.* In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.
- *Jurisdiction.* By accepting benefits (whether the payment of such benefits is made to a covered person or made on behalf of the covered person to any provider) from the Plan, the covered person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the covered person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

The Benefits Guide also may set forth subrogation rights and procedures. Failure by a covered person to follow the above terms and conditions may result, at the discretion of the Plan Administrator, in a reduction from future benefit payments available to the covered person under the Plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the Plan.

Section 20. **Claims Procedures**

Generally, you should follow the claims review and appeal procedure set forth in the applicable Benefits Guide for any claim for benefits. However, if no provision is set forth in the Benefits Guide or to the extent such provisions do not comply with ERISA, Plan claims will be reviewed in accordance with claims procedures (for health benefit claims) set forth in Claims for Benefits below.

Section 21. Grandfathered Status

The Health Care Reform Act includes market reform and consumer protection provisions. If a group health benefit option offered under the Plan has Grandfathered Status (as defined in Definition of Grandfathers Status), it is not legally required to include all of the market reform and consumer protection provisions of the Health Care Reform Act. For example, a group health benefit option offered under this Plan that has Grandfathered Status does not need to provide recommended preventative health services without cost sharing. A group health benefit option under this Plan with Grandfathered Status, however, must comply with a number of other market reform and consumer protection provisions in the Health Care Reform Act, for example, the elimination of lifetime limits on benefits. The remaining paragraphs of this Section describe the market reform and consumer protection provisions of the Health Care Reform Act and indicate which ones apply to group health options with Grandfathered Status and those without Grandfathered Status.

A. The Adoption Agreement shall indicate which of the group health benefit options offered under this Plan have Grandfathered Status. Any additional questions regarding which protections apply and which protections do not apply to a group health option with Grandfathered Status and what might cause such group health benefit option to lose its Grandfathered Status can be directed to the Plan Administrator indicated in the Adoption Agreement. You also may contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This web site has a table summarizing which protections do and do not apply to grandfathered health plans.

Section 22. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA prohibits the Employer and the Plan from:

- Using genetic information to determine eligibility for coverage or to impose pre-existing condition exclusions;
- Adjusting your premium and contribution amounts on basis of genetic information;
- Requesting or requiring you or a family member to undergo a genetic testing;
- Requesting, requiring or purchasing genetic information for underwriting purposes; or
- Requesting, requiring or purchasing genetic information about an individual prior to or in connection with an individual's enrollment under the plan

GINA also makes it illegal for the Employer to discriminate against you with respect to your compensation or the terms, conditions or privileges of employment on the basis of your genetic information and from collecting such data, except as otherwise permitted by law.

Section 23. Mental Health Parity Act

If the Medical Plan provides benefits for mental health or substance abuse disorders, the MHPA requires equal treatment of mental health and substance abuse benefits in parity with medical/surgical benefits. This generally means that:

- Financial requirements and treatment limits applicable to mental health and substance abuse are no more restrictive than those limits and requirements on medical/surgical (e.g. deductibles, co pays, coins, out-of-pocket, treatment limits, not just annual and lifetime dollar limits);
- Out-of-Network Benefits provided for medical/surgical also must be available for mental health and substance abuse; and
- Criteria for medical necessity and reason for claim denials must be made available.

The Benefits Guide for the Medical Plan will provide an explanation of the covered and excluded benefits, which will comply with the Mental Health Parity Act.

Section 24. Refunds and Medical Loss Ratio Rebates

For fully insured medical benefits, in certain circumstances under the Health Care Reform Act, rebates may be paid to the Plan. Federal law requires that the issuer of the rebate (the insurance company) provide you a written notice of a rebate, at the time the rebate is paid to the Plan. The rebate will be prorated between the amount attributable to Plan costs paid by the Plan Sponsor and Plan costs paid by participants. The participant portion of the rebate will be used for the benefit of Plan participants. This can be done by a number of actions, including but not limited to lowering the Plan costs for the participants for the next Plan Year, applying the rebate towards the cost of administering the Plan, paid as taxable income to the participants, or in any manner that allocates the rebate to participants based on each participant's actual contributions, or to apportion it on any other reasonable basis. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity. All refunds from the insurance policies paid to the Plan will be disbursed within 90 days of receipt by the Plan Administrator.

Article XXI. Cafeteria Plan

Section 1. Introduction

If the Adoption Agreement specifies that the Employer has established a Code Section 125 - Cafeteria Plan, then the terms of the Code Section 125 Plan document shall apply. In addition, the following provisions shall apply to the welfare benefit programs elected pursuant to an applicable Code Section 125 Plan to the extent they do not conflict with the applicable formal Code Section 125 Plan document.

Section 2. Type of Plan

The Cafeteria Plan is a cafeteria/fringe benefit plan, as described in and governed by Section 125 of the Internal Revenue Code (the "Code").

Section 3. Purpose of the Plan

The Plan allows you to pay certain premium payments on a pre-tax basis. Because you can pay for these expenses with before-tax dollars, you pay no federal income taxes or social security taxes on these dollars. In other words, you can trade before tax income for tax free benefits.

Section 4. Eligibility and Participation Requirements

In order to be eligible to participate in the Cafeteria Plan, you must be eligible to participate in one of the benefit programs identified in the Cafeteria Plan (e.g. the medical, prescription drug, dental, vision or disability programs) (collectively referred to as "Benefit Plans"). Your participation in the Cafeteria Plan will begin on the date you first become a Participant under one of the Benefit Plans.

The Plan Administrator, in its sole discretion, will determine your eligibility to participate and the effective dates of participation under each Benefit Plan. If you have any questions as to whether you qualify, please contact the Plan Administrator.

Section 5. Enrollment

To enroll in the Plan, you generally are required to complete the enrollment process (which may be electronic) established by the Plan Administrator. If you do not timely complete the enrollment process, you may lose the opportunity to participate in the Plan for the Plan Year, except as described below.

A. Annual Enrollment. Before the beginning of each Plan Year, the Employer will hold an enrollment period during which you may change your Benefit elections for the upcoming Plan Year. The enrollment period will begin and end on dates determined by the Plan Administrator. These dates always will be prior to the beginning of the next Plan Year. The law requires that you make your elections before the start of the new Plan Year. Coverage for each Benefit elected becomes effective on the first day of the Plan Year following each enrollment period and continues until the last day of such Plan Year (the Adoption Agreement sets forth the Plan Year).

If you do not timely make your annual elections, you will be deemed to have elected the same benefit choices that are in effect for the current Plan Year, except as otherwise provided in the Adoption Agreement for the Cafeteria Plan or in your open enrollment materials. Payroll deductions automatically will be adjusted as of the beginning of each new Plan Year to reflect the cost of the benefit choices you made or were deemed to have made.

B. Enrollment for New Employees. New employees will be enrolled in the Plan upon becoming eligible to participate (i.e. on the effective date of participation as specified under each Benefit Plan) and timely completing the election process established by the Plan Administrator. Coverage in the Plan as elected by new employees will begin on the effective date of participation and continues until the last day of the Plan Year.

   If you fail to timely complete the election process, you generally will not be covered under the Benefit Plans, except as otherwise set forth in the Adoption Agreement for the Cafeteria Plan or your open enrollment materials (regarding default elections).

C. Default Elections. The Plan Administrator, in its sole discretion, may establish a default election procedure under which you may be deemed to have elected one or more benefit options for a Plan Year (or reminder thereof). Unless otherwise noted in the Adoption Agreement for the Cafeteria Plan, the Plan Administrator has established a default election procedure for existing Participants that provides they will be deemed to have elected the same elections in effect for the prior Plan Year with respect to all Benefit Plans. If elected in the Adoption Agreement for the Cafeteria Plan, the Plan Administrator also may establish a default election procedure for newly hired Eligible Employees. If the Plan Administrator decides to implement such a default election procedure or is otherwise required by law to do so, the Plan Administrator will notify you in writing (e.g. in the initial or open enrollment materials) of such default election procedures, including a description of the default elections, the amount of the salary reduction, the period of time for which the election is effective, the procedures to decline coverage and the deadline for making elections.

Section 6. **Change in Benefit Elections**

Generally, you may not change your election under the Plan during a Plan Year. Your elections are required by law to be irrevocable during a Plan Year, except under limited circumstances permitted by law. These limited circumstances include when you experience a change in status event. You may revoke your election for a given Plan Year and file a new election only if both the revocation and the new election were caused by a change in your status and the underlying Benefit Plan also permits such change. In addition, you may only make a mid-year benefit election change if the change is consistent with the change in status event in accordance with applicable IRS regulations. For this purpose, a change in status event may include:

- A change in your legal/marital status (marriage, death of Spouse, divorce, legal separation and annulment);
- A change in the number of your dependents (birth, death, adoption or placement for adoption);
- A change to employment status (termination or commencement of employment of your Spouse, switching from part-time to full-time employment status or from full-time to part-time status, commencement of or return from an unpaid leave of absence, etc.);
- Your dependent ceasing to satisfy eligibility requirements;
- A change in the place of residence of the employee, Spouse or dependent;
- In case of a Benefit Plan that is a group health plan, a significant increase or decrease in the cost of coverage or a significant addition or curtailment in the type of coverage under such Benefit Plan;
- Issuance of a Qualified Medical Child Support Order requiring health coverage of a dependent under a Benefit Plan;
- Becoming enrolled in Medicare;
- Losing coverage under another group health plan, Medicaid or a State's Children Health Insurance Program;
- Another event which the Plan Administrator determines permits a change under rules and regulations of the Internal Revenue Code.
- Enrollment in a health plan on the Exchange/Marketplace during a special enrolment period or annual enrollment.
- A reduction in hours for the employee where he/she averages less than 30 hours of service per week resulting in the employee enrolling in another minimal essential coverage plan no later than the first day of the second month following the revocation of coverage.

You must provide notice to the Plan Administrator of the above changes within **30 days** (or such later date specified in the Adoption Agreement) following the date on which one of the events described above occurs. If you are permitted to make a change, it will be effective at such time as the Plan Administrator prescribes, but not earlier than the first pay period beginning after your election change form is completed and filed with the Plan Administrator.

Section 7. **Termination of Coverage**

Your participation in and coverage under the Plan generally will end upon the occurrence of any events described in ("Termination of Coverage").

If you are rehired within 30 days of your termination of employment, you may begin to participate in the Plan again upon satisfying the eligibility requirements, but your previous elections will apply and you may not make new elections for the same Plan Year in which you terminated employment. If you are rehired more than 30 days after your termination of employment, or you are rehired in a subsequent Plan Year, you may make new elections under the Plan, except as otherwise provided in the Benefits Guide.

Section 8. Non-Discrimination Tests

Federal tax law requires the Cafeteria Plan to satisfy certain nondiscrimination tests annually. If the Cafeteria Plan does not satisfy such nondiscrimination rules, Participants with high salaries or who are key employees, as defined by the IRS, may be subject to additional income taxes. The Plan Administrator will notify you if these rules have adverse tax consequences to you.

Section 9. Social Security Taxes

Social Security taxes are not deducted from the amount you contribute to the Plan on a before tax basis. Your take-home pay is larger because you save on taxes, including "FICA" taxes, but your future Social Security benefits may be less at retirement because of this. In most cases, however, the reduction in Social Security benefits is minimal, and the tax advantages you otherwise gain through contributing to the Plan offset any possible reduction in Social Security benefits.

Section 10. Claims Procedure

Claims filed with respect to the Cafeteria Plan will be reviewed in accordance with the claims procedures (for all other types of claims (not involving health or disability benefits)) set forth in Claims for Benefits below.

Section 11. Plan Funding

The benefits provided by the Cafeteria Plan (through your employee contributions) are paid from the general assets of the Employer. The Plan will not use a trust fund or other separately maintained fund for accumulating Plan assets or providing benefits under the Plan, unless otherwise required by law.

Section 12. Tax Savings

The Cafeteria Plan allows you to contribute "before-tax" dollars to purchase certain non-taxable benefits. By paying with "before-tax" dollars, you will reduce the amount of income and social security taxes that you otherwise would be required to pay. The below example demonstrates these tax savings.

Example: Jack and his wife Janet combined earn $50,000 per year. Under Jack' s old health care plan, he was required to pay his premiums with "after-tax" dollars. Under Jack's new cafeteria plan, he will be permitted to pay his premiums with "before-tax" dollars. Jack's employer requires that Jack contribute $200 per month towards the cost of his coverage under the medical, prescription and dental programs.

	Old Plan Without Cafeteria Plan	Cafeteria Plan
Gross Income	$50,000	$50,000
Jack's Annual Premiums on a Before-tax Basis	-0-	(2,400)
Adjusted Gross Income	$50,000	$47,600
Estimated Federal and State Income and FICA (Social Security and Medicare) Taxes (estimated at a 27% of pay tax rate)	(13,500)	(12,852)
Jack's Annual Premiums and Health and Dependent Care Expenses on an After-tax Basis	(2,400)	-0-
Disposable Income	$34,100	$34,748

Jack and Janet's annual savings under the cafeteria plan will be $648 per year ($34,748 - $34,100). [**Note:** these numbers are used as examples only and actual amounts would depend upon your individual situation.]

Article XXII. Miscellaneous Provisions

Section 1. Introduction

The provisions in this Article apply to all programs described under this Basic SPD and Plan document.

Section 2. Plan Amendment or Termination

The Employer (or its delegated Plan Administrator) reserves the right to amend, modify or terminate any and all of the benefit programs at any time. The Employer may delegate, through resolutions of the Board of Directors, its power to amend or terminate any and all Plans to another person or organizations.

Section 3. Employer's Rights

While the Employer believes in the benefits, policies and procedures described in this Basic SPD and Plan document, the language in this document is not intended to create, nor is it construed to constitute, a contract of employment between the Employer and any of its Employees. The Employer retains all of its rights to discipline or discharge Employees or to exercise its rights as to incidents of employment. You have the right to terminate your employment at any time for any reason, and the Employer has a similar right with regard to terminating your employment.

Section 4. Non-Alienation of Benefits

No right or benefit provided for under any of the benefit programs will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so will be void. However, this non-alienation provision will neither be construed to restrict or forfeit any subrogation rights of the Employer under the Plan nor prevent you from directing the Employer to pay expenses directly to a provider of services or products if those expenses are otherwise reimbursable to you under the Plan. In such event, the Employer shall be relieved of all further responsibility with respect to that particular expense.

Section 5. Your Rights Under ERISA

As a participant in the benefit programs that are governed by ERISA, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

A. Receive Information About your Plan and Benefits. Examine, without charge, at the Plan Administrator's (or your local Human Resources representative' s) office and at other specified locations, such as worksites and union halls, 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 Benefit Security Administration, if any.

   Obtain, upon written request to the Plan Administrator (or your local Human Resources representative), copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

B. Continuation Group Health Plan Coverage. Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under a group health 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.
C. Preexisting Condition Limitations. Reduce or eliminate any exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a

certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ends, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

D. Conversion Privileges. When you are no longer eligible under the Plan (either as an active participant or as a qualified beneficiary receiving continuation coverage) you may be eligible to obtain an individual conversion policy for one or more of your insured benefits. The availability of this conversion coverage and the rules concerning eligibility are set forth in the policy with each insurance carrier.

E. 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.

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

   Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

G. Assistance with Your Questions. If you have any questions about your Plan you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 6. **A Leave of Absence**

A. Continuation of Coverage. If you are absent from work due to (i) an approved medical or family leave of absence which is covered under the Family and Medical Leave Act of 1993 ("FMLA"), (ii) a military leave of absence which is covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") or (iii) an Employer-Approved Leave of Absence (collectively referred to as leave), you will have the following rights:
   i. To revoke your coverage with respect to any Plan for the remainder of the Plan Year.
   ii. To continue, in accordance with paragraph (b) below, your election of benefit coverage during the leave period, but only with respect to a group health plan and any other Plan under which the Employer specifically agrees in writing to continue your coverage and the Benefit Guides specifically provides for your continued coverage, during such leave period.
   iii. To suspend your election during the leave period with respect to any Plan and to reinstate such election upon your return to work with the Employer in accordance with paragraph (d) below.

B. Payment for Coverage. If you are entitled to and do elect to continue coverage under a Plan during your leave, the continued cost of coverage under the Plan is payable as follows:
   i. *Paid Leave*. If your leave is a paid leave, your cost of coverage will be paid by payroll deduction under your existing salary reduction agreement (unless you have a change in status event as provided in the Cafeteria Plan, if any, and you elect to change your coverage).
   ii. *Unpaid Leave*. If your leave is unpaid, then you are required to pay your share of the cost of coverage under the Plan under one of the following methods as approved in advance to your leave by the Employer:
      - Make payments to the Employer on an after-tax basis at the same time as payment would be required if

made by payroll deduction.

- Make payments to the Employer on a pre-payment basis from any taxable compensation paid to you (including the use of sick day or vacation day compensation, as permitted by the Employer). Any pre-payment made in one taxable year cannot be applied to a later taxable year.
- To the extent specifically authorized in the Adoption Agreement for the Cafeteria Plan, make payments to the Employer on a pre-tax or after-tax basis when you return from the leave; provided, however, that you and the Employer agree in advance of your leave that (i) you elect to continue coverage while on an unpaid leave; (ii) the Employer will assume responsibility for advancing payment of your contributions during your leave; and (iii) you will repay all advance amounts when you return to work from your leave or when you fail to return to work upon the expiration of such leave.

C. Cessation of Coverage. If you fail to timely make any scheduled payments, coverage under the Plan will cease retroactively to the date that the required payment was due, provided the Employer has given you at least 15 days advance written notice that if payment is not received within 30 days of the required due date, coverage will be dropped on that date retroactive to the date the required payment is due. If the notice is not timely sent, coverage will cease 15 days after the required notice is given or the date specified in the notice, if later, unless the payment has been received by that date.

   If you do not return to work at the end of your leave, the Employer, in its discretion, will have the right to collect the Employer-paid share of the cost of your and your Eligible Dependents coverage during the leave. This provision does not apply if you do not return to work for a serious health reason (either affecting you or an immediate family member) that would entitle you to leave under FMLA, or other circumstances beyond your control, as approved by the Employer.

   If you do not return to work at the end of the approved period for your leave, you and/or your Eligible Dependents' coverage under Plan will terminate (you may have COBRA health continuation rights - see COBRA Continuation Coverage).

D. Reinstatement. If you suspend your coverage during a leave and then return to work with the Employer within the same Plan Year the leave commenced, you automatically will resume participation in the Plan without any change in your prior elections under the Plan for such Plan Year. Your cash compensation will be reduced to the rate in effect on the day before the leave commenced and an amount equal to the reduction will be credited by the Employer in accordance with the applicable benefit program.

If you suspend your coverage during a leave and you return from a leave in a Plan Year subsequent to the year the leave commenced, you generally will be required to complete and submit a new election form (under the Cafeteria Plan if applicable) by the deadline established by the Plan Administrator, if you want to resume participation in the applicable benefit program. Participation in such benefit program generally will commence as of the first pay period immediately following receipt of your completed election form by the Employer.

Section 7. Plan Administration

This Plan is administered by the Employer, as the ERISA Plan Administrator. The Plan Administrator has full discretion and authority to administer the Plan; interpret the Plan; determine eligibility for and the amount of benefits; determine the status and rights of participants, beneficiaries and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the power and authority contemplated by ERISA and the Internal Revenue Code with respect to the Plan; employ or appoint persons to help or advise in any administrative functions; appoint investment managers and trustees; and generally do anything needed to operate, manage and administer the Plan. The Plan Administrator has full discretionary and binding authority and control over the Plan, including that contemplated by the U.S. Supreme Court's decision in Firestone Tire & Rubber Co. v. Bruch.

The Employer also shall have the power to delegate its fiduciary duties under the Plan to officers or employees of the Employer and to other persons, all of whom, if employees of the Employer, shall serve without compensation other than their regular remuneration from the Employer. The Employer agrees to indemnify and to defend to the fullest extent permitted by law any delegated employee or officer against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer), occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of another Plan fiduciary, to the extent provided in ERISA Section 405(a).

Section 8. Governing Law

This Plan shall be interpreted under federal law, including ERISA, and under the laws of the State identified in the Adoption Agreement to the extent not preempted by ERISA. This Plan will provide additional benefits to the extent required by applicable, non-preempted law.

Section 9. Collective Bargaining Agreements

An individual whose employment is covered under and subject to a collective bargaining agreement generally is eligible to participate in this Plan to the extent that the terms of such agreement expressly requires and provides for coverage under the Plan. If you are an eligible union Employee who is enrolled in this Plan, you can request a copy of the Collective Bargaining Agreement from the Plan Administrator.

Section 10. Return of Dividends, Premiums or Reserves

Because the amount of employee contributions is fixed each year and the Employer makes up the difference between those contributions and the costs of the Plan, any dividends and returned premiums or reserves, credited under an insurance policy are the property of the Employer. To that extent, dividends and return of premiums or reserves do not become assets of the Plan.

Section 11. Tax Consequences

Neither the Employer nor the Plan makes any representations or warranties regarding the federal, state, local or other tax treatment of benefits provided pursuant to the Plan and you shall have no rights against the Employer or the Plan if any tax consequences contemplated are not achieved.

Section 12. Funding of Plan Benefits

The Adoption Agreement sets forth whether the Employer's welfare benefit programs are self-funded through the general assets of the Employer, or if they are fully insured through the insurer identified in the Adoption Agreement.

A self-funded plan means that the Employer, rather than a managed care organization or insurance company, is financially responsible for paying plan expenses, including claims made by plan participants. Also known as a self-insured plan.

Notwithstanding anything to the contrary, the Plan will not utilize a trust fund or other separately maintained fund for accumulation of Plan assets or the provision of other benefits. In the event of Plan termination, there are no specific assets set aside to use to pay claims incurred prior to the date of such termination. If the Plan should be terminated, only claims incurred prior to the date of such termination would be considered for payment by the Plan.

Section 13. Third Party Administrators

The Plan Administrator has engaged certain third party administrators (TPA) to assist in the administration of the Plan. Under these TPA arrangements, the Employer has agreed to provide the following information to you (in compliance with the Third Party Administrator Act (e.g. MCL 550.901 et seq):

- This Basic SPD and Plan document, the Adoption Agreement, and the applicable Benefits Guides, describe your benefits under each benefit program and whether such benefits are self-funded through the general assets of the Employer or fully-insured through an insurance company.
- If a benefit program is self-funded from the general assets of the Employer (and not fully insured), and in the event such self-funded program or the Employer does not ultimately pay medical expenses that are eligible for payment under the benefit program for any reason, the individuals covered by the Plan may be liable for those expenses. The TPA merely processes claims and does not insure that any medical expenses of individuals covered by the benefit program will be paid. Complete and proper claims for benefits made by individuals covered by the Plan will be promptly processed but that in the event there are delays in processing claims, the individuals covered by the benefit program shall have no greater rights to interest or other remedies against the TPA than as otherwise afforded them by law.

Article XXIII. Claims for Benefits

Section 1. **Claims for Benefits**

You generally should follow the claims review and appeal procedure set forth in the applicable Benefits Guide with respect to any claim for benefits under the Plans. There will be no liability for the payment of benefits imposed upon the officers, directors, employees, or stockholders of the Employer and, to the extent that benefits are provided through insurance, your right to receive such benefits will be solely governed by the terms of the applicable insurance contract and the Employer will have no obligation to provide such benefits to you.

However, the claim procedures that are described in the remaining sections of this Article IX will apply in the event that (i) the claim relates to the administration of this Plan, (ii) a particular benefit program does not prescribe a claims procedure that satisfies ERISA requirements, or (iii) the Plan Administrator determines that the claims procedures specified below should apply in lieu of the claims procedures described in a particular benefit program.

Section 2. **Initial Claims**

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A claimant may file a claim, either in writing or electronically, which claim must include the following information:

A. The name and address of the claimant;
B. The specific basis for the claim;
C. A specific reference to the applicable Plan and pertinent plan provision upon which the claim is based; and
D. Any additional material or information which the claimant desires to submit in justification of the claim.

Section 3. **Claim Administrator's Initial Determination**

The Plan Administrator, or its designated claims administrator, (collectively referred throughout this Article as "Claims Administrator") will notify a claimant of its claim determination no later than the deadlines specified below. These deadlines differ based on whether the claim involves group health plan benefits, disability benefits or any other types of benefits or claims:

A. Health Benefit Claims. If the claimant files a claim for health care benefits, the following shall apply:
    i. Urgent Care. An urgent care claim is a claim in which a delayed determination (i) could seriously jeopardize the life or health of the affected individual or the ability of the individual to regain maximum function, or (ii) in the opinion of an informed physician, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Plan shall defer to the attending physician with respect to the decision as to whether a claim constitutes "urgent care" for purposes of this Section.

    Approval or denial of an initial urgent care claim will be furnished to a claimant as soon as possible taking into account the medical urgency, but not later than **72 hours** after receipt of the claim. Any denial will contain a description of the expedited review process. This notice may be given orally, in which case a written notice will be sent within 3 days of the oral notice.

    If more information is needed from a claimant, the Claims Administrator will notify a claimant not later than 24 hours after receipt of the claim of the specific information necessary to complete the claim. A claimant then has at least 48 hours to provide the information. The Claims Administrator will notify a claimant of the decision not later than 48 hours after the earlier of (i) the receipt of the specified information, or (ii) the end of the period afforded a claimant to provide the additional information.

    ii. Concurrent Care. If the Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments and the Claims Administrator makes a decision to reduce or terminate such course of treatment (other than by plan amendment or plan termination) before the end of the period of time or number of treatments, then the Claims Administrator will notify the claimant sufficiently in advance of the reduction or termination of the benefit to allow him or her to appeal and obtain a decision on review before the benefit is reduced or terminated.

    If the Claims Administrator receives a request by the claimant to extend beyond the approved period of time or approved number of treatments a course of treatment that qualifies as "urgent care" , the Claims Administrator will notify the claimant of its determination no later than 24 hours after receipt of the claim, provided the claim is made at least 24 hours before the course of treatment otherwise is scheduled to terminate.

iii. Pre-Service Claim. A pre-service claim is a claim that requires pre-approval as a condition of coverage. Approval or denial of an initial pre-service claim will be sent to a claimant within **15 calendar days** after receipt of the claim, unless an extension is required. The 15-day period may be extended once up to 15 calendar days. A claimant will be notified of any such extension before the expiration of the initial 15 day period. If the extension is required due to a claimant's failure to provide the necessary information, the Claims Administrator will describe the required information. A claimant will have at least 45 calendar days from receipt of the notice to provide the information. If a claimant fails to follow the Plan's procedures for filing a pre-service claim, the Claims Administrator will notify such claimant of such failure no later than 5 days (24 hours if the pre-service claim also is an urgent care claim) following receipt of the claim. The preceding sentence only will apply in the case of a claim that (i) is received by the person responsible for handling benefit matters; and (ii) names a specific claimant, a specific medical condition or symptom and a specific treatment, service or product.

iv. Post-Service Claim. A post-service claim is a claim that does not require pre-approval as a condition of coverage. Approval or denial of an initial post-service claim will be sent to a claimant within **30 calendar days** after receipt of the claim, unless an extension is required. The 30-day period may be extended once up to 15 calendar days. If the extension is required due to a claimant's failure to provide the necessary information, the Claims Administrator will describe the required information. A claimant will have at least 45 calendar days from receipt of the notice to provide the information.

B. Disability Benefit Claims. Approval or denial of an initial disability claim will be sent to a claimant within **45 calendar days** after receipt of the claim, unless extensions are required. The 45-day period may be extended twice, up to 30 calendar days each, provided the extensions are due to matters beyond the control of the Plan. A claimant will be notified of the first extension before the expiration of the initial 45-day period. A claimant will be notified of the second extension before the expiration of the first 30-day extension period. This extension notice will explain: the circumstances requiring an extension; the date by which the Claims Administrator expects to make the benefit determination; the standards on which entitlement to a benefit is based; the unresolved issues that prevent a decision on a claim; and the additional information needed to resolve those issues. A claimant will be afforded at least 45 days within which to provide any specified information.

C. All Other Claims. Approval or denial of any other type of claim (not involving health or disability benefits) will be sent to a claimant within **90 calendar days** after receipt of the claim, unless an extension is required. The 90-day period may be extended once up to 90 calendar days, provided the Claims Administrator determines that special circumstances require an extension of time for processing the claim. A claimant will be notified of the extension before the expiration of the initial 90-day period. The extension notice will explain the circumstances requiring an extension and the date by which the Claims Administrator expects to make the benefit determination.

Section 4. Claimant's Deadline for Filing an Appeal of a Denied Claim

A claimant may request, either in writing or electronically, a full and fair review off an initial decision denying his or her claim generally within:

A. **180 days** following receipt of the Claims Administrator's denial of a group health or disability claim for benefits; or
B. **60 days** following receipt of the Claims Administrator's denial of any other type of claim.

Section 5. Appeal Procedures

On appeal, the following procedures will apply:

A. During the review, a claimant may represent himself or herself or will have the right to appoint a representative, provided that the claimant is responsible for all of fees and expenses of such representative.
B. A claimant will have reasonable access (free of charge and upon request) to copies of all documents, records and other information relevant to his or her claim for benefits.
C. A claimant will be provided the opportunity to submit, and any review will take into account, all comments, documents, records, and other information relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
D. The review of a denied claim involving a group health plan benefit or disability benefit will be conducted by an independent fiduciary who is neither the individual who made the adverse decision nor a subordinate of that individual. Such reviewer will not give deference to the original decision to deny the claim. If the denial of the claim was based in whole or in part on a medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted, nor a subordinate of an individual who was consulted, in connection with the original adverse decision.
E. In the case of an urgent care claim for health benefits, the claimant may request expedited review of the claim whereby the request may be made orally or in writing and all necessary information may be transmitted between the Plan and the

claimant by telephone, facsimile or other similar expeditious method.

F. The Claims Administrator will identify to the claimant the medical or vocational experts whose advice was obtained in connection with the adverse decision, even if the advice was not relied upon in making the benefit determination.

Section 6. Claims Administrator's Deadline for Deciding an Appeal

The Claims Administrator will notify the claimant of its decision regarding the claimant's appeal as follows:

A. Health Benefit Claims:
   i. For **urgent care claims** - the Claims Administrator will notify a claimant of the decision as soon as possible, taking into account medical exigencies, but not later than **72 hours** after receipt of the claim for review.
   ii. For **pre-service claims** - the Claims Administrator will notify a claimant of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than **30 calendar days** after receipt of the initial claim for review. However, if the Claims Administrator provides the claimant with two level of appeals, then the Claims Administrator will notify the claimant, with respect to any one of such two appeals, of its decision not later than 15 days after receipt by the Plan of the claimant's request for review.
   iii. For **post-service claims** - the Claims Administrator will notify a claimant of the decision within a reasonable period of time, but not later than **60 calendar days** after receipt of the initial claim for review. However, if the Claims Administrator provides the claimant with two level of appeals, then the Claims Administrator will notify the claimant, with respect to any one of such two appeals, of its decision not later than 30 days after receipt by the Plan of the claimant's request for review.

B. Disability Benefit Claims: For disability benefit claims - the Claims Administrator will notify a claimant of the decision within a reasonable period of time, but not later than **45 calendar days** after receipt of the claim for review, unless the claims administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, a claimant will receive written notice of the extension prior to the expiration of the initial 45 day period. In no event will the extension exceed a period of 45 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the determination of a claimant's appeal.

C. All Other Claims: For all other type of claims (not involving health or disability benefits):
   i. the Claims Administrator generally will notify the claimant of the decision within a reasonable period of time, but not later than **60 calendar days** after receipt of the claim for review, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, a claimant will receive written notice of the extension prior to the expiration of the initial 60 day period. In no event will the extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the determination of a claimant' s appeal;
   ii. In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, subsection (1) above shall not apply. The appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the Plan's receipt of a request for a review, unless the request for review is filed within 30 days preceding the date of such meeting. In such a case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing the claim, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. If the Claims Administrator determines that such an extension of time is required due to special circumstances, the Claims Administrator will notify the claimant, in writing, of the extension prior to the commencement of the extension, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The Claims Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

Section 7. Notice of Claims Administrator's Decision

The Claims Administrator's notice of its decision to deny a claim will set forth:

A. the specific reasons for the denial;
B. references to specific Plan and provisions of the Plan upon which the denial is based;
C. for a notice involving the Claims Administrator's initial decision on a claim -- a description of any additional material or information necessary for the claimant to perfect his or her claim along with an explanation of why such material or

information is necessary, and an explanation of claim review procedures under the plan and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse decision on review;

D. the specific rule, guideline, or protocol, if any, that was relied on in making the adverse decision, or a statement that the rule, guideline, or protocol will be provided to the claimant free of charge;
E. if the adverse decision is based on a medical necessity or an experimental treatment limit or exclusion, either an explanation of the scientific or clinical judgment for the determination that applies the Plan to the claimant's medical circumstances or a statement that the explanation will be provided free of charge on request;
F. the identity of any medical or vocational experts whose advice was obtained by the Claims Administrator in the process of deciding the claim, regardless of whether Claims Administrator relied upon such advice; and
G. the following statement if the claim involves health care or disability benefits: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local US Department of Labor Office and your State insurance regulatory agency."

Section 8. General Claim Provisions

Notwithstanding anything to the contrary, the following provisions will apply to all claims:

A. Finality of Decisions. The Claims Administrator has full discretion in determining any matter regarding a claim for Benefits or other claims involving the Plan. The decision of the Claims Administrator upon review of any claim shall be binding upon a claimant, his or her heirs and assigns, and all other persons claiming by, through or under a claimant.
B. Limitation of Claims Procedure. Except as otherwise required under and subject to the terms of a Plan, including Cafeteria Plan: Claims Procedure and Plan Funding, any claim under this claims procedure must be submitted **within 12 months** from the earlier of:
    i. the date on which the claimant learned of facts sufficient to enable him to formulate such claim, or
    ii. the date on which the claimant reasonably should have been expected to learn of facts sufficient to enable him to formulate such claim.
C. Limitation on Court Action. Any suit brought to contest or set aside a decision of the Claims Administrator is to be filed in a court of competent jurisdiction within one year from the date of the receipt of written or electronic notice of the Claims Administrator's final decision. Service of legal process shall be made upon the Plan by service upon the agent for service of legal process or upon the Claims Administrator.
D. Legal Action. No legal action to recover Plan benefits or to enforce or clarify rights under the Plan shall be commenced under ERISA Section 502(a)(1)(B), or under any other provision of law, whether or not statutory, until a claimant first exhausts the claims and review procedures available to him or her hereunder.
E. Special Rulings. In order to resolve problems concerning the Plan and to apply the Plan in unusual factual circumstances, the Claims Administrator may make special rulings. Such special rulings will be in writing on a form to be developed by the Claims Administrator. In making its rulings, the Claims Administrator may consult with third party administrators, legal, accounting, investment, and other counsel or advisers. Once made, special rulings shall be applied uniformly, except that the Claims Administrator will not be bound by such rulings in future cases unless the factual situation of a particular case is identical to that involved in the special ruling. Special rulings shall be made in accordance with all applicable law and in accordance with the Plan. It is not intended that the special ruling procedure will be a frequently used device, but that it should be followed only in extraordinary situations. The Claims Administrator at all times will have the final decision as to whether resort will be made to this special ruling feature.
F. Forfeiture of Uncashed Checks. If the Plan (through the Employer, or its third party administrator or insurer) makes payment to you (and/or to your Eligible Dependents or to a provider on your behalf) of an approved benefit claim and the check for such benefit claim remains uncashed (regardless of the reason) for a period of more than one (1) year after the issue date of the check, then you (and/or your Eligible Dependents or the provider) will forfeit all rights for reimbursement or payment of such benefit claim under the terms of Plan and you will not be entitled to reinstate your rights with respect to such benefit claim at anytime thereafter. Also, the Plan generally requires that you submit your initial claim for payment within 12 months after the date of service for benefit claims (or by the earlier deadline with respect to Spending Account Plans). If you submit your claim after the applicable deadline, then you (or your Eligible Dependents or the provider acting on your behalf) will forfeit all rights to payment or reimbursement under the Plan, and the Plan will deny such benefit claim.

Section 9. New Appeal and External Review Claims Procedures for Non-Grandfathered Group Health Plans

If a group health benefit option under this Plan does not have Grandfathered Status, then, effective on the dates established under regulations and other guidance provided by IRS/DOL/HHS, such Plan option must comply with the Consumer Appeal Rights under the Health Care Reform Act, including the following requirements:

A. A claimant shall have the right to the Plan's internal claims and appeal processes for any cancellation or discontinuance of coverage that has retroactive effect.

B. The Plan shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim. Such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the Claims Administrator notifies the claimant of its decision to give the claimant a reasonable opportunity to respond to the Plan prior to that date. Before the Plan can deny a claim based on new or additional rationale, it must provide the claimant, free of charge, a notice of such rationale, which must be sent as soon as possible and sufficiently in advance of the date on which the Claims Administrator notifies the claimant of its decision to provide the claimant a reasonable opportunity to respond prior to that date.

C. The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved with making the claims decisions. Accordingly, the Claims Administrator's decision regarding hiring, compensation, termination, promotion or other similar matters with respect to any claims adjudicator or medical expert, must not be made based upon the likelihood that the individual will support a denial of benefits, contract with a medical expert based on the expert's reputation for outcomes in contested cases other than based on the expert's profession qualifications.

D. Any notice of an adverse benefit determination (i.e. denied claim) must be provided in a culturally and linguistically appropriate manner, as defined in the Health Care Reform Act's related regulations (published at 26 CFR Section54.9815-2719T; 29 CFR Section2590.715-2719; and 45 CFR Section147.136)), which may require notices to be provided in non-English language.

E. Any notice of an adverse benefit determination must include the following information:
   i. date of service;
   ii. the health care provider;
   iii. the claim amount (if applicable);
   iv. a description of how to request the diagnosis and treatment codes with the corresponding meaning of such codes;
   v. the reason(s) for denial must include the denial code and its corresponding meaning;
   vi. a description of the Plan's standard, if any, used in denying the claim;
   vii. a summary of the Claim Administrator's discussion regarding its final decision to deny the claim;
   viii. a description of the available internal appeals and external review processes, including information regarding how to initiate such processes; and
   ix. disclosure of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Health Care Reform Act to assist claimants with the internal claims and appeals and external review processes.

F. If the Plan fails to strictly adhere to all these new claim process requirements set forth above and in related regulations, the claimant shall be deemed to have exhausted the internal claims and appeal process, regardless of whether the Plan asserts that it substantially complied, and the claimant may initiate an external review and pursue any available remedies under applicable law unless the violation was: (a) *de minimis*;(b) non-prejudicial; (c) attributable to good cause or matters beyond the Plan's control; (d) in the context of an ongoing good faith exchange of information; and (e) not reflective of a pattern or practice of non-compliance. In the event that the Plan claims the purported violation is covered under the circumstances described in (a)-(e) of the immediately preceding sentence, the claimant shall be entitled, upon written request, to an explanation of the Plan's basis for asserting that it meets the requirements of (a)-(e) of this subsection, so that the claimant can make an informed judgment about whether to seek immediate review. If an external reviewer or court rejects the claimant's request for immediate review on the basis that the Plan met the standards in (a)-(e), the claimant shall have the right to resubmit and pursue the internal appeal of his or her claim.

G. The Plan shall provide the claimant with continued coverage under the Plan pending the outcome of the internal appeal. For this purpose, the Plan may not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review (as further explained in Article IX).

A Claimant shall have the right to file a request for an independent, external review of the Plan's decision. The Claimant must make this request within 4 months after the date of receipt of notice of an adverse benefit determination or final internal adverse benefit determination. The Plan shall comply with either a State's external review process or the Federal external review process. If a State's external review process applies and is binding on a fully-insured group health option offered under this Plan, and, at a minimum, after December 31, 2011, such process includes the consumer protections in the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010, then the issuer of such fully-insured group health benefit option shall be required to comply with that State's external review process (and the Federal external review process will not apply). A description of the minimum consumer protections under the NAIC Uniform Model Act are set forth in the Health Care Reform Act's related regulations published at 26 CFR Section54.9815-2719T; 29 CFR Section2590.715-2719; and 45 CFR Section147.136, and DOL Technical Release 2010-01, as amended by DOL Technical Release 2011-02. If a State's external review process does not apply to a group health benefit option offered under the Plan (e.g. because the option is a self-funded option or the State's external review does not meet the minimum consumer protections of the NAIC Uniform Model Act after December 31,

2011), then the Federal external review process will apply; provided, however, that claims for which external review has not been initiated before September 20, 2011, such Federal external review shall only apply to claims that involve (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or (2) a rescission of coverage. The Federal external review process is similar to the process set forth under the NAIC Uniform Model Act and is explained in detail under the Health Care Reform Act's related regulations (published at 26 CFR Section54.9815-2719T; 29 CFR Section2590.715-2719; and 45 CFR Section147.136) and DOL Technical Release 2010-01. Generally, all adverse benefit determinations shall be subject to the external review process requirements, except for a decision relating to an individual' s failure to meet the requirements for eligibility under the terms of the Plan (e.g. worker classification and similar issues)

Article XXIV. HIPAA Privacy and Security Rules

Section 1. Introduction

This section only applies to a self funded benefit program that is a group health plan (e.g. the medical, prescription drug, dental, vision and EAP programs).

The Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing privacy and security regulations (collectively referred to as "HIPAA") restrict the Employer's and Plan' s ability to use and disclose certain health information known as "protected health information" ("PHI") and requires that certain security measures be implemented with respect to any electronic PHI.

To the extent subject to HIPAA privacy and security laws, the Plan and the Employer intend to fully comply with HIPAA. However, the Plan and the Employer also intend to comply with the requirements of 45 C.F.R. Section 164.530(k) so that the Plan and the Employer are not subject to most of HIPAA's privacy requirements. The Plan, through the Employer, has entered into insurance contracts and/or third party administrative and business associate agreements with Business Associates to perform all administrative functions on behalf of the Plan, including HIPAA compliance. As a result, the Authorized Employees of the Employer generally will not receive, use, maintain, disclose or transmit PHI or ePHI on behalf of the Plan. The Employer, in its capacity as the employer, typically will have access only to certain enrollment and disenrollment information regarding the Plan's participants (including participant name, social security number and election amount under the Plan) and to Summary Health Information. To the extent that the Employer is subject to HIPAA and its Authorized Employees actually receive, use, maintain, disclose or transmit PHI or ePHI, then the Employer will implement the administrative, technical and other safeguard policies and procedures required by HIPAA and as specified below.

Section 2. Definition

Throughout this Article, various terms are used repeatedly. These terms have specific and definite meanings and generally have been capitalized throughout this Article. Whenever capitalized terms appear, they shall have the meanings specified in HIPAA. HIPAA generally defines PHI and electronic PHI as follows:

- **PHI** includes information that (i) the Plan creates or receives, (ii) relates to the past, present, or future health or medical condition of an individual and, (iii) identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. **Electronic PHI** is PHI that is transmitted by or maintained in electronic media (e.g. memory devices in computers, removable/transportable digital memory medium, etc.).

Section 3. Use and Disclosure of PHI

The Plan can use or disclose PHI only in a manner consistent with HIPAA, which generally is for purposes of Payment and Health Care Operations. Payment generally means activities to obtain and provide reimbursement for the health care provided to an individual, including determinations of eligibility and coverage under the Plan, and other health care utilization review activities. Health Care Operations generally means the support functions related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management, and administrative activities.

PHI also may be used or disclosed as specifically permitted by HIPAA, including the following examples:

A. The Plan may share PHI with government or law enforcement agencies when required to do so or when required to in a court or other legal proceeding;
B. The Plan may share PHI to obey Workers' Compensation laws; and
C. The Plan may share PHI with the individual if the individual requests access to PHI.

Section 4. **Hybrid Entity Election**

The document is a wrap plan document that incorporates by reference separate Plan documents, some of which are group health plans and others are non-group health plans. HIPAA allows entities to elect a "hybrid entity" designation as defined under Section 45 CFR 164.103 of HIPAA. To the extent the Employer has elected such designation, this wrap plan document may be treated as offering both a healthcare component and a non-healthcare component. In this case, the healthcare component of this document consists of the group health plans (e.g. the medical, prescription drug, dental, vision, EAP programs). The non-healthcare component of the Plan consists of other (non-health care) Plans (e.g., disability and life insurance programs, and Cafeteria Plan). The Plan and Employer intend to comply with HIPAA with respect to only the healthcare component of the Plan and to ensure adequate separation between the healthcare component and the non-healthcare component (i.e. such healthcare component and non-healthcare component are separate and distinct plans). In this regard and to the extent required by HIPAA, the Plan and the Employer will ensure compliance with the safeguard requirements relating to hybrid entities as set forth in Section 45 CFR 164.105(a) of HIPAA and in the Plan's HIPAA Privacy Policies and Procedures.

Section 5. **Employer Certification**

The Plan may disclose PHI to the Employer (including certain members of the Employer's workforce) only to perform administrative functions on behalf of the Plan in a manner consistent with HIPAA requirements, and as more fully described in the Employer's HIPAA Privacy and Security Policies and Procedures. In this regard, the Employer adopts and signs the Adoption Agreement as certification to the Plan that the Employer will appropriately safeguard and limit the use and disclosure of PHI that it receives from the Plan only to perform plan administration functions. Specifically, the Employer agrees to:

A. use or further disclose PHI only as permitted by and consistent with this Plan Document and HIPAA;
B. ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to Employer with respect to such information;
C. not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan;
D. report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted by the HIPAA Rule of which it becomes aware;
E. make available information in accordance with the HIPAA Rules regarding individual access to PHI;
F. make available PHI for amendment in accordance with the HIPAA Rules;
G. make available the information required under the HIPAA Rules to provide an accounting of non-routine disclosures to the individual;
H. make internal practices, books, and records relating to PHI available to the Department of Health and Human Services for purposes of determining compliance as required by the HIPAA Rules;
I. if feasible, return or destroy all PHI received from the Plan that Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
J. ensure adequate separation between the Plan and Employer and
K. to the extent it creates, receives, maintains or transmits any electronic PHI on behalf of the Plan, the Employer will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Employer will report to the appointed Security Official any security incident of which it becomes aware, that results in a breach, and it will implement reasonable and appropriate security measures for electronic PHI to ensure that the adequate separation provisions of Section 10.7 are satisfied.

Section 6. **Workforce of the Plan**

The Plan has designated a Privacy and Security Official. The Privacy and Security Official is the privacy and security fiduciary responsible for the Plan's compliance with the HIPAA Privacy and Security Rules. Compliance includes ensuring that appropriate administrative, physical and technical procedures and safeguards are in place to protect PHI and to reasonably and appropriately protect the integrity, confidentiality and availability of any electronic PHI that the Employer creates, receives, maintains or transmit

on behalf of the Plan. This also includes ensuring that certain members of the Employer's Workforce comply with, are trained in and appropriately handle PHI and electronic PHI under the HIPAA Privacy and Security Rules, and understand the sanctions for HIPAA violations.

Certain employees of the Employer whose duties include administrative and management functions on behalf of the Plan also are considered part of the Workforce of the Plan and thus privacy and security fiduciaries of the Plan. Their access to PHI is limited to the minimum necessary information needed to perform administrative functions on behalf of the Plan, including using or disclosing Summary Health Information for the purpose of obtaining premium bids (including bids in connection with the placement of stop loss coverage) or making decisions to modify, amend or terminate the Plan, or enrollment or disenrollment information about participants. The Employer's HIPAA Privacy and Security Policies and Procedures includes a complete listing of the designated employees who serve as members of the Workforce with access to PHI or electronic PHI.

Section 7. **Adequate Separation between the Plan and Employer**

The Employer shall allow access to PHI received from the Plan only to those Workforce members who have been specifically designated by Employer as individuals authorized to access PHI pursuant to the Employer's HIPAA Privacy and Security Policies and Procedures.

No other persons shall have access to PHI. These individuals who have authorized access to PHI only shall use and disclose PHI to the extent necessary to perform the plan administration functions that Employer performs for the Plan. These authorized individuals generally may not use or disclose PHI for purposes of payment, operation or other administrative functions of the Employer's non-group health benefit plans (e.g. disability, life insurance, workers compensation, dependent day care spending account plans etc.) or of any other non-plan activity such as employment related decisions without individual authorization. The Employer will ensure that the adequate separation between the Plan and Employer is supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

Section 8. **Violations of Privacy or Security Rules**

If Employer becomes aware of violations of these HIPAA privacy or security rules, it shall arrange for the HIPAA Privacy or Security Officer appointed by Employer to consult with the person who has violated the privacy or security rules with respect to his or her obligations under the privacy or security rules. A person who violates these privacy or security rules may be subject to discipline up to and including discharge. The Employer also shall comply with any notice requirements regarding breach of Unsecured PHI, as set forth in the Employer's HIPAA Privacy and Security Policies and Procedures.

Section 9. **Individual Rights**

The Plan will provide Participants with certain individual rights to access, amend, account for or restrict uses or disclosures of PHI, as more fully described in the Plan's Notice of Privacy Practice and HIPAA, attached as Appendix B.

Article XXV. Procedures for Qualified Medical Child Support Orders

A. Procedure

Except in the case of a National Medical Support Notice as described in Section A.5, if the Plan receives a Medical Child Support Order (as hereinafter defined), the following procedures shall apply with respect to group health plans of the Employer:

i. The Plan Administrator will promptly notify the Participant and each Alternate Recipient (as hereinafter defined) of the Plan's receipt of such order, of the Plan's procedures for determining whether a Medical Child Support Order is a Qualified Medical Child Support Order, and of the right of the Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.
ii. Within a reasonable period after receipt of such order, the Plan Administrator shall determine whether such order is a Qualified Medical Child Support Order and notify the Participant and each Alternate Recipient of such determination. In making such determination, the Plan Administrator may, in its sole discretion, apply to a court of competent jurisdiction for its determination.
iii. Any determination of the Plan Administrator shall be subject to the Claim and Claims Review Procedures under the Plan.

B. Effect of Determination.

If the Plan Administrator determines that a Medical Child Support Order is a Qualified Medical Child Support Order or a National Medical Support Notice is deemed to be a Qualified Medical Child Support Order as described in Section A.5, then:

i. The Alternate Recipient shall be considered a Dependent Child of the Participant under the Plan.
ii. Any payment for benefits in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian (or the provider, with the approval of the custodial parent or guardian). A payment of benefits to an official of a State or political subdivision thereof whose address has been substituted for the address of the Alternate Recipient, shall be treated as payment of benefits to the Alternate Recipient for purposes hereof.
iii. The Alternate Recipient shall be considered a Participant of the Plan for purposes of the reporting and disclosure requirements of Part 1 of ERISA.
iv. Except as provided in Section A.5, coverage of the Alternate Recipient shall be effective as of the latest of:
    1. the first day of the month specified in the Order;
    2. the first day of the month following the determination by the Plan Administrator; or
    3. the earlier of (A) the first day of the month following the receipt by the Plan of the first premium payment required for coverage, if any, or (B) the effective date of a court or administrative order requiring the Employer to withhold from the Participant' s compensation, the Participant' s share, if any, of premiums for health coverage and to pay such share of premiums to the Plan.
v. If the Plan and any fiduciary under the Plan acts in accordance with the provisions of these procedures in treating a medical child support order as being (or not being) a Qualified Medical Child Support Order, the Plan's obligation to the Participant and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

C. Special Eligibility Rules for Qualified Medical Child Support Orders.

Solely for purposes of determining if an Order is a Qualified Medical Child Support Order under these procedures:

i. The definition of Dependent Children in the Plan shall not be deemed to exclude from health coverage under the Plan:
    1. A Child born out of wedlock;
    2. A Child not claimed as a dependent on the Participant's Federal income tax return; or
    3. A Child that does not reside with the Participant;

    but only if a Qualified Medical Child Support Order is in effect for such Child which requires the Participant, the other parent or a State Agency to pay 100% of the cost of health coverage for such child, through withholding from the Participant's compensation or otherwise.

ii. If any Qualified Medical Child Support Order requires a participant to provide health coverage for an Alternate Recipient:
    1. Such Participant may enroll such Alternate Recipient for family coverage pursuant to the procedures under the Plan.
    2. If the Participant is enrolled but fails to make application to obtain coverage of such Alternate Recipient, such Alternate Recipient shall be enrolled in family coverage upon application by the Alternate Recipient's other parent or by the State Agency administering the program under Subchapter XIX or Part D of Subchapter IV of Chapter 17 of Title XIX of the Social Security Act (42 U.S.C.A. Section 1396 et seq.) (the "Social Security Act").

D. Termination of Coverage

Except to the extent required by law (e.g. COBRA), coverage for an Alternate Recipient will terminate:

i. When the Qualified Medical Child Support Order is no longer in effect;
ii. When the Alternate Recipient's age exceeds the maximum age under which a Dependent Child may participate under the Plan;
iii. When the Employer is provided written evidence that the Alternate Recipient is or will be enrolled in comparable health coverage which will take effect not later than the effective date of such disenrollment; or
iv. The Employer has eliminated family health coverage for all of its employees.

E. National Medical Support Notice.

i. If the Plan Administrator receives an appropriately completed National Medical Support Notice promulgated pursuant to section 401(b) of the Child Support Performance and Incentive Act of 1998 (the "Child Support Act")

with respect to a Child of a noncustodial parent, and the Notice meets the requirements of Section A.6(d)(2) hereunder, the Notice shall be deemed to be a Qualified Medical Child Support Order in the case of such Child.

ii. In any case in which an appropriately completed National Medical Support Notice is issued with respect to a Child of a Participant who is such Child's noncustodial parent, and the Notice is deemed under subsection (a) to be a Qualified Medical Child Support Order, the Plan Administrator, within 40 business days after the date of the Notice, shall:
    1. Notify the State agency issuing the Notice with respect to such Child whether coverage of the Child is available under the terms of the Plan and, if so, whether such Child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a State or political subdivision thereof substituted for the name of such Child) to effectuate the coverage; and
    2. Provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

iii. Nothing in this Section shall be construed as requiring the Plan, upon receipt of a National Medical Support Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before receipt of such notice.

iv. A noncustodial parent shall be liable to the Plan for employee contributions required under the Plan for enrollment of the Child, unless such noncustodial parent properly contests such enforcement based on a mistake of fact.

F. Definitions.

For purposes of these procedures, the following definitions shall be applicable:

i. "Alternate Recipient" means any Child of an employee of the Employer who is recognized under a medical child support order as having a right to enrollment under the Plan with respect to such Employee.

ii. "Child" includes any child adopted by or placed for adoption with the Participant.

iii. "Medical Child Support Order" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or an authorized government agency which:
    1. provides for child support with respect to a Child of a Participant under the Plan or provides for health benefit coverage to such a Child, is made pursuant to a state domestic relations law (including community property law), and relates to group health benefits under the Plan, or
    2. enforces a law relating to medical child support described in Section 1396g of Title XIX of the Social Security Act with respect to the group health benefit under the Plan.

iv. "Qualified Medical Child Support Order" means a Medical Child Support Order which:
    1. creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive health benefits for which a Participant or Beneficiary is eligible under the group health provisions of the Plan, and
    2. meets the following requirements:
        a. clearly specifies the name and last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order.
        b. clearly specifies a reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined,
        c. clearly specifies the period to which such order applies,
        d. clearly specifies each plan to which such order applies, and
        e. does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1396g of Title XIX of the Social Security Act.

Article XXVI. Notice of Privacy Practices for Group Health Plans

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

Article XXVII. Introduction

The Employer sponsors and maintains the group health plans specified in the Adoption Agreement (collectively referred to as the "Plan"). The Privacy Rules under the Health Insurance Portability and Accountability Act ("HIPAA") generally restrict the ability to use and disclose certain health or medical information about you that is created or received by the Plan with respect to these health care benefit programs or by the Employer in connection with such health care benefit programs.

The Plan is required to provide this Notice of Privacy Practice (the "Notice") to you pursuant to HIPAA. This Notice describes how medical information about you may be used or disclosed by the Plan or by others that assist in the administration of Plan claims. This Notice also describes your legal rights regarding your medical information held by the Plan. References to the Plan throughout this Notice taking certain actions also shall mean the Employer, as plan sponsor of the Plan.

Section 1. **Contact Person**

If you have any questions about this Notice, please contact the HIPAA Privacy Officer listed in the Adoption Agreement.

Section 2. **Protected Health Information**

The HIPAA Privacy Rules protect only certain medical information known as "protected health information ("PHI"). Generally, PHI is individually identifiable health information, including demographic information, collected from you or received by a health care provider, a health care clearinghouse, a health plan or your employer on behalf of a group health plan, that relates to:

A. your past, present or future physical or mental health or condition;
B. the provision of health care to you; or
C. the past, present or future payment for the provision of health care to you.

Section 3. **Effective Date**

This Notice is originally effective April 1, 2004, and has been amended and restated on several occasions, most recently effective February 17, 2009.

Section 4. **Our Pledge and Responsibilities Regarding PHI**

We understand that PHI about you and your health is personal and the Plan is committed to protecting PHI. The Plan is required by law to satisfy the following responsibilities with respect to any PHI created or received by the Plan:

- Maintain the privacy of your PHI;
- Provide you with certain rights with respect to your PHI;
- Give you this Notice of the Plan's legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the Notice that is currently in effect.

Section 5. **How the Plan May Use and Disclose Medical Information About You**

Under law, the Plan may use or disclose your PHI under certain circumstances without your permission. The following categories describe different ways that the Plan may use and disclose PHI. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category is listed. However, all of the ways the Plan is permitted to use and disclose PHI will fall within one of the categories.

For Treatment. The Plan may use or disclose your PHI to facilitate medical treatment or services by providers. The Plan may disclose PHI about you to providers, including doctors, nurses, technicians, medical students or other hospital personnel, who are involved in taking care of you. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contra indicate a pending prescription.

For Payment. The Plan may use and disclose PHI about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational or medically necessary or to determine whether the Plan will cover the treatment. The Plan also may share PHI with a utilization review or precertification service provider. Likewise, the Plan may share PHI with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

The Plan may release PHI about you to a family member, friend or other person who is involved in your medical care or payment for

your medical care, unless you tell us not to release such information.

For Health Care Operations. The Plan may use and disclose PHI about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use PHI in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

To the extent required under HIPAA regulations, protected health information includes genetic information and, notwithstanding any permitted uses or disclosures, the Plan generally may not use or disclose genetic information for underwriting purposes.

To Business Associates. The Plan may contract with individuals or entities known as Business Associates to perform various functions or to provide certain types of services on the Plan's behalf. In order to perform these functions or provide these services, Business Associates will receive, create, maintain, use and/or disclose your PHI, but only if they agree in writing with the Plan to implement appropriate safeguards regarding your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide support services, such as utilization, management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with the Plan.

As Required by Law. The Plan will disclose PHI about you when required to do so by federal, state or local law. For example, the Plan may disclose PHI when required by a court order in a litigation proceeding, such as a malpractice action.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose PHI about you in a proceeding regarding the licensure of a physician.

To Plan Sponsor (i.e. the Employer). For the purpose of administering the Plan, PHI may be disclosed to certain employees of the Employer. However, those employees will only use or disclose that PHI only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further uses or disclosures. Your PHI cannot be used for employment related purposes without your specific, written authorization. Information also may be disclosed to another health plan maintained by the Employer for purposes of facilitating claim payments under that health plan.

Section 6. Special Situations

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your PHI. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, the Plan may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release PHI about you as required by military command authorities. The Plan also may release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release PHI about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Plan may disclose PHI about you for public health activities. The activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic

violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan may disclose PHI about you in response to a court or administrative order. The Plan also may disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release PHI if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person' s agreement;
- About a death we believe may be the result of criminal conduct; and
- About criminal conduct.

Coroners, Medical Examiners and Funeral Directors. The Plan may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Section 7. Required Disclosures

The following is a description of disclosures of your PHI the Plan is required to make:

Government Audits. The Plan is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy rule.

Disclosures to You. When you request, the Plan is required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan also is required, when requested, to provide you with an accounting of most disclosures of your PHI where the disclosure was for reasons other than for payment, treatment or health care operations, and where the PHI was not disclosed pursuant to your individual authorization.

Section 8. Other Disclosures

Personal Representatives. The Plan will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney in fact, etc., as long as you provide the Plan with a written notice/authorization and any supporting documents (e.g. durable power of health care attorney). Note that under HIPAA privacy rule, the Plan does not have to disclose PHI to a personal representative if we have a reasonable belief that:

A. you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
B. treating such person as your personal representative could endanger you; or
C. in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, the Plan will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below "Your Rights"), and the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your PHI not described above will only be made with your written authorization. You may revoke written authorization at any time, as long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 9. Your Rights

You have the following rights regarding PHI that the Plan maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to the Contact Person listed above. If you request a copy of the information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. To the extent required under the Health Information Technology for Economic and Clinical Health Act which is part of the American Recovery and Reinvestment Act of 2009 and related regulations issued thereunder (collectively referred to as "HITECH"), on and after February 17, 2010, if the Plan uses or maintains an electronic health record of your PHI, you shall have the right to obtain from the Plan, upon written request, a copy of such information in an electronic format, and, if you choose, to direct the Plan to transmit such copy to an entity or person designated by you, provided that any such choice is clear, conspicuous and specific.

The Plan may deny your request to inspect and copy PHI in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed by submitting a written request to the Contact Person listed above.

Right to Amend. If you believe that PHI the Plan has about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Contact Person listed above. In addition, you must provide the reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask us to amend information that:

- Is not part of the PHI kept by or for the Plan;
- Was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is already accurate and complete.

If the Plan denies your request, you have the right to file a statement of disagreement with the Plan and any future disclosure of the disputed information will include your statement. File this statement with the Contact Person listed above.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your PHI. The accounting generally will not include (1) disclosures made for purposes of treatment, payment or health care operations, (2) disclosures made to you, (3) disclosures made pursuant to your authorization, (4) disclosures made to friends or family in your presence or because of an emergency, (5) disclosures for national security purposes, and (6) disclosures incidental to otherwise permissible disclosures. However, to the extent required under HITECH, certain disclosures to carry out treatment, payment or health care operations which are maintained in electronic health records may need to be included in the accounting of disclosures beginning on the effective date set forth in HITECH (please call the Contact Person if you would like additional information regarding such accounting rights under the applicable guidance).

To request this list of accounting of disclosures, you must submit your request, in writing, to the Contact Person listed above. Your request must state a time period which may not be longer than six years and may not include dates before April 1, 2004. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12 month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI the Plan discloses about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

The Plan is not required to agree to your request, except in limited case of self-payment. Effective on and after February 17, 2010, your request for restriction is required to be honored to the extent required by HITECH when the disclosure is to a group health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment) and the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full by you.

To request restrictions, you must make your request in writing to the Contact Person listed above. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Contact Person listed above. The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your PHI could endanger you. Your request must specify how or where you wish to be contacted.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask the Plan to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

To obtain a paper copy of this Notice, contact the Contact Person listed above.

Section 10. Changes to This Notice

The Plan reserves the right to change the terms of this Notice and to make new provisions regarding your protected health information that the Plan maintains, as allowed or required by law. The Plan reserves the right to make the revised or changed Notice effective for PHI the Plan already has about you as well as any information the Plan receives in the future. If the Plan makes any material change to this Notice, you will be provided with a copy of a revised Notice of Privacy Practices either by mail or electronically.

Section 11. Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Office of Civil Rights. Complaints to the Plan must be submitted in writing to the Contact Person listed above.

A complaint to the Office of Civil Rights should be sent to Office for Civil Rights,
U.S. Department of Health & Human Services, 233 N. Michigan Ave. - Suite 240,
Chicago, IL 60601, (312) 886-2359; (312) 353-5693 (TDD), (312) 886-1807 (fax).
You also may visit OCR's website at: http://www.hhs.gov/ocr/privacyhowtofile.htm, for more information.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Plan or the Office of Civil Rights.

Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

BCN HMO SM Gold $1000/20%

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract**. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo**. Select ***Approving covered services.***

Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

Note: The Deductible will apply to certain services as defined below.

Deductible **Note:** Coinsurance and select fixed dollar copays apply once the deductible has been met.	$1,000 per individual/$2,000 per family per calendar year
Fixed dollar copays **Note:** If you have a deductible, the deductible must be met first for certain services as listed below.	$20 for office visits, $40 for specialist visits, $50 for urgent care visits, $250 for emergency room visits, $150 for high tech imaging and $5 for allergy injections
Coinsurance	20% and 50% for select services as noted below
Annual Coinsurance Maximum – The following services DO NOT apply to the Annual Coinsurance Maximum if they are included in your coverage: • Deductible amounts • Services with a flat dollar copay • Infertility services • Male Mastectomy • Reduction Mammoplasty • Male Sterilization • Elective Abortion • TMJ • Orthognathic Surgery • Weight Reduction procedures • Durable Medical Equipment • Prescription Drugs • Prosthetics and Orthotics • Diabetic Supplies	$3,500 per member/$7,000 per family per calendar year
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug cost-sharing amounts	$8,150 per member/$16,300 per family per calendar year

Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine Colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits **Note:** Applicable cost sharing applies when other services are received in the office	Covered – $20 copay
Medical Online Visits	Covered – 100%
Consulting Specialist Care – when referred for other than preventive services **Note:** Applicable cost sharing applies when other services are received in the office	Covered – $40 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – $250 copay after deductible
Urgent Care Center	Covered – $50 copay
Retail Health Clinic	Covered – $50 copay
Ambulance Services – medically necessary	Covered – 80% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%
Diagnostic Tests and X-rays	Covered – 80% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered – $150 copay after deductible
Radiation Therapy	Covered – 80% after deductible

Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – $20 copay
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible when authorized
Home Health Care	Covered – $40 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50% after deductible
Elective Abortion (One procedure per two-year period of membership)	Not Covered
Human Organ Transplants (subject to medical criteria)	Covered – 80% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) –	Covered – 50% after deductible

Limited to one procedure per lifetime	

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)

Inpatient Mental Health Care and Substance Use Disorder	Covered – 80% after deductible
Outpatient Mental Health Care includes online visits **Note:** For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	Covered – $20 copay
Outpatient Substance Use Disorder	Covered – $20 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment through age 18 **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCN approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered – $20 copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18 Unlimited visits for physical, speech and occupational therapy with autism spectrum disorder diagnosis	Covered – $40 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visits and preventive benefit

Other Services

Allergy Testing and serum	Covered – 50% after deductible
Allergy Office Visits	Covered – 50%
Allergy Injections	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $40 copay; up to 30 visits per calendar year
Rehabilitative Services – subject to meaningful improvement within 90 days • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – $40 copay after deductible
Habilitative Services • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – $40 copay after deductible
Outpatient Cardiac and Pulmonary Rehabilitation	Covered – $40 copay after deductible; limited to a benefit maximum of 30 visits per calendar year
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Diabetic Supplies Note: Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.	Covered – 80%
Pediatric Vision • Eye Exam – Limited to once per calendar year through the last day of the year in which an individual turns age 19 • Prescription Glasses – Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which an individual turns age 19	Covered – 100%

Prescription Drugs

Tier 1A – Value Generics	Covered – $15 copay
Tier 1B – Generics	Covered – $40 copay
Tier 2 Preferred Brand	Covered – $80 copay
Tier 3 Non-Preferred Brand	Covered – $100 copay
Tier 4 Preferred Specialty	Covered – 20% Coinsurance of the BCN Approved Amount (Maximum Copayment $200) - Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Tier 5 Non-Preferred Specialty	Covered – 20% Coinsurance of the BCN Approved Amount (Maximum Copayment $300) – Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Drugs for sexual dysfunction, weight loss, cough & cold	Not Covered
Diabetic Supplies	Select diabetic supplies and equipment are covered – applicable cost sharing will apply. Cost-sharing may not apply to certain preferred glucometers as defined on the drug list.
Contraceptives	Covered – Tier 1A – 100% , Tier 1B – $40 copay, Tier 2 - $80 copay, Tier 3 - $100 copay
Preventive Drugs	Covered – 100%
90 Day Retail: 84-90 day supply	Covered – Three times applicable copay minus $10
Out-of-Pocket Maximum	Applies to deductibles, copays and coinsurance amounts for all covered medical and prescription drug services. **Note:** When a manufacturer coupon is used through the BCN high cost drug discount program, the amount paid after the discount applies toward the out- of-pocket maximum.

CLSSSM, D1000, WDRPOV, CI20%, 35ECM, 8150PM, CO20, 40RP, ER250, UR50, IMG150, DSR20%, ONVCW, PVSN, 1548CS, 90D3X, RXVAR

Optional Rider:

- VACR50 – Elective Abortion 50% Coinsurance Rider

Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

BCN HMO SM Silver $4000

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract**. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo**. Select ***Approving covered services.***

Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

Note: The Deductible will apply to certain services as defined below.

Deductible **Note:** Coinsurance and select fixed dollar copays apply once the deductible has been met.	$4,000 per individual/$8,000 per family per calendar year
Fixed dollar copays **Note:** If you have a deductible, the deductible must be met first for certain services as listed below.	$40 for office visits, $60 for specialist visits, $60 for urgent care visits, $250 for emergency room visits, $150 for high tech imaging and $5 for allergy injections
Coinsurance	30% and 50% for select services as noted below
Annual Coinsurance Maximum	None
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug cost-sharing amounts	$8,150 per member/$16,300 per family per calendar year

Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine Colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits **Note:** Applicable cost sharing applies when other services are received in the office	Covered – $40 copay
Medical Online Visits	Covered – 100%
Consulting Specialist Care – when referred for other than preventive services **Note:** Applicable cost sharing applies when other services are received in the office	Covered – $60 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – $250 copay after deductible
Urgent Care Center	Covered – $60 copay
Retail Health Clinic	Covered – $60 copay
Ambulance Services – medically necessary	Covered – 70% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%
Diagnostic Tests and X-rays	Covered – 70% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered – $150 copay after deductible
Radiation Therapy	Covered – 70% after deductible

Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – $40 copay
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 70% after deductible; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 70% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 70% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible when authorized
Home Health Care	Covered – $60 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 70% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50% after deductible
Elective Abortion (One procedure per two-year period of membership)	Not Covered
Human Organ Transplants (subject to medical criteria)	Covered – 70% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment

Inpatient Mental Health Care and Substance Use Disorder	Covered – 70% after deductible
Outpatient Mental Health Care includes online visits **Note:** For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	Covered – $40 copay
Outpatient Substance Use Disorder	Covered – $40 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment through age 18 **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCN approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered – $40 copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18 Unlimited visits for physical, speech and occupational therapy with autism spectrum disorder diagnosis	Covered – $60 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visits and preventive benefit

Other Services

Allergy Testing and serum	Covered – 50% after deductible
Allergy Office Visits	Covered – 50%
Allergy Injections	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $60 copay; up to 30 visits per calendar year
Rehabilitative Services – subject to meaningful improvement within 90 days • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – $60 copay after deductible
Habilitative Services • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – $60 copay after deductible
Outpatient Cardiac and Pulmonary Rehabilitation	Covered – $60 copay after deductible; limited to a benefit maximum of 30 visits per calendar year
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Diabetic Supplies Note: Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.	Covered – 70%
Pediatric Vision • Eye Exam – Limited to once per calendar year through the last day of the year in which an individual turns age 19 • Prescription Glasses – Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which an individual turns age 19	Covered – 100%

Prescription Drugs

Tier 1A – Value Generics	Covered – $15 copay
Tier 1B – Generics	Covered – $40 copay
Tier 2 Preferred Brand	Covered – $80 copay
Tier 3 Non-Preferred Brand	Covered – $100 copay
Tier 4 Preferred Specialty	Covered – 20% Coinsurance of the BCN Approved Amount (Maximum Copayment $200) - Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Tier 5 Non-Preferred Specialty	Covered – 20% Coinsurance of the BCN Approved Amount (Maximum Copayment $300) – Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Drugs for sexual dysfunction, weight loss, cough & cold	Not Covered
Diabetic Supplies	Select diabetic supplies and equipment are covered – applicable cost sharing will apply. Cost-sharing may not apply to certain preferred glucometers as defined on the drug list.
Contraceptives	Covered – Tier 1A – 100% , Tier 1B – $40 copay, Tier 2 - $80 copay, Tier 3 - $100 copay
Preventive Drugs	Covered – 100%
90 Day Retail: 84-90 day supply	Covered – Three times applicable copay minus $10
Out-of-Pocket Maximum	Applies to deductibles, copays and coinsurance amounts for all covered medical and prescription drug services. **Note:** When a manufacturer coupon is used through the BCN high cost drug discount program, the amount paid after the discount applies toward the out- of-pocket maximum.

CLSSSM, D4000, WDRPOV, CI30%, 8150PM, CO40, 60RP, ER250, UR60, IMG150, DSR30%, ONVCW, PVSN, 1548CS, 90D3X, RXVAR

Optional Rider:

- VACR50 – Elective Abortion 50% Coinsurance Rider

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Simply Blue℠ HSA PPO Bronze $6900 0% with Rx Drug
Simply Blue PPO HSA℠ SG with Rx
Benefits-at-a-glance
Effective for groups on their plan year

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo**. Select ***Approving covered services.***

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician **must** contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Benefits	In-network	Out-of-network
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage.	$6,900 per member, $13,800 for the family (when two or more members are covered under your contract) **(no 4th quarter carry-over)**	$13,800 per member, $27,600 for the family (when two or more members are covered under your contract) **(no 4th quarter carry-over)**
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for bariatric surgery	• 20% of approved amount for most other covered services • 50% of approved amount for bariatric surgery
Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$6,900 per member, $13,800 for the family (when two or more members are covered under your contract)	$15,800 per member, $31,600 for the family (when two or more members are covered under your contract)
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

Benefits	In-network	Out-of-network
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	80% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Routine screening colonoscopy	100% (no deductible or copay/coinsurance), for routine colonoscopy **Note:** Medically necessary colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance, if applicable.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered.	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Benefits	In-network	Out-of-network
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services - must be medically necessary	100% after in-network deductible	100% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	100% after in-network deductible	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Note: Nonemergency services must be rendered in a **participating** hospital.		
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 90 days per member per calendar year	

Benefits	In-network	Out-of-network
Hospice care	100% after in-network deductible	100% after in-network deductible
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	100% after in-network deductible	100% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	100% after in-network deductible	80% after out-of-network deductible
Elective abortions	Not covered	Not covered
Bariatric surgery	50% after in-network deductible	50% after out-of-network deductible
	Limited to a **lifetime** maximum of one bariatric procedure per member	

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	

Benefits	In-network	Out-of-network
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential treatment facility • treatment **must** be preauthorized • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a non-BCBSM selected vendor are not covered	100% after in-network deductible	80% after out-of-network deductible
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	100% after in-network deductible	100% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after in-network deductible	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Rehabilitative care: • Outpatient physical and occupational therapy	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.

Benefits	In-network	Out-of-network
• Chiropractic and osteopathic manipulation	100% after in-network deductible	80% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year **Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy.**	
Outpatient speech therapy - when provided for rehabilitative care	100% after in-network deductible	80% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year	
Habilitative care: Outpatient physical and occupational therapy (excludes chiropractic and osteopathic manipulation)	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a 30-visit maximum per member per calendar year **Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical and occupational therapy**	
Outpatient speech therapy - when provided for habilitative care	100% after in-network deductible	80% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year	
Durable medical equipment **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	100% after in-network deductible	80% after out-of-network deductible
Prosthetic and orthotic appliances **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	100% after in-network deductible	80% after out-of-network deductible
Private duty nursing care	Not covered	Not covered

Simply Blue℠ HSA PPO Bronze $6900 0% with Rx Drug
Prescription Drug Coverage
Benefits-at-a-glance
Effective for groups on their plan year

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. AllianceRx Walgreens Prime will handle mail order prescriptions only for specialty drugs. You may obtain specialty drugs through a Walgreens retail pharmacy as well as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. ***If you go to a non-AllianceRx Walgreens Prime, you may be responsible for 100% of the cost of the specialty drug.*** Other mail order prescriptions for non-specialty medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a **90-Day Retail Network provider or** mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the initial quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at **bcbsm.com/pharmacy**.

Member's responsibility (copays and coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until after you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The 20% member liability for covered drugs obtained from an out-of-network pharmacy will not contribute to your annual out-of-pocket maximum.

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic drugs	1 to 30-day period	After deductible, you pay nothing.	After deductible, you pay nothing.	After deductible, you pay nothing.	After deductible, you pay 20% coinsurance plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay nothing.	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible, you pay nothing.	No coverage	No coverage
	84 to 90-day period	After deductible, you pay nothing.	After deductible, you pay nothing.	No coverage	No coverage

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 2 - Preferred brand-name drugs	1 to 30-day period	After deductible, you pay nothing.	After deductible, you pay nothing.	After deductible, you pay nothing.	After deductible, you pay 20% coinsurance plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay nothing.	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible, you pay nothing.	No coverage	No coverage
	84 to 90-day period	After deductible, you pay nothing.	After deductible, you pay nothing.	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	After deductible, you pay nothing.	After deductible, you pay nothing.	After deductible, you pay nothing.	After deductible, you pay 20% coinsurance plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay nothing.	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible, you pay nothing.	No coverage	No coverage
	84 to 90-day period	After deductible, you pay nothing.	After deductible, you pay nothing.	No coverage	No coverage
Tier 4 - Generic and preferred brand-name specialty drugs	1 to 30-day period	After deductible, you pay nothing.	After deductible, you pay nothing.	After deductible, you pay nothing.	After deductible, you pay 20% coinsurance plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage
Tier 5 - Nonpreferred brand-name specialty drugs	1 to 30-day period	After deductible, you pay nothing.	After deductible, you pay nothing.	After deductible, you pay nothing.	After deductible, you pay 20% coinsurance plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA.	100% of approved amount	No coverage	100% of approved amount	80% of approved amount
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug plus an additional 20% prescription drug out-of-network penalty
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers

Features of your prescription drug plan

BCBSM Custom Select Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Select Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay for these drugs. • **Tier 4 (generic and preferred brand-name specialty)** - Tier 4 includes covered specialty drugs listed as generic drugs (Tier 1) or preferred brand-name drugs (Tier 2) from the Custom Select Drug List. These drugs have a proven record for safety and effectiveness, and offer the best value to our members. They have the lowest specialty drug copay. • **Tier 5 (nonpreferred brand-name specialty)** - Tier 5 includes covered specialty drugs listed as nonpreferred brand name (Tier 3). These drugs may not have a proven record for safety or their clinical value may not be as high as the specialty drugs in Tier 4. They have the highest specialty drug copay.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Exclusions	The following drugs are not covered: • Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service • State-controlled drugs • Brand-name drugs that have a generic equivalent available • Drugs to treat erectile dysfunction and weight loss • Prenatal vitamins (prescribed and over-the-counter) • Brand-name drugs used to treat heartburn • Compounded drugs, with some exceptions • Cosmetic drugs

Simply Blue℠ HSA PPO Bronze $6900 0% with Rx Drug
Vision Coverage (Pediatric)
Benefits-at-a-glance
Effective for groups on their plan year

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

Note: Vision benefits are only available to members up to age 19. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Member's responsibility (copays)

Benefits	In-network	Out-of-network
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses	None	None

Eye exam

Benefits	In-network	Out-of-network
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	100% of approved amount	Reimbursement up to $34 (member responsible for any difference)
	One eye exam per calendar year	

Lenses and Frames

Benefits	In-network	Out-of-network
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	One pair of lenses, with or without frames, per calendar year	
Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.		
Standard frames from a "select" collection	100% of approved amount	Reimbursement up to $38.25 (member responsible for any difference)
	One frame per calendar year	

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Contact Lenses

Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to $210 (member responsible for any difference)
	Covered - annual supply	
Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply)	100% of approved amount	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Covered according to quantities outlined in your certificate, per calendar year	

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Simply Blue℠ PPO Gold $1500 with Rx Drug
Simply Blue PPO℠ SG
Benefits-at-a-glance
Effective for groups on their plan year

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Specialty Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo**. Select *Approving covered services*.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility**.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing

Benefits	In-network	Out-of-network
Deductibles	$1,500 for one member, $3,000 for the family (when two or more members are covered under your contract) each calendar year	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $30 copay for office visits and office consultations with a **primary care physician** • $50 copay for office visits and office consultations with a **specialist** • $30 copay for chiropractic and osteopathic manipulative therapy • $250 copay for emergency room visits • $60 copay for urgent care visits	• $250 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 20% of approved amount for most other covered services • 50% of approved amount for bariatric surgery	• 40% of approved amount for most other covered services • 50% of approved amount for bariatric surgery
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays and prescription drug cost-sharing amounts	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year	$2,000 for one member, $4,000 for the family (when two or more members are covered under your contract) each calendar year **Note**: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.
Annual out-of-pocket maximums - applies to deductibles, copays and coinsurance amounts for all covered services - including prescription drugs cost-sharing amounts	$6,600 for one member, $13,200 for the family (when two or more members are covered under your contract) each calendar year	$13,200 for one member, $26,400 for the family (when two or more members are covered under your contract) each calendar year **Note**: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note**: Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note**: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Benefits	In-network	Out-of-network
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	• $30 copay for each office visit with a **primary care physician** • $50 copay for each office visit with a **specialist** **Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered.	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	• $30 copay for each office consultation with a **primary care physician** • $50 copay for each office consultation with a **specialist** **Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible

Urgent care visits

Benefits	In-network	Out-of-network
Urgent care visits - must be medically necessary	$60 copay for each urgent care visit **Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$250 copay per visit (copay waived if admitted)	$250 copay per visit (copay waived if admitted)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care	80% after in-network deductible	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible Unlimited days	60% after out-of-network deductible

Note: Nonemergency services must be rendered in a **participating** hospital.

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Benefits	In-network	Out-of-network
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization-consult with your doctor	80% after in-network deductible	80% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males **Note**: For voluntary sterilizations for females, see **"Preventive care services."**	80% after in-network deductible	60% after out-of-network deductible
Elective abortions	Not covered	Not covered
Bariatric surgery	50% after in-network deductible	50% after out-of-network deductible
	Limited to a **lifetime** maximum of one bariatric procedure per member	

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**

Benefits	In-network	Out-of-network
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit, we will process the claim under your office visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment must be preauthorized • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a non-BCBSM selected vendor are not covered	80% after in-network deductible	60% after out-of-network deductible
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	80% after in-network deductible	80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Rehabilitative care: • Outpatient physical and occupational therapy	80% after in-network deductible	60% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered.
• Chiropractic and osteopathic manipulation	$30 copay per visit	60% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year **Note: This 30-visit outpatient maximum is a <u>combined</u> maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy.**	
Outpatient speech therapy - when provided for rehabilitative care	80% after in-network deductible	60% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year	
Habilitative care: Outpatient physical and occupational therapy (excludes chiropractic and osteopathic manipulation)	80% after in-network deductible	60% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a 30-visit maximum per member per calendar year **Note: This 30-visit outpatient maximum is a <u>combined</u> maximum for all outpatient visits for physical and occupational therapy**	
Outpatient speech therapy - when provided for habilitative care	80% after in-network deductible	60% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year	
Durable medical equipment **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	80% after in-network deductible	60% after out-of-network deductible
Prosthetic and orthotic appliances **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	80% after in-network deductible	60% after out-of-network deductible
Private duty nursing care	Not covered	Not covered

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Simply Blue℠ PPO Gold $1500 with Rx Drug
Prescription Drug Coverage
Benefits-at-a-glance
Effective for groups on their plan year

Prescription Drug Discount Program - Prescription drug manufacturers provide coupon programs for certain medications. Your benefit plan allows you to take advantage of BCBSM-approved coupon programs for select medications. This benefit may lower the cost-sharing typically required for these drugs. Your out-of-pocket expense will be no more than your benefit cost-sharing. When a manufacturer coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.

NOTE: Adjustments may be required to accurately reflect your annual out-of-pocket maximum to reflect your true out-of-pocket cost.

This program may be discontinued at any time if it is no longer supported by the vendor.

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. AllianceRx Walgreens Prime will handle mail order prescriptions only for specialty drugs. You may obtain specialty drugs through a Walgreens retail pharmacy as well as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. ***If you go to a non-AllianceRx Walgreens Prime, you may be responsible for 100% of the cost of the specialty drug.*** Other mail order prescriptions for non-specialty medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a **90-Day Retail Network provider or** mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the initial quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at **bcbsm.com/pharmacy**.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copays and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The 25% member liability for covered drugs obtained from an out-of-network pharmacy will **not** contribute to your annual out-of-pocket maximum.

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic drugs	1 to 30-day period	You pay $20 copay	You pay $20 copay	You pay $20 copay	You pay $20 copay plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $40 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $50 copay	No coverage	No coverage

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Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	84 to 90-day period	You pay $50 copay	You pay $50 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay $60 copay	You pay $60 copay	You pay $60 copay	You pay $60 copay plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $120 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $170 copay	No coverage	No coverage
	84 to 90-day period	You pay $170 copay	You pay $170 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay $80 or 50% of the approved amount (whichever is greater), but no more than $100	You pay $80 or 50% of the approved amount (whichever is greater), but no more than $100	You pay $80 or 50% of the approved amount (whichever is greater), but no more than $100	You pay $80 or 50% of the approved amount (whichever is greater), but no more than $100 plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $160 or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $230 or 50% of the approved amount (whichever is greater), but no more than $290	No coverage	No coverage
	84 to 90-day period	You pay $230 or 50% of the approved amount (whichever is greater), but no more than $290	You pay $230 or 50% of the approved amount (whichever is greater), but no more than $290	No coverage	No coverage
Tier 4 - Generic and preferred brand-name specialty drugs	1 to 30-day period	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200 plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage
Tier 5 - Nonpreferred brand-name specialty drugs	1 to 30-day period	You pay 25% of approved amount, but no more than $300	You pay 25% of approved amount, but no more than $300	You pay 25% of approved amount, but no more than $300	You pay 25% of the approved amount, but no more than $300 plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA.	100% of approved amount	No coverage	100% of approved amount	75% of approved amount
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers

Features of your prescription drug plan

BCBSM Custom Select Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Select Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay for these drugs. • **Tier 4 (generic and preferred brand-name specialty)** - Tier 4 includes covered specialty drugs listed as generic drugs (Tier 1) or preferred brand-name drugs (Tier 2) from the Custom Select Drug List. These drugs have a proven record for safety and effectiveness, and offer the best value to our members. They have the lowest specialty drug copay. • **Tier 5 (nonpreferred brand-name specialty)** - Tier 5 includes covered specialty drugs listed as nonpreferred brand name (Tier 3). These drugs may not have a proven record for safety or their clinical value may not be as high as the specialty drugs in Tier 4. They have the highest specialty drug copay.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Exclusions	The following drugs are not covered: • Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service • State-controlled drugs • Brand-name drugs that have a generic equivalent available • Drugs to treat erectile dysfunction and weight loss • Prenatal vitamins (prescribed and over-the-counter) • Brand-name drugs used to treat heartburn • Compounded drugs, with some exceptions • Cosmetic drugs

Simply Blue℠ PPO Gold $1500 with Rx Drug Vision Coverage (Pediatric) Benefits-at-a-glance Effective for groups on their plan year

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

Note: Vision benefits are only available to members up to age 19. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Member's responsibility (copays)

Benefits	In-network	Out-of-network
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses	None	None

Eye exam

Benefits	In-network	Out-of-network
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	100% of approved amount	Reimbursement up to $34 (member responsible for any difference)
	One eye exam per calendar year	

Lenses and Frames

Benefits	In-network	Out-of-network
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	One pair of lenses, with or without frames, per calendar year	
Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.		
Standard frames from a "select" collection	100% of approved amount	Reimbursement up to $38.25 (member responsible for any difference)
	One frame per calendar year	

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Contact Lenses

Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to $210 (member responsible for any difference)
	Covered - annual supply	
Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply)	100% of approved amount	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Covered according to quantities outlined in your certificate, per calendar year	

Basic Plan Document

For the Code Section 125 - Cafeteria Plan

PREPARED BY:

#michbusiness

Powered by MBPA

BASIC PLAN DOCUMENT FOR THE CODE SECTION 125 CAFETERIA PLAN

BASIC PLAN DOCUMENT FOR THE CODE SECTION 125 CAFETERIA PLAN

Article I. General Information

Sponsoring Employer's Name, Address and Telephone Number [Note: the Sponsoring Employer also is the Plan Administrator]

LCJ, INC
30777 Plymouth Rd, Livonia, Michigan, 48150
(734) 525-5000

Primary Contact

Colleen McDonald
30777 Plymouth Rd, Livonia, Michigan, 48150
(734) 525-5000

Sponsoring Employer's Federal Employer Identification Number

38-2245869

Original Effective Date of Plan

January 1, 2016

Effective Date of the Amendment and Restatement of the Plan

January 1, 2018

Plan Year

01/01 - 12/31

Article II. Benefit Plan Options

The Employer hereby elects that the following Qualified Benefits are available to Plan Participants (check all that apply)

- The Employee's pre-tax premium payment for coverage under the Employer's Medical Plan.
- The Employee's pre-tax premium payment for COBRA continuation coverage offered under a group health plan sponsored by the Employer.
- The Employee's pre-tax premium payment for COBRA continuation coverage offered under a group health plan sponsored by a different employer.
- The Employee's pre-tax premium payment for Employer's Dental Plan.
- The Employee's pre-tax premium payment for Employer's Vision Plan.
- The Employee's pre-tax contribution (or Employer's non-taxable contribution on behalf of the Employee) to a Health Savings Account.

The Employer hereby offers an Opt-Out Cash Payment to any Employee who waives coverage under one or all of the following plans (check all that apply)

The amount of Opt-Out Cash Payment will be determined in advance of each Plan Year in the sole discretion of the Employer, which amount may be zero. Any Out-Out Cash Payments will be paid to applicable Employees as taxable income and paid out in a manner than shall be communicated to Employees prior to each Plan Year.

- No Opt-Out Cash Payment is available.

If a newly eligible Participant fails to timely elect benefits under this Plan, he or she will be deemed to have elected the following benefit elections (check all that apply)

- No default elections apply for newly eligible Participants (i.e. he or she will not participate in Employer's benefit programs for the remainder of the Plan Year).

If Participants fail to timely elect benefits under the Plan during an annual Open Enrollment Period in accordance with the elections procedures set forth by the Employer, the following will apply (check one)

- The Employee will be deemed to not participate in any of the Employer's benefit programs for the subsequent Plan Year.

The Employer hereby elects the following additional payment methods to be offered to an Employee during his FMLA, USERRA or Employer-Approved Leave of Absence (Note that the Pay-As-You Go Payment Method will always be offered to Employees) [the Employer may elect just one, both or neither of the following additional options]

- Pre-Payment Method

Article III. Participating Employers

This Employer hereby establishes a Code Section 125 - Cafeteria Plan under Internal Revenue Code Section 125. This Adoption Agreement is incorporated by reference and is made part of the Basic Plan Document attached hereto. Nothing in this Adoption Agreement shall be intended to override the terms of the Basic Plan Document to which this Adoption Agreement is attached.

Completed By:

Article IV. Consent Resolutions of the Board of Directors

The undersigned, being all of the directors of LCJ, INC (the "Company"), hereby consent to the adoption of the following resolutions.

WHEREAS, the Company desires to amend and restate its Premium Only Plan by adopting, in the form submitted to the Directors, the Basic Plan Document and accompanying Adoption Agreement (the "Plan"). NOW THEREFORE, BE IT RESOLVED, that the restated Plan, in the form presented to the Directors, is approved and adopted effective as of January 1, 2018. RESOLVED FURTHER, that the President of the Company is authorized and directed to execute the Plan, and to take such other action as may be necessary or appropriate to implement these resolutions.

Article V. Preambles

Section 1. Adoption of Plan

Effective as of the date set forth in the Adoption Agreement, the Employer specified in the Adoption Agreement has established a Code Section 125 - Cafeteria Plan (the "Plan") for its Employees. The Adoption Agreement is incorporated by reference and made part of this Plan document.

Section 2. Purpose

The purpose of the Plan is to provide eligible Employees with the opportunity to select among various combinations of taxable and non-taxable Benefits and taxable compensation. Specifically, the Plan allows a Participant to pay for the Participant's share of the premium payments under certain Benefit Plans on a pre-tax basis. The Employer, in its sole discretion, also may adopt an Opt-Out Cash Payment feature under which a Participant would be allowed to elect, in writing, to waive coverage under certain Benefit Plans and, in lieu thereof, receive a taxable opt-out cash payment. The Employer will determine the amount of this Opt-Out Cash Payment, if any, and Participants will be informed of such availability and amount during their initial enrollment period or during the Open Enrollment Period.

This Plan document also is intended to wrap and join together each of the Benefit Plans to constitute a single employee welfare benefit plan for ERISA and annual reporting purposes. However, the specific rights, terms and conditions for each Benefit Plan are solely described in the applicable Plan Documents, Summary Plan Descriptions and/or insurance contracts, all of which shall be incorporated herein by reference.

Section 3. Interpretation and Law

The Plan is intended to comply with Section 125 of the Internal Revenue Code of 1986, as amended, and with the regulations promulgated thereunder. Where not governed or preempted by federal law, the Plan shall be administered and construed in accordance with Michigan law. The Plan is not intended to nor shall it be construed to be an amendment or interpretation of the provisions of any benefit plan maintained by the Employer, except to the extent that this Plan permits Employees who participate in this Plan to elect to participate in any such benefit plan. It is the intention of the Employer that the Plan be maintained for the exclusive benefit of eligible Employees.

Article VI. Definitions

Throughout the Plan, various terms are used repeatedly. These terms have specific and definite meanings when capitalized in the text. For convenience, capitalized terms are collected and defined in this Article. Whenever capitalized terms appear in the Plan, they shall have the meanings specified in this Article. Where necessary or appropriate to the context, the masculine shall include the feminine, the singular shall include the plural and vice versa.

"Adoption Agreement" means the agreement under which the Employer duly adopts this plan document, which agreement is incorporated by reference herein.(Articles I, II, III and IV)

"Affiliated Employer" means any entity who is considered with the Employer to be a single employer in accordance with Code Section 414(t).

"Benefit" means the Permitted Taxable Benefits (e.g. cash) and nontaxable Qualified Benefits made available to Participants from time to time under this Plan. Such Benefits shall be determined by the Plan Administrator each Plan Year, a list of which will be provided to Participants during each Open Enrollment Period (see the Adoption Agreement). The specific provisions of Qualified Benefits shall be set forth in separate plan documents, agreements, or contracts, and are incorporated by reference into this Plan (referred to as "Benefit Plan(s)").

"Code" means the Internal Revenue Code of 1986, as amended, together with its related rules and regulations. References to any Section of the Code shall include any successor provision.

"Dependent" means any individual who is deemed a "Dependent" under the terms of the applicable Benefit Plan. However, a Participant can pay premiums on a pre-tax basis under this Plan only for the Participant's Spouse or for the Participant's Dependents who meet the Code Section 152 definition of "dependent" (without regard to the earnings limit under Section 152(d)(1)(B); the special exclusions under Section 152(b)(1) or (2); or the age or student status requirements under Section 152(c)(3), provided that such qualifying child is age 26 or under during the entire Plan Year), even if a Benefit Plan allows coverage for individuals who do not qualify as such.

"Effective Date" of the Plan means the original effective date specified in the Adoption Agreement on which this Plan was first established and adopted by the Employer.

"Employee" means any individual who is a common law employee directly and actively employed in the regular business of, and compensated for services by, the Employer. However, the term "Employee" will not include:

- any self-employed individual (e.g. a sole proprietor, partner or 2% shareholder of an S corporation);
- any individual whose employment is covered under and subject to a collective bargaining agreement, unless such agreement expressly requires and provides for coverage under this Plan; and/or
- any individual for whom the Employer designates as an independent contractor, leased or contract employee, or casual or temporary employee (regardless of the finding by any third party as to the common law employment status of any such person).

"Employer" means the Employer identified in the Adoption Agreement as the sponsoring employer and any Affiliated Employer who adopts the Plan pursuant to authorization provided by the sponsoring Employer. However, whenever the Plan indicates that the Employer may or shall take any action under the Plan, the Employer identified in the Adoption Agreement as the sponsoring Employer shall have sole authority to take such action for itself and as agent for any such Affiliated Employer. The Adoption Agreement identifies a current listing of Participating Employers.

"Employer-Approved Leave of Absence" shall include any leave of absence of the Employee that the Employer has, in writing, approved and agreed to continue the coverage of such Employee under the applicable Benefits Plan during such leave period.

"ERISA" means the Employee Retirement Income Security Act of 1974, as presently enacted and as it may be amended from time to time, together with its related rules and regulations.

"Health Savings Account ("HSA")" means the health savings account established in accordance with Code Section 223 and related regulations and IRS guidance.

Open Enrollment Period means a period during which a Participant may enroll in or change coverage under the Plan. The Open Enrollment Period will begin and end on dates determined by the Plan Administrator, which will be prior to the beginning of the next Plan Year.

Opt-Out Cash Payment means the taxable cash payment benefit available to a Participant if he or she declines and waives in writing coverage under certain Benefit Plans for a Plan Year. The Plan Administrator shall annually determine, in its sole discretion, which Benefit Plans will offer an Opt-Out Cash Payment and the amount of any such Opt-Out Cash Payment, which may be zero. A Participant is eligible for the Opt-Out Cash Payment only if he or she is eligible to participate in the particular Benefit Plan that offers such an Opt-Out Cash Payment.

"Participant" means an Employee who has met the eligibility requirements specified in Article III, who has commenced participation in the Plan pursuant to Article IV, and whose participation has not terminated under other applicable provisions of the Plan.

"Permitted Taxable Benefits" mean cash and certain other taxable benefits treated as cash for purposes of Code Section 125, including any Opt-Out Cash Payments and any other benefits attributable to Employer contributions that are currently taxable to the Employee upon receipt and benefits purchased with after-tax employee contributions.

"Plan" means this Cafeteria Plan, as set forth in this plan document.

"Plan Administrator" means the person(s) or organization(s) specifically designated by Article X as the administrator of the Plan.

"Plan Year" means the 12-month period set forth in the Adoption Agreement.

"Qualified Benefit" means any benefit excluded from the Employee's taxable income pursuant to an express provision of the Code which is specifically recognized as a "qualified benefit" under Code Section 125 and related Treasury Regulations. Generally, qualified benefits include group term life insurance benefits (Code Section 79), accident and health plan benefits(Code Sections 105 and 106); premiums for COBRA continuation coverage under the Employer's group health plan or under a group health plan sponsored by a different employer; accidental death and dismemberment insurance benefits (Code Section 106); long-term or short-term disability benefits (Code Section 106); dependent care assistance benefits (Code Section 129); adoption assistance benefits (Code Section 137); qualified cash or deferred arrangement that is part of a qualified defined contribution (401(k)) plan; and contributions to a Health Savings Accounts.

Notwithstanding the foregoing, Qualified Benefits do not include and thus cannot be offered under the Plan the following: scholarship benefits (Code Section 117); employer-provided meals and lodging benefits (Code Section 119); educational assistance benefits (Code Section 127); fringe benefits (Code Section 132); long-term care insurance benefits or services (Code section 106); group-term life insurance benefits on the life of any individual other than an employee; health reimbursement arrangement benefits; contributions to Archer MSA (Code Section 106(b) and 220); elective deferrals to a section 403(b) plan; or group-term life insurance benefits that offer a permanent benefit, or any other benefits prohibited by treasury regulations or other IRS guidance.

"Spouse" means an Employee's Spouse by legal marriage, but specifically excluding any common law marriages even if recognized under the laws of the Employee's state of domicile, and excluding an individual who is legally divorced from the Employee, or subject to a decree of legal separation or separate maintenance. However, the legal married status between the Employee and Spouse must have existed at the time that the expense was incurred for which reimbursement is claimed.

Article VII. Eligibility

An Employee who has properly enrolled in coverage under one or more of the Benefit Plans will be eligible to participate in this Plan. Each Benefit Plan will set forth its own eligibility requirements for participation.

Article VIII. Participation

Section 1. Commencement of Participation

An Employee shall commence participation in the Plan as of the first payroll period following the date he or she has met the eligibility requirements of Article III above, provided such Employee timely elects Benefits for the remainder of the Plan Year pursuant to Article VI below. In no event may participation in the Plan commence as of a date prior to the Effective Date of this Plan.

Section 2. Meaning of Participation

Participation entitles a Participant to elect among the Benefits made available by the Employer under the Plan for each Plan Year and to pay certain employee related costs for such Benefits on a pre-tax basis. Each of the Benefit Plans incorporated in this Plan may have its own eligibility requirements for participation which differ from those set forth in this Plan. The eligibility and participation requirements set forth in this Plan relate only to participation in this Plan and shall have no effect on any eligibility or participation requirements set forth under the applicable Benefit Plan.

Section 3. Spouses and Beneficiaries

The Participant's Dependents may not participate actively in the Plan (i.e., a Dependent may not be given the opportunity to select or purchase Benefits offered under the Plan), but the Participant's Dependent may benefit from the Participant's election of Benefits. Further, upon the Participant's termination of Plan participation under Article IX. Termination, Section 1. Termination of Participation below, no rights under the Plan will inure to a Dependent, except as provided under a specific Benefit Plan.

Article IX. Termination

Section 1. Termination of Participation

Except as provided in Article IX. Termination, Section 2. COBRA Continuation Coverage (COBRA Coverage) and Article IX (Leave of Absence), participation in the Plan shall terminate upon the earliest of:

(a) termination of the Plan;
(b) termination of a Participant's employment with the Employer (including voluntary or involuntary termination of employment, layoffs, death, retirement, or unapproved leave of absence);
(c) failure to meet the eligibility requirements of Article III;
(d) failure to timely pay required contributions under the Plan;
(e) failure by a Participant to return to work after an approved leave of absence period; or
(f) any other event causing termination as described in the Plan.

A Participant who terminates participation in the Plan may be able to continue coverage under a Benefit Plan to the extent that the terms and conditions of such Benefit permit continued coverage.

Section 2. COBRA Continuation Coverage

Notwithstanding the provisions of Article IX. Termination, Section 1. Termination of Participation, continuation coverage under any Benefit Plan which is a "group health plan" as that term is defined in Code Section 5000 shall be provided under the group health plan to Participants, their covered spouses and dependents to the extent required under ERISA Sections 601 through 608, and Code Section 4980B ("COBRA"). The terms of such COBRA continuation coverage, if any, shall be described in the group health plan or plans identified in the Adoption Agreement. If a Participant elects COBRA coverage under an applicable Benefit Plan, the Participant may continue participation under this Plan to pay for required contributions under such Benefit Plan.

Article X. Election of Benefits

Section 1. Available Benefits

Prior to the beginning of each Plan Year, the Employer shall designate the Benefits, including any Opt-Out Cash Payments, that are available for Participant election under the Plan for the following Plan Year and the cost to Participants of each such Benefit and the amount of each such Opt-Out Cash Payments (available Benefits will be specified in the Employer's Adoption Agreement). In determining such costs or amounts, the Employer shall consider all relevant data including, but not limited to, the cost of insurance to fund the benefit, the direct and indirect expense to the Employer if the benefit is paid directly from the general assets of the Employer, and the value of the coverage to the Participant. Further, the Employer may consider the age, pay, length of service, employment status, coverage status, and number of dependents of a Participant in determining the cost of a Benefit or the amount of an Opt-Out Cash Payment to each Participant, provided the Employer makes such determination on an equitable and nondiscriminatory basis.

The Employer may impose such conditions on allowing a Participant to decline Benefits coverage as it determines are appropriate, in its discretion; including, but not limited to, requiring that a Participant provide proof of other, comparable coverage that is then in effect with respect to the Participant (e.g., through a spouse's employer, etc.). If the Employer is an "applicable large employer" as defined by the Health Care Reform Act and offers a cash payment to those who waive medical coverage, eligible Emlployees must attest that the Employee and each tax dependent are or will be covered by another medical insurance plan that provides "minimal essential coverage" (other than an individual health insurance policy, including a policy purchased through the Marketplace).

Section 2. Notification

Prior to the beginning of each Plan Year, the Employer will notify (electronically or otherwise) each Employee who is eligible for participation in the Plan for the following Plan Year of the Benefits available for selection under the Plan for such following Plan Year. The notice may include:

(a) A description of each Benefit available under the Plan for the Plan Year and whether the Benefit is taxable or non-taxable;
(b) The maximum amount of salary reduction that a Participant may direct to be used on his or her behalf to provide Benefits;
(c) The available minimum and maximum levels of coverage under each Benefit; and
(d) The cost to the Participant of each Benefit provided under the Plan for the Plan Year.

Section 3. Election of Benefits

Prior to the beginning of each Plan Year, and in conjunction with the notice materials as provided in Article X. Election of Benefits, Section 2. Notification, the Employer will provide enrollment instructions to each Employee who is eligible for participation in the Plan for the following Plan Year. For new Participants, the Employer shall provide the enrollment instructions as soon as practicable before an Employee becomes a Participant.

The Employee must complete the enrollment process with the Employer in a manner designated by the Employer and at any time up to and including a date specified by the Employer, but, in any event, prior to the beginning of the following Plan Year or, for newly eligible Participants, within 30 days of first becoming eligible to participate in the Plan. The completed enrollment process will specify the amount which the Employer will reduce the Employee's salary in order to pay for Benefits for the following Plan Year. See Article X. Election of Benefits, Section 5. Failure to Elect with regard to the failure to timely elect benefits.

A Participant may not revoke or modify any election under this Article X. Election of Benefits, Section 3. Election of Benefits for the Plan Year, except as provided in Article X. Election of Benefits, Section 7. Other Election Modifications.

Section 4. Minimum Benefits

Article X. Election of Benefits, Section 3. Election of Benefits notwithstanding, the Employer may require Employees to elect, with respect to a specified Benefit, a minimum level of such Benefit for the Plan Year. Minimum benefits shall be determined by the Employer from the Benefits available under the Plan for the Plan Year, and each Employee shall be notified in writing of the identity and amount of minimum benefits for the Plan Year. Such notification will be in conjunction with the notification of available Benefits pursuant to Article X. Election of Benefits, Section 2. Notification and will be given prior to the beginning of the Plan Year or participation. If a Participant fails to elect at least the minimum amount of a specified Benefit, he or she will not be permitted to elect that Benefit or will be deemed to have elected the minimum default elections as described in this Plan or as established by the Plan Administrator and described in open enrollment materials.

Section 5. Failure to Elect

Failure of a newly hired Employee to timely complete the enrollment process shall be administered in accordance with the election(s) made in Article II . The treatment of elections in the event a Participant fails to timely complete the enrollment process with the Plan Administrator during the annual Open Enrollment Period on or before the specified due date for the Plan Year shall be administered in accordance with the election(s) made in Article II.

If the Plan Administrator decides to implement such a default election procedure or is otherwise required by law to do so, the Plan Administrator will notify Participants in writing (e.g. in the initial or open enrollment materials) of such default election procedures, including a description of the default elections, the amount of the salary reduction, the period of time for which the election is effective, the procedures to decline coverage and the deadline for making elections.

Section 6. Involuntary Election Modifications

At any time prior to or during the Plan Year, the Employer may require some or all Participants to modify their Benefit elections under the Plan if the Employer determines to its satisfaction that such modifications are necessary in order to preserve the tax-preferred status of this Plan under Code Section 125 or of any Benefit available under the Plan under any other applicable provision of the Code. Specifically, such modifications may be required in order to enable the Plan or any Benefit available under the Plan to satisfy the nondiscrimination requirements of applicable provisions of the Code. The Employer shall adopt and follow uniform and nondiscriminatory rules for purposes of this section and its decisions regarding involuntary election modifications shall be final and binding.

Section 7. Other Election Modifications

Under the circumstances specified below, the Employer may permit or require a Participant to revoke a Benefit election under the Plan during a Plan Year, and, in some cases, to make a new election with respect to the remainder of the Plan Year. All such election modifications shall be consistent with Code Section 125 and applicable Treasury Regulations.

(a) **Cost or Coverage Changes.** This Article X. Election of Benefits, Section 7. Other Election Modifications(a)(1) through (4) explains the circumstances under which a Participant's election may be modified as a result of certain cost or coverage changes to a Benefit or a benefit package option available under the applicable Benefit Plan (other than a flexible medical spending account plan):

(1) Cost Changes. In the event that the cost of a Benefit increases or decreases during a Plan Year, the Plan automatically may increase or decrease, as applicable, all affected Participants' salary reduction contributions for such Benefits on a reasonable and consistent basis.

If the cost charged to an Employee for a Benefit significantly increases or decreases during the Plan Year, the Participant may make a corresponding change in his or her salary reduction contributions under the Plan. Changes that may be made include electing to participate in the Plan with respect to the Benefit with the decreased cost or in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving similar coverage or dropping coverage if no other benefit package option providing similar coverage is available. The Plan Administrator in its sole discretion shall determine if the increase or decrease is significant.

A cost increase or decrease refers to an increase or decrease in the amount of salary contributions under the Plan, whether the increase or decrease results from an action taken by the employee (such as switching from full-time to part-time) or from action taken by the Employer (such as increasing or decreasing the amount of employer contributions for Employees).

(2) Coverage Changes. If an Employee (or his or her dependents) has a significant curtailment of coverage (i.e. an overall reduction in coverage) under a Benefit which does not result in a loss of coverage (as defined below) (e.g. a significant increase in the deductible, co-pay or out-of-pocket cost sharing limit), an Employee receiving such coverage may revoke his or her election for such coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option with respect to the applicable Benefit which provides similar coverage. The Plan Administrator in its sole discretion shall determine if the curtailment is significant.

If an Employee (or his or her dependents) has a significant curtailment of coverage under a Benefit that is a loss of coverage, the Employee may revoke his or her election for such coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option with respect to the applicable Benefit which provides similar coverage or completely drop coverage if no other benefit package option providing similar coverage is available. A loss of coverage means a complete loss of coverage under the benefit package option with respect to a Benefit, a substantial decrease in medical providers available under a benefit package option or a reduction in benefits for a specific type of medical condition or treatment with respect to which the Employee (or his or her dependents) is currently in a course of treatment.

If the Plan adds a new Benefit Plan or benefit package option, or an existing benefit package option is significantly improved during the Plan Year, an Employee may revoke his or her election under the Plan and, in lieu thereof, make an election on a prospective basis for coverage under the new or improved Benefit or benefit package option.

(3) Change In Coverage Under Another Employer Plan. An Employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same employer or of another employer), if the other employer plan permits participants to make an election change under the same circumstances described under this Article X. Election of Benefits, Section 7. Other Election Modifications.

(4) Loss Of Coverage Under Another Group Health Plan. If an Employee (or his or her Dependents) loses coverage under any group health coverage sponsored by a governmental or educational institution, the Employee may make a corresponding election change under this Plan to add coverage for himself or herself (or for his or her Dependents), on a prospective basis, under the applicable Benefit plan.

(b) **Special Enrollment Events of HIPAA.** If the Benefit is a "group health plan" subject to the Health Insurance Portability and Accountability Act ("HIPAA") (as codified under Code Section 9801 and related regulations) and to the extent permitted by the applicable plan document or insurance policy for such Benefit, a Participant may revoke an election during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f) and related regulations.

Under Code Section 9801(f) and related regulations, special enrollment rights allow an Employee to enroll in group health plan coverage, upon the occurrence of an "Enrollment Event." For example, an Employee and/or his or her Dependent will have an Enrollment Event if, when the Employee declined coverage under the applicable group health plan, he or she certified that he or she was covered by another group health plan or health coverage and he or she (his or her spouse or child) loses eligibility for coverage under that other health plan for reasons such as legal separation, divorce, annulment of marriage, death, termination of employment, reduction in number of hours of employment (e.g., leave of absence, transfer from full-time to part-time status, strike), change in place of residence or work, failure to elect COBRA coverage on termination of employment, cessation of the other employer's contributions for health coverage, or exhaustion of COBRA coverage. The Employee will not be considered to have lost coverage under this provision if he or she failed to pay the required premiums for such other coverage or such other coverage was terminated

for cause. An Employee and/or his Dependent also may experience an Enrollment Event if he or she loses coverage under Medicaid or a State's Child Health Insurance Program (CHIP). Finally, an Employee may experience an Enrollment Event under HIPAA upon acquiring a new Dependent through marriage, birth or adoption.

(c) **Change in Status.** To the extent permitted by the Employer and the applicable plan document or insurance policy for the Benefit, an Employee may revoke a benefit election during a Plan Year and make a new election with respect to the remainder of the Plan Year provided that both the revocation and new election are on account of and correspond with a change in status that affects eligibility for coverage under a Benefit (i.e. the new election is consistent with the reason that such change is permitted). The following events are permissible "changes in status" for purposes of this subsection:

(1) Legal Marital Status. Events that change an Employee's legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment

(2) Number of Dependents. Events that change an Employee's number of Dependents, including birth, adoption, placement for adoption (as defined in regulations under Code Section 9801), or death of a Dependent.

(3) Employment Status. A termination or commencement of employment by the Employee, spouse, or Dependent.

(4) Work Schedule. A reduction or increase in hours of employment by the Employee, spouse, or Dependent, including a switch between part-time and full-time employment, a strike or lockout, or commencement or return from an unpaid leave of absence.

(5) Dependent Satisfies or Ceases to Satisfy the Requirements for Unmarried Dependents. An event that causes an Employee's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided under the applicable Benefit.

(6) Residence or Worksite. A change in the place of residence or work of the Employee, spouse or Dependent resulting in his or her becoming covered under another plan which provides the applicable Benefit.

(7) Reduction in Hours. If an Employee experiences a change in employment status resulting in a reduction in work hours to less than 30 hours per week during a stability period in which the employee was determined to be full-time, the employee may revoke coverage under the Plan if he or she plans to enroll in coverage through the Marketplace and such Marketplace coverage is effective by the first day of the second month following the month in which the Plan coverage is terminated.

(8) Enrollment in Marketplace Coverage during Marketplace Open Enrollment. Employees may enroll in Marketplace coverage during the Marketplace annual open enrollment or special enrollment period and such coverage must be effective immediately following loss of coverage from the Plan

(d) **QMCSO.** If a Qualified Medical Child Support Order requires coverage for a child under the applicable Benefit Plan, the Employee's election under the Plan may be revised to provide coverage to such child. If a Qualified Medical Child Support Order requires a former spouse to provide coverage and such coverage is in fact provided, the Employee's election may be revised to cancel coverage for the child. (e) **Entitlement to Medicare or Medicaid.** If an Employee (or his or her Dependent) is enrolled in a Benefit which is a group health plan and he or she becomes enrolled in coverage under Part A or B of Medicare or Medicaid (other than a program for distribution of pediatric vaccines), the Employee may make a prospective election change to cancel or reduce coverage of that Employee (or Dependent) under such Benefit Plan. In addition, if an Employee (or Dependent) who has been entitled to such Medicare or Medicaid coverage loses eligibility for such coverage, the Employee may make a prospective election to commence or increase coverage of that Employee (or Dependent) under the Benefit which is a group health plan.

(f) **Automatic Termination of Election.** Except as provided in Article IX. Termination, Section 2. COBRA Continuation Coverage (COBRA Continuation Coverage), a Participant's elections under this Plan shall automatically terminate on the date the Participant ceases to be a Participant in this Plan or in one of the Benefit Plans.

(g) **Failure to Make Contribution.** In the event a Participant fails to make the required contributions with respect to a Benefit elected under the Plan, his or her receipt of such Benefit under the Plan for the remainder of the Plan Year shall be terminated and he or she shall not be permitted to make a new benefit election under the Plan during the remainder of that Plan Year.

(h) **Election Changes for HSA Contributions.** If the Employer indicates in the Adoption Agreement that a Participant may make pre-tax contributions to his or her Health Savings Account, the Participant may prospectively elect to increase, decrease or

completely revoke the amount of his or her salary reduction election for such HSA contribution with respect only to salary that has not become currently available to the Participant.

Any change in election permitted under Article X. Election of Benefits, Section 7. Other Election Modifications(a), (b), (c) and (e) above must be made no later than the last business day falling on or before 31 days following the date on which one of the events described in such paragraph occurs.

Notwithstanding the foregoing, a Participant shall not revoke an election and make a new election that would cause him or her to maintain less than the minimum benefits, if any, required with respect to any Benefit for a Plan Year. The Employer shall adopt and follow uniform and nondiscriminatory rules for purposes of this Section and its decisions regarding voluntary election modifications shall be final and binding.

Article XI. Salary Reduction Contributions

Section 1. Salary Reduction

The Participant may direct the Employer to reduce his or her compensation each pay period over the Plan Year in an amount equal to the cost of his or her elected Qualified Benefits. Such salary reduction amounts shall be designated and authorized by each Participant on his or her benefit election form and such form shall constitute a salary reduction agreement between the Participant and the Employer. The amount of salary reduction available to a Participant under the Plan for a Plan Year shall be equal to a portion of the cost necessary for the Employer to purchase the elected Qualified Benefit. Such amount shall be determined by the Employer prior to the beginning of each Plan Year. In the event of increases or decreases in the cost of providing Qualified Benefits during a Plan Year, a Participant's salary reduction amount may be automatically adjusted to reflect such increase or decrease.

Section 2. Substantiation of Claims

A Participant must satisfy the substantiation requirements set forth in this section and in Treasury Regulations 1.125-6(b) before the Plan can pay or reimburse a Participant for the expense of Qualified Benefits listed in the Employer's Adoption Agreement. Expenses must be substantiated by information from a third-party that is independent of the Participant and his or her spouse or dependents. The independent third-party must provide information describing the service or product, the date of service or sale and the amount.

Section 3. Payments to Insurer

The Employer shall maintain separate bookkeeping records of a Participant's salary reduction amounts and shall apply such amounts on behalf of a Participant for the sole purpose of paying premiums or reimbursements to the appropriate party in accordance with a Participant's Benefit elections.

Section 4. Funding Benefits

All Participant salary reduction amounts contributed to the Plan shall be used to provide Benefits in accordance with Participants' Benefit elections pursuant to Article X. Election of Benefits, Section 3. Election of Benefits. Benefits shall be funded from the general assets of the Employer or, alternatively, through the direct payment of insurance premiums to an insurer from the general assets of the Employer. The Plan shall not utilize a trust fund or other separately maintained fund for accumulation of Plan assets or the provisions of other benefits, unless required by law.

Article XII. Insurance

Section 1. Insurance

To the extent that a Benefit is provided through insurance, a Participant's right to receive benefits will be governed by the terms and conditions of the applicable insurance contract, and the amount of such benefits will be limited to the amount payable under such Insurance Contract. The Employer will have no obligation or duty to provide Benefits to Participants to the extent such benefits are provided through insurance.

Section 2. **Claims for Benefits**

In the event of a dispute regarding eligibility for participation in a Benefit Plan, the right to receive a Benefit or the amount of benefit payable with respect to a claim, the Participant must submit claims for Benefits in accordance with the rules and procedures established under and applicable to each particular Benefit Plan. There will be no liability for the payment of Benefits imposed upon the officers, directors, employees, or stockholders of the Employer.

However, the claim procedures that are described in the remaining sections of this Article VIII will apply in the event that the claim relates to the administration of this Plan (e.g. those issues germane to electing between taxable or nontaxable benefits under this Plan, such as change in status, change in costs or other eligibility determinations made under this Plan).

Section 3. **Initial Claims**

A claimant may file a claim, either in writing or electronically, which claim must include the following information:

(a) The name and address of the claimant;
(b) The specific basis for the claim;
(c) A specific reference to the applicable Benefit Plan and pertinent plan provision upon which the claim is based; and
(d) Any additional material or information which the claimant desires to submit in justification of the claim.

Section 4. **Claim Administrator's Initial Determination**

The Plan Administrator, or its designated claims administrator, (collectively referred throughout this Article as "Claims Administrator") will notify a claimant of its claim determination within 90 calendar days after receipt of the claim, unless an extension is required. The 90-day period may be extended once up to 90 calendar days, provided the Claims Administrator determines that special circumstances require an extension of time for processing the claim. A claimant will be notified of the extension before the expiration of the initial 90-day period. The extension notice will explain the circumstances requiring an extension and the date by which the Claims Administrator expects to make the benefit determination.

Section 5. **Claimant's Deadline for Filing an Appeal of a Denied Claim**

A claimant may request, either in writing or electronically, a full and fair review of an initial decision denying his or her claim generally within 60 days following receipt of such denial.

Section 6. **Appeal Procedures**

On appeal, the following procedures will apply:

(a) During the review, a claimant may represent himself or herself or will have the right to appoint a representative, provided that the claimant is responsible for all of fees and expenses of such representative.
(b) A claimant will have reasonable access (free of charge and upon request) to copies of all documents, records and other information relevant to his or her claim for benefits.
(c) A claimant will be provided the opportunity to submit, and any review will take into account, all comments, documents, records, and other information relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Section 7. **Claims Administrator's Deadline for Deciding an Appeal**

The Claims Administrator will notify the claimant of its decision regarding the claimant's appeal within a reasonable period of time, but not later than 60 calendar days after receipt of the claim for review, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, a claimant will receive written notice of the extension prior to the expiration of the initial 60 day period. In no event will the extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the determination of a claimant's appeal.

Section 8. **Notice of Adverse Benefit Determinations**

Any notice of a denied claim by the Claims Administrator will set forth:

(a) the specific reasons for the Administrator's decision;
(b) references to specific Benefit Plan and provisions of the Plan upon which the decision is based; and
(c) for a notice involving the Claims Administrator's initial decision on a claim -- a description of any additional material or information necessary for the claimant to perfect his or her claim along with an explanation of why such material or information is necessary, and an explanation of claim review procedures under the plan and the time limits applicable to such procedures.

Section 9. **General Claim Provisions**

Notwithstanding anything to the contrary, the following provisions will apply to all claims:

(a) Finality of Decisions. The Claims Administrator has full discretion in determining any matter regarding a claim for Benefits or other claims involving the Plan. The decision of the Claims Administrator upon review of any claim shall be binding upon a claimant, his or her heirs and assigns, and all other persons claiming by, through or under a claimant.

(b) Limitation of Claims Procedure. Any claim under this claims procedure must be submitted within 12 months from the earlier of:
(1) the date on which the claimant learned of facts sufficient to enable him to formulate such claim, or
(2) the date on which the claimant reasonably should have been expected to learn of facts sufficient to enable him to formulate such claim.

(c) Limitation on Court Action. Any suit brought to contest or set aside a decision of the Claims Administrator is to be filed in a court of competent jurisdiction within one year from the date of the receipt of written or electronic notice of the Claims Administrator's final decision. Service of legal process shall be made upon the Plan by service upon the agent for service of legal process or upon the Claims Administrator.

(d) Legal Action. No legal action to recover Plan benefits or to enforce or clarify rights under the Plan shall be commenced under any federal or state provision of law, whether or not statutory, until a claimant first exhausts the claims and review procedures available to him or her hereunder.

(e) Special Rulings. In order to resolve problems concerning the Plan and to apply the Plan in unusual factual circumstances, the Claims Administrator may make special rulings. Such special rulings will be in writing on a form to be developed by the Claims Administrator. In making its rulings, the Claims Administrator may consult with third party administrators, legal, accounting, investment, and other counsel or advisers. Once made, special rulings shall be applied uniformly, except that the Claims Administrator will not be bound by such rulings in future cases unless the factual situation of a particular case is identical to that involved in the special ruling. Special rulings shall be made in accordance with all applicable law and in accordance with the Plan. It is not intended that the special ruling procedure will be a frequently used device, but that it should be followed only in extraordinary situations. The Claims Administrator at all times will have the final decision as to whether resort will be made to this special ruling feature.

Article XIII. Leave of Absence

Section 1. In General

Except as otherwise provided in a Benefit Plan, if a Participant is absent from work due to (i) an approved medical or family leave of absence which is covered under the Family and Medical Leave Act of 1993 ("FMLA") (to the extent FMLA applies to the Employer); (ii) a military leave of absence which is covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), or (iii) an Employer-Approved Leave of Absence, the Participant shall have the following rights:

(a) To revoke his or her election with respect to any Benefit under the Plan for the remainder of the Plan Year.
(b) To continue, in accordance with Article XIII. Leave of Absence, Section 2. Payment for Coverage below, his or her election of Benefit coverage during the leave period, but only to the extent permitted by the Employer and under a Benefit Plan.
(c) To suspend his or her election during the leave period with respect to any Benefit Plan and to reinstate such election upon his or her return to work with the Employer in accordance with Article XIII. Leave of Absence, Section 4. Restoration below.

Section 2. Payment for Coverage

If the Participant elects to continue his or her election of coverage during an FMLA leave, a USERRA leave or an Employer-Approved Leave (to the extent permitted by the Employer and under a Benefit Plan), the Participant's share of the cost of continued coverage for such Benefit will be paid as follows:

(a) **Paid Leave.** If the leave is a paid leave, the Participant's share of the cost of coverage shall be paid by a reduction in the Participant's cash compensation under this Plan.

(b) **Unpaid Leave.** If the leave is unpaid, the Participant may elect to pay his or her share of the cost of coverage due during the leave pursuant to any of the payment methods made available to him or her by the Employer as indicated in the Adoption Agreement. The Employer may elect one or more of the following payment options:

(1) Pay-As-You Go Option. The Participant may elect to make payments to the Employer on an after-tax basis on the same schedule as if the Participant were not on a leave;
(2) Pre-Payment Option. If elected by the Employer in the Adoption Agreement, the Participant may elect to make payments to the Employer on a pre-payment basis from any taxable compensation payable to the Participant (including the cashing out of sick days or vacation days); provided, however, that no pre-payment may be made in a manner that will permit a pre-tax payment to be made in one taxable year of the Participant that will be applied to a subsequent taxable year of the Participant.
(3) Catch-Up Payment. If elected by the Employer in the Adoption Agreement, the Employer may agree to permit the Participant to make payments to the Employer on a catch-up basis from compensation payable to the Participant upon his or her return to work with the Employer from leave; provided, however, that the Employer and the Participant agree in advance of the leave that:

(A) The Participant elects to continue coverage while on an unpaid leave;
(B) The Employer will assume responsibility for advancing payment of the Participant's contributions during the leave; and
(C) The advance amounts must be paid by the Participant when he returns from the leave.

Section 3. Cessation of Coverage

If a Participant fails to timely make any scheduled payments, coverage under the Plan during a leave will cease retroactively to the date the required payment was due, provided the Employer has given the Participant at least 15 days advance written notice that if payment is not received by the 30th day after the required due date, coverage will be dropped on the that date retroactive to the date the required payment is due. If the notice is not timely sent, coverage will cease 15 days after the required notice is given or the date specified in the notice, if later, unless the payment has been received by that date.

Section 4. Restoration

If a Participant suspends his or her election under the Plan during a leave and then returns to work with the Employer within the same Plan Year the leave commenced, he or she automatically will resume participation in the Plan without any change in his or her prior elections under the Plan for such Plan Year, except as otherwise permitted under Article X. Election of Benefits, Section 7. Other Election Modifications (Voluntary Election Modifications) above. The Participant's cash compensation will be reduced to the

rate in effect on the day before the leave commenced and an amount equal to the reduction will be credited by the Employer in accordance with the Benefit Plan.

If the Participant elected to discontinue or suspend his or her coverage during, or fails to pay the required premiums for, a leave period, the Participant is not entitled (i) to reimbursement for claims incurred during the period when his or her coverage was terminated, nor (ii) to greater benefits upon restoration for the remainder of the Plan Year relative to premiums or contributions paid by an Employee who is continuously employed during the Plan Year.

A Participant who returns from a leave in a Plan Year subsequent to the year the leave commenced will be required to complete and submit a new election form as specified in Article X. Election of Benefits, Section 3. Election of Benefits if he or she is to resume participation in the Plan. Participation in this Plan shall commence as of the first pay period immediately following receipt of a Participant's completed election form by the Employer.

Article XIV. Provisions Relating to Administration and Fiduciaries

Section 1. Plan Administration

The Employer (or such person or entity as it shall designate) shall be the Plan Administrator and shall administer the Plan in accordance with its terms. The Plan Administrator shall have such powers and duties as may be necessary to discharge its functions under the Plan, including, but not limited to the following:

(a) Construction. To have full discretionary and binding authority to construe and interpret the Plan and decide all questions of eligibility to participate in and for benefit under the Plan;
(b) Forms. To require Participants (1) to complete and file with it such forms as the Plan Administrator finds necessary or desirable for the administration of the Plan, and (2) to furnish all pertinent information requested by the Plan Administrator, and to rely upon all such forms and information furnished, including each Participant's mailing address;
(c) Procedures. To prescribe procedures to be followed by Participants in electing Benefits and filing claims for Benefits;
(d) Rules. To promulgate uniform rules and regulations whenever in the opinion of the Plan Administrator such rules and regulations are required by the terms of the Plan or would facilitate the effective operation of the Plan;
(e) Information. To prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan, and to receive from Participants such information as shall be necessary for the proper administration of the Plan;
(f) Annual Reports. To prepare, furnish, and file such annual reports with respect to the administration of the Plan as are required by law or as are reasonable and appropriate;
(g) Insurers. To appoint and remove insurance carriers;
(h) Records. To prepare, receive, review, and keep on file (as it deems convenient and proper) records of benefit payments and disbursements for expenses; and
(i) Appointments. To appoint and remove fiduciaries, fix their compensation, if any, and exercise general supervisory authority over them. Notwithstanding any provision of this Plan to the contrary, the Plan Administrator in its sole discretion may enroll Participants in the Plan over the telephone, may furnish notices and other disclosures via electronic transmission and may otherwise administer the Plan in a paperless manner.

Section 2. Finality of Decisions

All determinations of the Plan Administrator or the Employer or any of its delegates shall be final and binding on all persons except as otherwise expressly provided herein.

Section 3. Fiduciaries and Other Duties

The Employer shall be a "named fiduciary" of this Plan and of any Benefit Plan available under the Plan only to the extent they are considered "employee welfare benefit plans," as those terms are described in ERISA. The Employer shall have only those duties, responsibilities, and obligations (referred to collectively as "fiduciary duties") as specifically are given it under the Plan, under any Benefit Plan available under the Plan, or as otherwise are imposed by applicable law. The Employer shall have the sole responsibility for making contributions or purchasing insurance in order to provide the Benefits available under the Plan. The Employer may allocate or delegate its fiduciary duties under the Plan to other Plan fiduciaries by written agreement between the Employer and such other fiduciaries.

Section 4. Employment of Advisers

The Employer shall have the authority to employ such legal, accounting, and financial counsel and advisers as it shall deem necessary in connection with the performance of its duties under the Plan, and to act in accordance with the advice of such counsel and advisers. In administering the Plan and to the extent permitted by law, the Employer may rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the Employer.

Section 5. Delegation to Officers or Employees

The Employer shall have the power to delegate its fiduciary duties under the Plan or under any Benefit available under the Plan to officers or employees of the Employer and to other persons, all of whom, if employees of the Employer, shall serve without compensation other than their regular remuneration from the Employer. The Employer agrees to indemnify and to defend to the fullest extent permitted by law any delegated employee or officer against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer), occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

Section 6. Fees and Expenses

All expenses incurred in the operation and administration of the Plan, including the fees and expenses of counsel and other advisors and the compensation, if any, of the fiduciaries, agents, and administrators shall be paid or reimbursed by the Employer unless the Employer shall determine that such fees and expenses shall be paid in whole or in part by the Plan or by Participants.

Article XV. General

Section 1. Amendment and Termination

The Plan and all Benefits available under the Plan shall be subject to alteration, amendment, or termination in whole or in part, at any time by action by the Board of Directors of the Employer (which power may be delegated, through resolutions of the Board of Directors, to another person or organization selected by the Employer).

Section 2. Non-Alienation of Benefits

No right or benefit provided for under the Plan or under any Benefit available under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge the same shall be void.

Section 3. Employer's Rights

While the Employer believes in the benefits, policies and procedures described in the Plan, the language used in the Plan is not intended to create, nor is it to be construed to constitute, a contract of employment between the Employer and any of its Employees. The Employer retains all of its rights to discipline or discharge Employees or to exercise its rights as to incidents and tenure of employment. Employees retain the right to terminate their employment at any time and for any reason, and the Employer retains a similar right.

Section 4. Construction

Whenever any words are used in the Plan in the masculine gender, they shall be construed as though they are also used in the feminine gender, where applicable. Similarly, words used in the single form shall be construed as though they are also in the plural form, where applicable. Headings of sections and paragraphs of this document are inserted for convenience of reference. They constitute no part of the Plan and are not to be considered in the construction of the Plan.

Section 5. Tax Consequences

Neither the Employer nor the Plan makes any representations or warranties regarding the federal, state, local or other tax treatment of benefits provided pursuant to the Plan and a Participant shall have no rights against the Employer or the Plan if any tax consequences

contemplated by any Participant are not achieved.

Section 6. Law Governing

This Plan is made pursuant to, and shall be governed by, construed under and enforced in accordance with federal law and, to the extent not preempted, the laws of the State of Michigan.

Section 7. Exclusive Benefit

All contributions made under this Plan and all benefits received shall inure to the exclusive benefit of the Participants and their beneficiaries, and such contributions and benefits shall not be used for nor diverted to purposes other than for the exclusive benefit of the Participant and their beneficiaries (including the costs of maintaining and administering the Plan).

Section 8. Binding Effect

The Employer hereby adopts the Plan (and amendments thereto) through the proper execution of the Adoption Agreement. The Plan and such Adoption Agreement (including any amendments thereto), and all actions and decisions hereunder, shall be binding on the Employer and any and all Participants, present and future.