

## **ARTICLE I**

### **INTRODUCTION**

This plan, as set forth on this and the following pages, is distributed to employers by Hantz Benefit Services LLC (“Hantz Benefit Services LLC”). This plan, together with the adoption agreement executed by the Employer (“Adoption Agreement”), shall constitute the Employer’s welfare benefit plan for eligible employees, and shall be known by the name set forth in the Adoption Agreement, and shall be referred to herein as the “Plan.”

Section 1.01 Establishment of Plan. Effective as of the original effective date provided in Part 1(g) of the Adoption Agreement, the Employer has adopted the Plan for the purpose of providing welfare benefits for its eligible employees and, if elected by the Employer in Section 3(b) of the Adoption Agreement, certain retirees.

Section 1.02 Interpretation and Law. The Plan is intended to comply with Sections 105, 106 and 125 of the Internal Revenue Code of 1986, as amended, and with the regulations promulgated thereunder. Where not governed by federal law, the Plan shall be administered and construed in accordance with Michigan law. It is the intention of the Employer that the Plan be maintained for the exclusive benefit of its eligible Employees and/or eligible retirees.

Section 1.03 ERISA. This document, together with the Adoption Agreement executed by the Employer, constitutes the ERISA “plan document” and “summary plan description.” The insurance contracts and/or benefit booklets published by the insurers of benefits and/or the third party administrators of self insured benefits are incorporated into this document.

## **ARTICLE II**

### **ELIGIBILITY AND PARTICIPATION**

Section 2.01 Eligibility. In order to be eligible to participate in the Plan, an individual must be within the eligible class of Employees or the eligible class of Retirees described in Part 3 of the Adoption Agreement. An eligible individual shall complete such enrollment forms as may be required by the Plan Administrator, the insurers of benefits, and/or the third party administrator.

Section 2.02 Commencement of Participation. An individual shall commence participation in the Plan on the later of the Effective Date or the date described in Part 3(e) of the Adoption Agreement.

Section 2.03 Dependent Coverage. A Participant may elect to cover his or her “dependents” under certain benefits offered under the Plan if elected by the Employer in Section 3(d) of the Adoption Agreement. The term “dependent” is defined in the applicable insurance contracts and/or brochures published by the insurers of benefits and/or the third party administrators of self insured benefits.

Section 2.04 Termination of Participation. A Participant's participation in the Plan shall terminate as of the date described in Part 6 of the Adoption Agreement. A dependent's coverage, if applicable, terminates when an employee's coverage terminates or when the dependent no longer qualifies as a dependent under the Plan, whichever occurs first.

### **ARTICLE III** **ENROLLMENT**

Section 3.01 New Employees. New Employees will be given the opportunity to enroll when they are first eligible for benefits. If a new employee fails to enroll when he is initially eligible for benefits, he will participate in the default benefits described in Part 4(d) of the Adoption Agreement.

Section 3.02 Open Enrollment. Each Employee must enroll in the Plan each year during the open enrollment period. Elections made during the open enrollment period will be effective on the first day of the following Plan Year.

If an Employee fails to return a completed election form to the Employer on or before the specified due date for the following Plan Year, he will be deemed to have elected to continue the benefit elections as were in effect for the prior Plan Year.

Section 3.03 Changes in Elections. This Section 3.03 applies to any benefit that is paid for with employee pre-tax contributions, as specified in Section 5(c) of the Adoption Agreement.

Generally, if a Participant fails to enroll when he first become eligible, he must wait until the next open enrollment period to enter the Plan. In addition, the benefit elections that a Participant makes during the open enrollment period will be in effect for the entire Plan Year following his election, and he will not be permitted to change his elections during the Plan Year. However, as explained below, there are several exceptions to these general rules:

(a) New Dependents. If a Participant acquires a new dependent during the Plan Year as a result of marriage, birth, adoption, or placement for adoption, he generally will be able to enroll that dependent during the Plan Year. However, he must give notice to the Plan Administrator within 30 days of the event. If the Participant requests enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, coverage will be effective retroactive to the date of the event. If the Participant fails to request enrollment within 30 days after the event, he must wait until the following open enrollment period to elect coverage for the new dependent.

(b) Change in Status. Benefit elections generally may be changed during the Plan Year due to certain changes in a Participant's status which are acceptable under rules and regulations adopted by the Department of Treasury, the provisions of which are incorporated by reference, as described below:

(i) If a Participant has a right to enroll in the medical benefits offered under the Plan or to add coverage for a family member pursuant to the Health Insurance Portability and Accountability Act of 1996, then he may revoke an election and make a new election for the remaining Plan Year.

(ii) In the event the cost of a benefit increases or decreases during a Plan Year, the Plan automatically may increase or decrease, as applicable, on a reasonable and consistent basis, all affected Participants' salary reduction contributions for such benefit. Alternatively, if the cost of a benefit increases significantly, a Participant may either (1) make a corresponding change in his or her salary reduction contributions, or (2) revoke his or her election and, in lieu thereof, elect similar coverage on a prospective basis under another benefit package option providing similar coverage.

(iii) In the event that coverage is significantly curtailed or ceases during a Plan Year, all affected Participants may revoke their elections and, in lieu thereof, elect similar coverage on a prospective basis under another benefit package option providing similar coverage. For health coverage, coverage is considered significantly curtailed only if there is an overall reduction in coverage provided to Participants under the Plan so as to constitute reduced coverage to Participants generally.

(iv) A Participant 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 the Plan. A change in status includes: (1) change in marital status of the Participant (marriage, divorce, legal separation, annulment or death of spouse); (2) change in number of dependents (death of the Participant's dependent; birth, adoption, or placement for adoption of a child of the Participant); (3) change in employment status of Employee, dependent or spouse (termination or commencement of employment, strike or lockout, commencement or return from an unpaid leave of absence, change in work-site, change in employment status that affects that individual's eligibility under a cafeteria or other employee benefit plan); (4) dependent ceasing to meet Plan's eligibility requirements for dependent children; and (5) change in the place of residence of Employee, spouse or dependent.

(v) If the Plan receives an order that is a Qualified Medical Child Support Order requiring an Employee to provide medical coverage for an Employee's child, the Plan must permit the Employee to change his or her election in a manner consistent with an increase or decrease in the Employee's responsibility to provide medical coverage to the child.

(vi) If an Employee, spouse or dependent becomes covered under Medicare or Medicaid, or loses eligibility for Medicare or Medicaid, or if Medicare becomes primary for an Employee, spouse or dependent, the Plan may permit the Employee to cancel or reduce medical coverage prospectively for such Employee, spouse or dependent, to commence or

increase coverage prospectively for such Employee, spouse or dependent, or to change his or her election to a medical plan that coordinates with Medicare.

(vii) If an Employee takes a leave under the Family and Medical Leave Act, the Employee may revoke existing medical elections and make such other election for the remaining portion of the Plan Year as may be provided for under the Family and Medical Leave Act.

(viii) If the Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option), the Plan may permit affected Employees to elect the newly-added option (or elect another option if an option has been eliminated) prospectively.

(ix) If the plan of the spouse's, former spouse's or a dependent's employer permits participants to make an election change for a period of coverage that is different from the period of coverage under the Plan, the Plan may permit an Employee to make a prospective election change that is on account of or corresponds with a change made under the plan of the spouse's, former spouse's, or dependent's employer.

Any change in elections must be consistent with the change in status. **If a Participant has a change in status he generally must notify the Plan Administrator within 30 days of the event in order to change his election.** If a Participant provides timely notice of the change in status event, except as otherwise provided above, his election change will be effective on the first payroll date following receipt of the notice. However, if a Participant fails to timely notify the Plan Administrator, he will need to wait until the following open enrollment period to change his coverage. Benefit election changes must be approved by the Plan Administrator.

(c) Waiver of Medical Coverage. If a Participant waived medical coverage under the Plan for himself or his dependents as a result of being covered under another employer's medical plan, the Participant may elect medical coverage under this Plan upon termination of the other coverage if he requests enrollment in this Plan within 30 days of the termination and (a) the other coverage was COBRA continuation coverage that was exhausted, (b) the other coverage terminated because the Participant is no longer eligible under the terms of the other plan, or (c) the other coverage terminated due to the termination of employer contributions. If the Participant requests enrollment within 30 days of the termination of the other coverage, the coverage under this Plan will be effective on the first payroll date following receipt of the request for coverage.

(d) Nondiscrimination Rules. The Employer may alter or revoke a Participant's election if the Participant is a highly compensated employee (as defined by the Internal Revenue Code) or a key employee (as defined by the Internal Revenue Code) if needed to satisfy restrictions imposed by the Internal Revenue Code.

## **ARTICLE IV** **CONTRIBUTIONS**

Section 4.01 Sources of Contributions. Both the Employer and Employees may contribute to the Plan to pay for benefits, as specified by the Employer in Part 5 of the Adoption Agreement.

If elected by the Employer in Section 5(c) of the Adoption Agreement, Participants may pay the Employee portion of the cost for certain benefits with pre-tax dollars. Pre-tax dollars are not subject to withholding for federal income or FICA taxes. Consequently, the amount withheld from a Participant's pay for taxes is reduced. This means a higher take-home pay for Participants than if the Participant purchased benefits with after-tax dollars. Because the Participant's taxes are reduced, his Social Security benefits may be reduced upon retirement or disability. The reduction will most likely be small.

Section 4.02 Funding Benefits. All contributions to the Plan shall be used to provide benefits to Participants. 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.

## **ARTICLE V** **BENEFITS**

Section 5.01 Benefits. The benefits that are currently available under the Plan are described in Part 4 of the Adoption Agreement. The insurance contracts and/or benefit brochures published by the insurers of benefits and/or the third party administrators of self insured benefits are incorporated into the Plan.

## **ARTICLE VI** **COBRA CONTINUATION COVERAGE**

Federal law requires that all employers with 20 or more employees offer employees and their families ("qualified beneficiaries") the opportunity for a temporary extension of health coverage (called "COBRA" or "continuation coverage") at group rates in certain instances where coverage under the health plan would otherwise end due to certain specified events (called "qualifying events"). This Article 6 applies only to employers who employed 20 or more employees on a typical business day in the previous calendar year.

If a Participant loses *health* coverage under this Plan he and his family may be entitled to elect a temporary extension of the coverage (called "continuation coverage"). For purposes of this section, the term health coverage means medical, prescription drug, dental and vision benefits. This section describes the continuation coverage rules.

If a Participant is an employee of the Employer covered by the Plan he has a right to choose this continuation coverage if he loses his group health coverage because of a reduction in his hours of employment or the termination of his employment (for reasons other than gross misconduct on the employee's part).

If the Participant is the spouse of an employee covered by the Plan, he has the right to choose continuation coverage for himself if he loses group health coverage under the Plan for any of the following four reasons:

- (1) The death of the employee spouse;
- (2) A termination of the employee spouse's employment (for reasons other than gross misconduct) or reduction in the employee spouse's hours of employment with the Employer;
- (3) Divorce or legal separation from the employee spouse; or
- (4) The employee spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the Plan, he has the right to continuation coverage if group health coverage under the Plan is lost for any of the following five reasons:

- (1) The death of the employee;
- (2) A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with the Employer;
- (3) The employee's divorce or legal separation;
- (4) The employee becomes entitled to Medicare; or
- (5) The dependent child ceases to be a "dependent child" under the Plan.

Under the law, the employee or a family member has the responsibility to inform the Plan Administrator, or COBRA Administrator if one is appointed in Section 2(c) of the Adoption Agreement, of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the date of the event. The Employer has the responsibility to notify the Plan Administrator, or the COBRA Administrator if one is appointed in Section 2(c) of the Adoption Agreement, of the employee's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if the employer commences a bankruptcy proceeding and these individuals lose coverage.

When the Plan Administrator, or COBRA Administrator if one is appointed in Section 2(c) of the Adoption Agreement, is notified that one of these events has happened, the Plan Administrator, or COBRA Administrator if one is appointed in Section 2(c) of the Adoption Agreement, will in turn notify the Participant that he has the right to choose continuation coverage. Under the law, the Participant has at least 60 days from the date he would lose coverage because of one of the events described above to inform the Plan Administrator, or the COBRA Administrator if one is appointed in Section 2(c) of the Adoption Agreement, that he wants continuation coverage.

If the Participant does not choose continuation coverage on a timely basis, his health coverage will end on the date specified in Section 2.04 of this Plan.

If a Participant chooses continuation coverage, the Employer is required to give the Participant coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. The law requires that the Participant be afforded the opportunity to maintain continuation coverage for 36 months unless he lost health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended for affected individuals to 36 months from termination of employment if other events (such as death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period. In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

The 18 months may be extended to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11 month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. To benefit from this extension, a qualified beneficiary must notify the Plan Administrator of that determination within 60 days after the date of determination, and before the end of the original 18 month period. The affected individual must also notify the Plan Administrator, or the COBRA Administrator if one is appointed in Section 2(c) of the Adoption Agreement, within 30 days of any final determination that the individual is no longer disabled.

A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator, or the COBRA Administrator if one is appointed in Section 2(c) of the Adoption Agreement, upon birth or adoption.

However, the law also provides that continuation coverage may be cut short for any of the following five reasons:

- (1) The Employer no longer provides group health coverage to any of its employees;

- (2) The premium for continuation coverage is not paid on time;
- (3) After the COBRA election is made, the qualified beneficiary becomes covered under another group health plan, and the other group health plan does not contain any exclusion or limitation with respect to any preexisting condition that the qualified beneficiary may have (unless the other group health plan's preexisting condition exclusion or limitation does not apply to the qualified beneficiary due to the restrictions on preexisting condition exclusions contained in the Health Insurance Portability and Accountability Act of 1996);
- (4) After the COBRA election is made, the qualified beneficiary becomes entitled to Medicare;
- (5) The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

A Participant does not have to show that he is insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to his eligibility for coverage; the Plan Administrator reserves the right to terminate a Participant's COBRA coverage retroactively if the Participant is determined to be ineligible.

Under the law, a Participant may have to pay all or part of the premium for his continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan Participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). There is a grace period of at least 30 days for payment of the regularly scheduled premium.

At the end of the 18 month, 29 month or 36 month continuation coverage period, qualified beneficiaries may be allowed to enroll in an individual conversion health plan provided under the Plan.

Special COBRA rights apply to employees who have been terminated or have experienced a reduction in hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002. These employees must have made petitions for certification to apply for trade adjustment assistance on or after November 4, 2002. The employees, if they do not already have COBRA coverage, are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any employee who qualifies or may qualify for assistance under this special provision should contact the Plan Administrator for further information.

## **ARTICLE VII**

### **CLAIMS PROCEDURES**

Section 7.01 Application of This Section. The insurers of benefits and/or the third party administrators of self insured benefits generally are responsible for processing claims. Thus, the procedures for submitting claims and appealing denied claims for benefits generally are described in the contracts and/or booklets published by the insurers of benefits and/or the third party administrators for self insured benefits. This section will apply only to the extent the claims procedures are not otherwise described in the applicable contracts and/or booklets.

Section 7.02 Definitions. The following terms have the meanings specified in this section.

(a) “Disability Claim” means a claim for a disability benefit that is conditioned on a finding of disability. However, if the finding of disability is made by a party other than the Plan for purposes other than making a benefit determination under the Plan, then the special rules for disability claims do not apply.

(b) “Pre-Service Claim” means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care. If the Plan does not require prior approval for the benefit or service with respect to which the approval is being requested, the request is not a pre-service claim for benefits.

(c) “Post-Service Claim” means any claim for a benefit under the Plan that is not a Pre-Service Claim.

(d) “Urgent Care Claim” means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (b) in the opinion of the physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Any claim that a physician with knowledge of the claimant’s medical condition determines is a claim involving urgent care will be treated as a claim involving urgent care.

Section 7.03 Notification of Benefit Determination. The Plan Administrator (or it’s designee) will notify the claimant of the Plan’s benefit determination as follows:

(a) Medical Care Expense Claim.

(i) Urgent Care Claim. Notification of the Plan’s benefit determination, whether adverse or not, will be given as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered

or payable under the Plan. In the case of such a failure, the Plan Administrator (or its designee) will notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant will be offered no less than 48 hours to provide the specified information. The Plan Administrator (or its designee) will notify the claimant of the Plan's benefit determination as soon as possible but in no case later than 48 hours after the earlier of (A) the Plan's receipt of the specified information, or (B) the end of the period afforded to the claimant to provide the specified additional information.

(ii) Pre-Service Claim. Notification of the Plan's benefit determination, whether adverse or not, will be given within 15 days after receipt of the claim by the Plan.

(iii) Post-Service Claim. Notification of the Plan's adverse benefit determination will be given within 30 days after receipt of the claim by the Plan.

(b) Disability Claim. Notification of the Plan's adverse benefit determination will be given within 45 days after receipt of the claim by the Plan.

(c) All Other Claims. Notification of the Plan's adverse benefit determination will be given within 90 days after receipt of the claim by the Plan.

If special circumstances require an extension of time for processing the initial claim, a written notice of the extension and the reason therefore shall be furnished to the claimant before the end of the initial period.

**Section 7.04 Review of Denied Claims**. A claimant whose claim for benefits has been wholly or partially denied by the Plan Administrator (or its designee) may request, within 60 days (180 days in the case of a claim involving medical care or a disability claim) following the date of such denial, a review of such denial. The request for review must be in writing and must be delivered to the Plan Administrator (or its designee) within the specified time period. The request should set forth the reasons why the claimant believes the denial of his claim is incorrect. The claimant shall be entitled to submit such issues or comments, in writing or otherwise, as he shall consider relevant to a determination of his claim, and may include a request for a hearing in person before the Plan Administrator (or its designee). Prior to submitting his request, the claimant shall be entitled to review such documents as the Plan Administrator (or its designee) shall agree are pertinent to his claim. The claimant may, at all stages of review, be represented by counsel, legal or otherwise, of his choice, provided that the fees and expenses of such counsel shall be borne by the claimant. All requests for review shall be promptly resolved. The Plan Administrator's (or its designee's) decision with respect to any such review shall be set forth in writing and shall be provided to the claimant as follows:

(a) Medical Care Expense Claim.

(i) Urgent Care Claim. Notification of the Plan's benefit determination on review will be given as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan.

(ii) Pre-Service Claim. Notification of the Plan's benefit determination on review will be given within 30 days after receipt of the claim by the Plan.

(iii) Post-Service Claim. Notification of the Plan's benefit determination on review will be given within 60 days after receipt of the claim by the Plan.

(b) Disability Claim. Notification of the Plan's benefit determination on review will be given within 45 days after receipt of the claim by the Plan.

(c) All Other Claims. Notification of the Plan's benefit determination on review will be given within 60 days after receipt of the claim by the Plan.

**ARTICLE VIII**  
**COORDINATION OF BENEFITS**

Certain benefits offered under the Plan will be coordinated with benefits from other plans. Coordination of benefits applies whenever an employee and any member in his family is covered by this Plan and is also covered by any other plan(s). The contracts and/or booklets published by the insurers and/or the third party administrators describe the coordination of benefits provision.

**ARTICLE IX**  
**SUBROGATION AND REIMBURSEMENT**

When the Plan pays a claim or benefit, it assumes that it is the only party that will cover the expense. However, in certain circumstances, someone other than the Plan, called "other party" in this section, may also pay for or pay you for the same claims and costs. In these circumstances, this provision will apply. The contracts and/or booklets published by the insurers and/or third party administrators, describe the coordination of benefits provision.

**ARTICLE X**  
**PROVISIONS RELATING TO ADMINISTRATION**

Section 10.01 General Assignment of Responsibilities. Except as provided more specifically by other provisions of the Plan, the following shall be the assigned responsibilities of each party indicated:

(a) Plan Administrator. The Employer is the Plan Administrator. The Plan Administrator shall have the powers and duties as may be necessary to discharge its functions under the Plan, including, but not limited to the following:

(i) Construction: to construe and interpret the Plan;

(ii) Forms: to require Participants to complete and file with it such forms as the Plan Administrator finds necessary or desirable for the administration of the Plan;

(iii) 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;

(iv) 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;

(v) 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; and

(vi) Appointments: to appoint and remove fiduciaries, fix their compensation, if any, and exercise general supervisory authority over them.

(b) Employer. The Employer shall sign the Adoption Agreement and such other documents and forms as are necessary or appropriate to implement the Plan. The Employer shall make all determinations of Employees who are eligible for participation in the Plan under the eligibility requirements selected by the Employer in the Adoption Agreement and as specified by the Plan. The Employer shall appoint and remove insurance carriers and/or third party administrators.

Section 10.02 Employment of Advisers. The Employer, Plan Administrator and Hantz Benefit Services LLC shall have the authority to employ such legal, accounting, and financial counsel and advisers as each 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. The fees and expenses of such counsel and advisers shall be paid by the respective party who retained the counsel or adviser.

Section 10.03 Named Fiduciary. The Employer shall be a "named fiduciary" of this Plan. The Employer shall have only those duties, responsibilities, and obligations (referred to collectively as "fiduciary duties") as specifically are given it under the Plan, or as otherwise are imposed by applicable law. The Employer shall have the sole responsibility for purchasing insurance in order to provide the benefits available under the Plan. The insurers of benefits are a named fiduciary of this Plan with respect to claim determinations under the Plan. The Employer may allocate its fiduciary duties under the Plan to other Plan fiduciaries by written agreement between the Employer and such other fiduciaries.

## **ARTICLE XI**

### **ADDITIONAL INFORMATION**

Section 11. 01 Family and Medical Leave Act. This Section 11.01 applies to certain Employers who have 50 or more employees.

If an Employee is absent from work on a leave of absence covered by the Family and Medical Leave Act (FMLA), he is entitled to maintain certain benefits that he has under the Plan during his absence.

If an Employee takes an unpaid leave, he may either (a) revoke coverage or (b) continue coverage. If he elects to continue coverage he must continue paying his contributions for coverage by one of the methods selected by the Employer in Part 7 of the Adoption Agreement.

If an Employee revokes coverage or has coverage terminated because of lack of premium payments during the FMLA leave, he may be reinstated in certain benefits offered under the Plan on returning to work after the FMLA leave.

Section 11. 02 Certificate of Coverage. Federal law limits waiting periods for pre-existing conditions. A pre-existing condition exclusion generally may not be imposed for more than 12 months. The 12-month exclusion period is reduced by prior health coverage. If an Employee terminates his employment and becomes covered under another employer's plan, or if an Employee's spouse or dependent children become covered under another plan, coverage under this Plan may reduce any pre-existing condition waiting period imposed by the new plan.

The Employer is required to provide each Participant with a certificate describing the Participant's coverage under this Plan when an Employee or Participant terminates employment, loses coverage, becomes eligible for COBRA, and if a Participant elects COBRA, when COBRA coverage ceases. (However, the Employer may contract with the provider of medical benefits to provide this certificate). A Participant may also request a certificate of coverage within 24 months of loss of coverage.

Section 11. 03 Qualified Medical Child Support Orders. A qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (1) creates or extends the rights of an “alternate recipient” to participate in a group health plan, including this Plan, or (2) enforces certain laws relating to medical child support. An “alternate recipient” is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a participant’s group health plan.

A medical child support order must satisfy certain specific conditions to be qualified. An Employee will be notified by the Employer if it receives a medical child support order that applies to the Employee and the Plan’s procedures for determining whether the medical child support order is qualified.

Section 11. 04 Maternity and Newborn Coverage. Since this Plan may offer maternity and newborn coverage, each Participant is advised that under Federal law, group health plans and health insurance issuers generally 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, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay of up to 48 hours (or 96 hours). Details regarding maternity and newborn coverage are contained in the attached contracts and/or brochures.

Section 11. 05 Breast Reconstruction Benefit. In the case of a Participant or dependent who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. The deductibles and coinsurance limitations applicable to such coverage are described in the attached contracts and/or brochures.

Section 11. 06 Military Duty. A Participant’s right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Section 11. 07 Non-Alienation of Benefits. No right or benefit provided for 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. However, this Section shall not be construed to prevent a Participant from directing the Employer to pay expenses directly to a provider of services or products if those expenses are otherwise reimbursable to the Participant under the Plan. In such

event, the Employer shall be relieved of all further responsibility with respect to that particular expense.

Section 11.08 Construction. Whenever any words are used in the Plan in the masculine gender, they shall be construed as though they also were used in the feminine gender in all cases where they would so apply, and wherever any words are used in the Plan in the singular form, they shall be construed as though they also were used in plural form in all cases where they would so apply. 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 11.09 Privacy for Fully Insured Benefits.

(a) Application. This Section 11.09 applies to the fully insured medical, long-term care, dental and/or vision benefits that are available under the Plan, but only if the Employer creates or receives only (i) summary health information, (ii) information on whether an individual is enrolled in or disenrolled from the Plan, (iii) de-identified information, or (iv) no protected health information, as those terms are defined in the Health Insurance Portability and Accountability Act of 1996.

(b) Effective Date. This Section dealing with HIPAA privacy is effective on April 14, 2004.

(c) Uses and Disclosure of Protected Health Information. The Plan will use and disclose protected health information (“PHI”) to the extent of, and in accordance with, the uses and disclosures permitted by HIPAA. Specifically, the Plan may use or disclose PHI as follows:

(i) The Plan may disclose summary health information to the Employer if the Employer requests the information for the purpose of:

- (A) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
- (B) Modifying, amending, or terminating the Plan.

(ii) The Plan may disclose to the Employer information on whether the individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(iii) The Plan may disclose PHI with written authorization from the individual to whom the PHI relates (or the individual’s personal representative) specifying the entities or persons to whom disclosure of PHI may be made, in accordance with the authorization.

Section 11.10 Privacy for Self-Insured Benefits.

(a) Application. This Section 11.10 applies to any self-insured medical, long-term care, dental and/or vision benefits that are available under the Plan, and any insured benefits who do not meet the description of Section 11.09(a) above.

(b) Effective Date. This Section dealing with HIPAA privacy is effective on April 14, 2004.

(c) General Obligations of the Plan Administrator. The Plan Administrator will adopt procedures to ensure the privacy of protected health information (“PHI”) in accordance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Such procedures will comply with the requirements of HIPAA and any other applicable law.

(d) Use and Disclosure of PHI. The Plan will use PHI to the extent of, and in accordance with, the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to (1) health care treatment, (2) payment for health care, and (3) health care operations, as more fully described below. In addition, the Plan may permit an insurance company, insurance service, insurance organization, or HMO to disclose PHI to the Plan Administrator, consistent with HIPAA and this Section.

(1) *Treatment* means the medical treatment that an individual receives from a medical provider.

(2) *Payment* includes activities undertaken by the Plan to obtain premium payments from participants, determine coverage, fulfill its responsibility for providing Plan benefits, or obtain or provide reimbursement for providing health care to an individual covered by the Plan. These activities include, but are not limited to, the following:

- (a) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
- (b) coordination of benefits;
- (c) adjudication of health benefit claims (including appeals and other payment disputes);
- (d) subrogation of health benefit claims;
- (e) establishing employee contributions;
- (f) risk adjusting amounts due based on enrollee health status and demographic characteristics;
- (g) billing, collection activities and related health care data processing;
- (h) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

- (i) obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
- (j) medical necessity reviews or reviews of appropriateness of care or justification of charges;
- (k) utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- (l) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, social security number, payment history, account number and name and address of the provider and/or health plan).

(3) *Health Care Operations* include, but are not limited to, the following activities:

- (a) quality assessment;
- (b) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives and related functions;
- (c) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and changing ownership, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
- (d) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- (e) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- (f) business management and general administrative activities of the Plan, including, but not limited to:
  - (i) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;
  - (ii) customer service, including providing data analyses for policyholders, plan sponsors or other customers;
  - (iii) resolution of internal grievances; and
  - (iv) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

(e) Disclosure of Summary Health Information and Information on Enrollment.

(1) The Plan may disclose summary health information to the Employer if the Employer requests the information for the purpose of:

- (a) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
- (b) Modifying, amending, or terminating the Plan.

(2) The Plan may disclose to the Employer information on whether the individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(f) Disclosure as Required by Law and as Permitted by Authorization of the Participant or Beneficiary. The Plan will disclose PHI as required by law. In addition, with written authorization from the individual to whom the PHI relates (or the individual's personal representative) specifying the entities or persons to whom disclosure of PHI may be made, the Plan may disclose PHI in accordance with the authorization to other persons or entities, including to the Employer's life and disability carriers and workers compensation insurer for purposes related to the administration of these plans.

(g) Certification of Employer. The Plan will disclose PHI to the Employer only upon receipt of a certification from the Employer that this Section 11.10 has been adopted and that the Employer agrees to do the following:

- (1) Not use or further disclose the PHI other than as permitted or required by the Plan documents or as required by law;
- (2) Ensure that any agents, including a subcontractor, to whom it provides PHI will agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- (3) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefits plan of the Employer;
- (4) Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided herein, if and when the Employer becomes aware of such inconsistent use or disclosure;
- (5) In accordance with HIPAA and consistent with the Plan's HIPAA privacy policy, make an individual's PHI available to such individual;

(6) In accordance with HIPAA and consistent with the Plan's HIPAA privacy policy, make an individual's PHI available to him or her for amendment and incorporate into PHI any such amendments;

(7) In accordance with HIPAA and consistent with the Plan's HIPAA privacy policy, make available information to provide an individual with an accounting of disclosures of such individual's PHI;

(8) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with HIPAA;

(9) If feasible, the Employer will return or destroy all PHI that the Employer received from the Plan and that the Employer no longer needs for the purpose for which disclosure was made, except that if such return or destruction is not feasible, the Employer will limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that the adequate separations (described below) are established.

(h) Adequate Separations. The Employer will ensure that the following adequate separations are established between the Plan and the Employer:

(1) Only the persons identified in the Employer's HIPAA policies and procedures may be given access to PHI.

(2) The persons described in this section may only have access to and use and disclose PHI for plan administration functions that the Employer performs for the Plan;

(3) Issues of noncompliance by the persons described in this Section will be resolved by applying the disciplinary measures specified in the plan's HIPAA privacy policy.

Section 11.11 Amendment and Termination. Both the Employer and Hantz Benefit Services LLC reserve the right to amend the Plan. Amendments may be made by Hantz Benefit Services LLC in either the Plan or Adoption Agreement, provided that no such amendment shall alter or amend any of the elections or specifications set forth by the Employer in the Adoption Agreement, except as required by law or as approved by the Employer. Any amendments made by Hantz Benefit Services LLC, except as may be required by law, shall not be binding upon the Employer until approved in writing by the Employer.

Except as may be specifically provided otherwise in the Plan, or in any amendment to the Plan, each amendment to the Plan shall operate prospectively only from the effective date of the amendment.

The Employer reserves the right at any time to terminate its participation in the Plan, by delivering to Hantz Benefit Services LLC written notice of such termination.

Section 11.12 Type of Plan. Welfare benefit plan including the benefits elected by the Employer in Part 5 of the Adoption Agreement.

Section 11.13 Type of Administration. Some benefits are self-insured, meaning that the Employer pays benefits out of its general assets and receives only administrative services from an insurance company or other third party. Some benefits are insured, meaning that benefits are guaranteed under a policy of insurance issued by an insurance company, and the insurance company is responsible for the payment of claims. The insurers of benefits and third party administrators of self-insured benefits are listed in Part 4 of the Adoption Agreement.

## **ARTICLE XII** **RIGHTS UNDER ERISA**

The following statement is provided to inform you of your rights under the Employee Retirement Income Security Act of 1974 (“ERISA”).

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. This law provides that all Participants in the Plan shall be entitled to:

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

Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts 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 Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) 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 as reported in the IRS Form 5500, but only if the Plan Administrator is required to file a Form 5500 for the Plan. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report (again, only if the Plan Administrator is required by law to file a Form 5500).

## **Continue Group Health Plan Coverage**

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

## **Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another 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 ceases, 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.

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

## **Enforce Your Rights**

If you make a claim for a welfare benefit which 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 the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are

successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

## **ARTICLE XIII** **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.

Section 13.01 "Adoption Agreement" means the agreement executed by the Employer for purposes of the Plan and election of certain alternative provisions offered herein.

Section 13.02 "Code" means the Internal Revenue Code of 1986, as amended.

Section 13.03 "Effective Date" means the date that the terms of this Plan first become effective with respect to the Employer as set forth in Part 1 of the Adoption Agreement.

Section 13.04 "Employee" means any common-law employee of the Employer.

Section 13.05 "Employer" means the Employer identified in Section 1(a) of the Adoption Agreement that has adopted the Plan in accordance with the Adoption Agreement.

Section 13.06 "Participant" means an Employee or former Employee who has met the eligibility requirements and who has commenced participation in the Plan pursuant to Article II, and whose participation has not terminated under other applicable provisions of the Plan.

Section 13.07 "Plan" means the welfare benefit plan of the Employer as described in this instrument, the Adoption Agreement, and any subsequent amendments.

Section 13.08 "Plan Year" means the annual period defined in Part 2(a) of the Adoption Agreement.

Section 13.09 "Protected Health Information" or "PHI" means individually identifiable health information that is created or received by a health care provider, self funded or insured group health plan, or health care clearinghouse, that relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual. The information either must identify the individual or involve a reasonable basis to believe that the individual can be identified using the information.

(04/08/04)

# **WELFARE BENEFIT PLAN**