Annual Plan Participant Notices

2017-2018

608 Industrial Park Drive
Greenville, MI 48838

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QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Notwithstanding any contrary provision in any group health insurance policy under the Plan, an eligible dependent child may include a child for whom an employee is required to provide coverage pursuant to a qualified medical child support order ("QMCSO"). Participants can obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Administrator.

YOUR RIGHTS UNDER THE NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

YOUR RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Group health plan expenses for a mastectomy shall also include charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications relating to all stages of the mastectomy, including lymphedemas. Coverage shall be provided in a manner determined in consultation with the attending physician and the patient.

NOTICE REGARDING MICHELLE'S LAW

On Thursday, October 9, 2008, President bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medical necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of covering under the terms f the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. *Provisions under this law become effective for plan years beginning on or after October 9, 2009.*

YOUR RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The federal law known as HIPAA provides participants with the following rights:

Special Enrollment Rights

If an individual experiences a loss of coverage or if an employee has a new dependent, an eligible employee and/or a dependent may have special enrollment rights to participate in the group health plan immediately without being required to wait until the next annual open enrollment period. For this purpose, a loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), the other coverage is an HMO and the individual no longer lives or works in the HMO service area, or

coverage is lost due to the application of the other plan's maximum lifetime limit on all benefits. However, a loss of other coverage for this purpose does not include: 1) termination due to the nonpayment of required contributions, 2) termination for cause due to the filing of a fraudulent application or claim, or 3) termination where the individual voluntarily terminates other coverage. The addition of a new dependent may occur due to marriage, birth, adoption or placement for adoption. Enrollment must be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable.

In addition, the Children's Health Insurance Program Reauthorization Act of 2009 amended HIPAA to establish new special enrollment rights beginning April 1, 2009 for employees and their eligible dependents who are eligible but not enrolled in the Plan if:

- The employee's or eligible dependent's Medicaid or state Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility, and the employee requests coverage under the Plan within 60 days after such termination; or
- The employee or eligible dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within 60 days after such eligibility is determined.

Privacy and Security

Group health plans and health insurance issuers must make sure that medical information that identifies a participant is kept private, must maintain and follow privacy policies and procedures, and must notify participants of the privacy policies and procedures. In addition, group health plans and health insurance issuers must conduct a written risk analysis and maintain and follow policies and procedures to ensure the security of protected health information maintained or transmitted in electronic form.

SOURCES OF CONTRIBUTIONS AND COST OF BENEFITS

Employer makes contributions under the Plan on behalf of the employees who participate in the Plan. Employer applies its contributions under the Plan to purchase insurance coverage. Employees may be required to contribute to the cost of coverage. If employees are required to contribute to the cost of coverage, Employer will notify employees of the required premiums. If Employer maintains a Section 125 plan, required premiums may be paid on a pre-tax basis.

COBRA CONTINUATION COVERAGE

During any calendar year following a calendar year in which Employer employed 20 or more employees (including all part-time employees, each of whom are counted as a fraction of a full-time employee) during at least 50% of the business days in the calendar year, each person who is a qualified beneficiary will have the right to elect to continue health insurance coverage pursuant to the federal law known as COBRA upon the occurrence of a qualifying event. (Small employers (under 20 employees) are not subject to COBRA.). If your Employer is subject to COBRA, COBRA continuation coverage allows you and your dependents (including a child for whom you are required to provide health insurance pursuant to a QMCSO) an opportunity to temporarily extend your health insurance coverage at group rates in certain instances where coverage would otherwise end.

The Plan Administrator may delegate some or all of its responsibilities with respect to COBRA to a third-party COBRA administrator. You and your spouse (if any) will be notified if a COBRA administrator is appointed. The notice will provide information as to which responsibilities the COBRA administrator has assumed, and whether notices required to be provided to the Plan Administrator should be sent to the COBRA administrator.

Eligibility

You and/or your dependents who are eligible to purchase continuation coverage are "qualified beneficiaries." If a child is born to, adopted by, or placed for adoption with you during a period of COBRA continuation coverage, the

newborn or newly-adopted child will also be a qualified beneficiary. However, the newborn or newly-adopted child's maximum continuation period will be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle a qualified beneficiary to continuation coverage are "qualifying events." The qualifying events occur when health coverage is lost, even if Employer pays the cost of continuation coverage for a certain period of time. The qualifying events, the qualified beneficiaries, and the maximum continuation period are described in the following chart:

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)
Reduced hours* or termination of employment**	Employee and Dependents	18
Employee's death	Dependents	36
Employee's entitlement to Medicare	Dependents not entitled to Medicare	36
Dependent child becomes ineligible for coverage	Ineligible Dependent	36
Employee's divorce/legal separation***	Dependents	36

_* A reduction in hours due to a family or medical leave, as defined by the FMLA will not cause your participation to terminate, to the extent required by the FMLA. Thus, a reduction in hours pursuant to an FMLA leave will not constitute a qualifying event. However, if you do not return to work at the end of the FMLA leave, a qualifying event will occur as of the last day of the FMLA leave.

** Continuation coverage is not available if employment is terminated for gross misconduct.

*** Elimination of your spouse's or dependent child's health insurance coverage under the Plan in anticipation of a divorce or legal separation (at open enrollment, for example) is not a qualifying event, but it also does not cause the subsequent divorce or legal separation to fail to be a qualifying event. However, COBRA continuation coverage is not required to be made available between the date coverage under the Plan is eliminated in anticipation of the divorce or legal separation and the actual date of the divorce or legal separation.

Extension of Continuation Coverage

If you and/or your dependents become entitled to continuation coverage as a result of your termination of employment or reduction in hours, the 18-month continuation period may be extended for you and/or your dependents in the three circumstances described below ("extension events").

- *Second Qualifying Event:* If a second qualifying event (divorce, legal separation, your death, or a dependent child's loss of eligibility for health coverage under the Plan) occurs during the initial 18-month period (or 29 months, if there is a disability extension), your dependents may be eligible to elect continuation coverage for a period of 36 months, beginning on the date of your termination of employment or reduction in hours. Notice of this second qualifying event must be provided to the Plan Administrator within 60 days of the date of the second qualifying event.

- *Employee's Entitlement to Medicare:* If you become entitled to Medicare benefits during the initial 18-month period, your dependents may be eligible to elect continuation coverage for a period of 36 months, if, ignoring the original qualifying event, your entitlement to Medicare would have been a qualifying event under the Plan. The 36-month period begins on the date of your termination of employment or reduction in hours. Notice of your entitlement to Medicare in this situation must be provided to the Plan Administrator within 60 days of the date on which you became entitled to Medicare.

A special rule applies if you became entitled to Medicare before your termination of employment or reduction in hours. In that situation, the maximum continuation period for your dependents may be extended, and may end on the later of: 36 months after the date of your Medicare entitlement or 18 months (or 29 months, if there is a disability extension) after the date of your termination of employment or reduction in hours. *Notice of your entitlement to Medicare in this situation must be provided to the Plan Administrator within 60 days of your termination of employment or reduction in hours.*

- *Social Security Disability Determination:* Your dependents will be entitled to an additional 11 months of continuation coverage (up to 29 months total) in either of the following circumstances: (i) it is determined, before your termination of employment or reduction in hours, that you or one of your dependents are entitled to Social Security disability benefits; or (ii) within 60 days after your termination of employment or reduction in hours, it is determined that you or one of your dependents are entitled to Social Security disability benefits. Notice of the Social Security disability determination must be provided to the Plan Administrator within 60 days of the date of the disability determination (or within 60 days of your termination of employment or reduction in hours, if later) and before the end of the 18-month continuation period.

  If there is a final determination that the disabled qualified beneficiary is no longer disabled, the disabled qualified beneficiary *must notify the Plan Administrator of that determination within 30 days of the date of the final determination.*

  In this event, continuation coverage for the additional 11-month period will terminate as of the first day of the month beginning more than 30 days after the date of the final determination or on the date continuation coverage would otherwise terminate, if earlier (see the "Termination" subsection below).

Plan Administrator's Notice Obligations

The Plan Administrator will provide you and your spouse (if any) with certain information regarding your rights under COBRA in the following situations:

- *Notice of Eligibility to Elect COBRA*: The Plan Administrator will generally notify qualified beneficiaries of their eligibility for continuation coverage within 44 days of a qualifying event. However, a special rule applies where the qualified beneficiary is required to provide the Plan Administrator with notice of a qualifying event in order to trigger the qualified beneficiary's eligibility for continuation coverage (see the "Qualified Beneficiary's Notice Obligations" subsection below). In that situation, the Plan Administrator will notify the qualified beneficiary of his or her eligibility for continuation coverage within 14 days of receiving notice of the qualifying event, but only if the notice of the qualifying event was submitted in accordance with the requirements described in the "
- Notice Procedures" subsection.

- *Notice of Unavailability of Continuation Coverage*: The Plan Administrator will provide a notice of the unavailability of continuation coverage in the following situations:

  - Where the Plan Administrator determines that continuation coverage is not available after receiving notice of a potential initial qualifying event.
  - Where the Plan Administrator determines that an extension of the continuation coverage period is not available after receiving notice of a potential extension event.

  The determination that continuation coverage or an extension of continuation coverage is not available could be made because the Plan Administrator determines that no qualifying event or extension event occurred, or because the notice of the qualifying event or extension event was defective. A notice will be

defective if it is not provided within the applicable time limit or is not provided in accordance with the requirements of the "
Notice Procedures" subsection.

The notice of unavailability of continuation coverage will be provided within 14 days of either: (i) the date that the notice of the potential qualifying (or extension) event is received by the Plan Administrator; or (ii) if additional information was requested by the Plan Administrator in order to supplement a defective notice, the deadline for submission of that information (if that date is later). Notice will be sent to the individual who submitted the notice of the qualifying event or extension event, and to all individuals for whom continuation coverage or an extension of continuation coverage was being requested.

Qualified Beneficiary's Notice Obligations

In some situations, you and/or your dependents have the obligation to provide notice of a qualifying event or extension event to the Plan Administrator in order to trigger their eligibility for continuation coverage or an extension of continuation coverage. You and/or your dependents have this obligation in the following situations:

- *Notice of Certain Initial Qualifying Events:* You, one of your dependents, or an individual acting on behalf of you and/or your dependents must inform the Plan Administrator of a qualifying event that is a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of:

  - The date of the qualifying event; or
  - The date the qualified beneficiary loses health insurance coverage under the Plan on account of that qualifying event.

- *Notice of an Extension Event*: In order to qualify for an extension of the continuation coverage period due to an extension event described in the "Extension of Continuation Coverage" subsection, you, one of your dependents, or an individual acting on behalf of you and/or your dependent must notify the Plan Administrator of the extension event within the time limits that apply to that extension event as described in the "Extension of Continuation Coverage" subsection.

These notices must be provided in accordance with the requirements of the "
Notice Procedures" subsection. If notice is not provided within the applicable time limit or is not provided in accordance with the notice procedures, continuation coverage or an extension of the continuation period will not be available as a result of the qualifying event or extension event.

Notice Procedures

This subsection describes the procedures a qualified beneficiary must follow to notify the Plan Administrator of qualifying events and extension events.

Employer is the Plan Administrator. Notification must be provided to Employer in writing at the address listed in the last section of this Summary Plan Description entitled "Other Basic Information About the Plan" and must contain all of the following information (as applicable):

- Your name.
- The name of the individual(s) for whom continuation coverage is being requested (i.e., the qualified beneficiary(ies)).
- The current addresses of the individual(s) for whom continuation coverage or an extension of continuation coverage is being requested.
- The date of the qualifying event or extension event.
- The nature of the qualifying event or extension event (for example, a divorce).

- If the notice relates to a divorce, a copy of the judgment of divorce.
- If the notice relates to a legal separation, a copy of the judgment of separate maintenance or other relevant court documents establishing the legal separation.
- If the notice relates to your entitlement to Medicare, a copy of the document(s) establishing the entitlement.
- If the notice relates to a determination that a qualified beneficiary is entitled to Social Security disability benefits, a copy of the disability determination.
- If the notice relates to a determination that a qualified beneficiary is no longer entitled to Social Security disability benefits, a copy of the determination.

A notice that is not made in writing and/or does not contain all of the required information is defective and may be rejected.

If the Plan Administrator receives notice of a qualifying event or extension event that is defective because it is not in writing or does not contain all of the required information, the Plan Administrator will request the missing information. If the defective notice was provided by a representative of a potential qualified beneficiary, the Plan Administrator will send the request to the representative and each individual who is a potential qualified beneficiary. If all of the requested information is not provided, in writing, within 30 days of the date the Plan Administrator requests the additional information, the notice may be rejected. If a notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

The Plan Administrator may also request additional information or documentation that is deemed necessary to determine whether a qualifying event or extension event has occurred. If the Plan Administrator does not receive the requested information or documentation within 30 days of the date it is requested, continuation coverage or an extension of continuation coverage may not be available.

Qualified Beneficiary's Election of Continuation Coverage

If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify the Plan Administrator within 60 days after the later of:

- The date the qualified beneficiary loses health coverage on account of the qualifying event; or
- The date on which the qualified beneficiary is sent notice of his or her eligibility for continuation coverage.

Notification is made by timely returning the election form to the Plan Administrator at the address specified in the election notice. If the qualified beneficiary does not choose continuation coverage during the 60-day period, his or her participation in the Plan will end as provided in the "Termination" subsection.

Special Trade Adjustment Assistance Election

Special COBRA rights may apply to you if you terminate employment or experience a reduction of hours and qualify for a "trade adjustment allowance" or "alternative trade adjustment assistance" under federal trade laws. In this situation, you are entitled to a second opportunity to elect COBRA continuation coverage for yourself and certain family members (if they did not already elect COBRA continuation coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after group health plan coverage ended.

If you qualify or may qualify for assistance under the federal trade laws, contact the Plan Administrator for additional information. You must contact the Plan Administrator promptly after qualifying for assistance under the federal trade laws or you will lose these special COBRA election rights.

Coverage

If a qualifying event occurs, the qualified beneficiaries must be offered the opportunity to elect to receive the group health insurance coverage that is provided to similarly-situated non-qualified beneficiaries. Generally, this means that

if the qualified beneficiaries purchase continuation coverage, it will be identical to the health coverage provided to them immediately before the qualifying event. Each qualified beneficiary has the right to make an independent election to receive continuation coverage. Alternatively, the qualified beneficiary may initially elect to purchase one or more of the medical, prescription drug, dental and vision coverages which are provided by Employer pursuant to any separate group health plans and/or which may be separately elected pursuant to Employer's Section 125 plan, if applicable. However, each coverage is initially available only if the qualified beneficiary was receiving coverage immediately before the qualifying event.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications will apply to the qualified beneficiary and his or her dependents. Qualified beneficiaries who purchase continuation coverage will have the opportunity to elect different types of coverage during the annual enrollment period just as active employees.

Cost

Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost will be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries and their dependents who elect an additional 11 months of continuation coverage, the cost will be 150% of the cost of the identical coverage for similarly situated participants for the additional 11-month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law).

The initial premium must be paid within 45 days after the qualified beneficiary elects continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the qualified beneficiary initially elects continuation coverage.

Termination

Generally, continuation coverage terminates at the end of the initial 18 or 36-month continuation period or at the end of any additional 11 or 18-month continuation period for which the qualified beneficiary is entitled to elect continuation coverage. However, continuation coverage may end sooner for any of the following reasons:

- *Coverage Terminated:* Employer no longer offers a group health plan to any of its employees.
- *Unpaid Premium:* The premium for continuation coverage is not timely paid, to the extent payment is required.
- *Other Coverage:* The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan. However, this provision will not apply during any time period the other group health plan contains an exclusion or limitation with respect to any pre-existing conditions, other than an exclusion or limitation which does not apply to the qualified beneficiary or is satisfied by the qualified beneficiary due to HIPAA.
- *Medicare:* The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B).
- *Cause:* The date on which a qualified beneficiary's coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly-situated non-qualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits).

The Plan Administrator will notify the qualified beneficiary if continuation coverage terminates before the end of the initial 18 or 36-month continuation period or before the end of any additional 11 or 18-month continuation period for which the qualified beneficiary is eligible to elect continuation coverage. The notification will be provided as soon as practicable following the Plan Administrator's determination that continuation coverage will terminate.

Keep Plan Informed of Address Changes

To protect your rights under COBRA, it is important that you and your dependents keep the Plan Administrator informed of any changes in address. You should also keep a copy, for your records, of any notices that are sent to the Plan Administrator.

CONTINUATION OF HEALTH COVERAGE UPON MILITARY LEAVE

If you cease to be eligible for health coverage under the Plan due to service in the U.S. military, you and your eligible dependents will be offered the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). You and your dependents may also be entitled to elect to continue your health coverage under COBRA if you cease to be eligible for health coverage due to your military service. Continuation coverage under USERRA runs concurrently with COBRA continuation coverage.

Length of USERRA Continuation Coverage

You may elect to continue health coverage under the Plan for yourself and your eligible dependents for the period that is the lesser of:

- 24 months, beginning with the first day you are absent from work to perform military service; or
- The period beginning on the first day you are absent from work to perform military service and ending with the date you fail to return to employment or apply for reemployment as provided under USERRA.

Electing USERRA Continuation Coverage

If you give Employer advance notice of a period of military service that will be 30 days or less, the Plan Administrator will treat your notice as an election to continue your health coverage during your military service unless you specifically inform Employer, in writing, that you want to cancel your health coverage during your military leave.

You will have to pay the required premiums for your health coverage, but you will not have to complete any additional forms or paperwork to continue your health coverage during your military service.

If you give Employer advance notice of a period of military service that will be 31 days or longer, the Plan Administrator will provide you with a notice of your right to elect to continue health coverage pursuant to USERRA and a form for you to elect USERRA continuation coverage for yourself and your eligible dependents. Unlike COBRA, your dependents do not have a separate right to elect USERRA coverage. If you want USERRA continuation coverage for any member of your family, you must elect it for yourself and all eligible dependents who are covered under the Plan when your military service begins.

If you choose USERRA continuation coverage, you must return the USERRA election form to the Plan Administrator within 60 days of the date it was provided to you. If you do not timely return the election form, USERRA continuation coverage will not be available to you and your eligible dependents.

A special rule applies if you do not give Employer advance notice of your military service. In that case, you and your eligible dependents will not be provided with USERRA continuation coverage during any portion of your military service, but you can elect to reinstate your health coverage (and the coverage of your eligible dependents) retroactive to the first day you were absent from work for military service under the following circumstances:

- You are excused from providing advance notice of your military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for you to provide advance notice or the advance notice was precluded by military necessity);
- You affirmatively elect to reinstate the coverage; and

- You pay all unpaid premiums for the retroactive coverage.

Paying for USERRA Continuation Coverage

For the first 30 days of military service, your required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If your period of military service is more than 30 days, beginning on the 31st day of your military service your required contributions will be 102% of the cost of identical coverage for similarly-situated active participants.

USERRA continuation coverage will be cancelled if you do not timely pay any required premiums for that coverage. If your USERRA continuation coverage is cancelled for non-payment of premiums, it will not be reinstated.

The initial premium must be paid within 45 days after the date you elect USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after you initially elect USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of your USERRA continuation coverage.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible dependents in health coverage immediately upon returning to active employment, even if you and your eligible dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting periods or pre-existing condition exclusions, except for illnesses or injuries connected to the military service.

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 your eligibility are set forth in the policy with each insurance carrier.

YOUR RIGHTS AS A PLAN PARTICIPANT

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

Receive Information About the Plan and its Benefits

- Examine, without charge, at the Plan Administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and (if 100 or more participants) a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, any updated summary plan description and, if 100 or more participants, a copy of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.
- If there are more than 100 participants in the Plan, receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Participant's 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 from the Plan and do not receive them within 30 days, you may file suit in 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 federal court.

The court shall 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 the participant's claim is frivolous.

Assistance With Questions

If you have any questions about the 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 the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.

PATIENT PROTECTIONS PLAN NOTICE

Blue Care Network generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Care Newtork at www.bcbsm.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Blue Care Network or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Blue Care Network at www.bcbsm.com.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as Jan. 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Tom Cripps, Firm Administrator.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Important Notice from Hungerford Nichols About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Aggressive Tooling Inc and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Aggressive Tooling Inc has determined that the prescription drug coverage offered by the Blue Care Network Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.
However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

OMB 0938-0990 **CMS Form 10182-CC Updated April 1, 2011**

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Aggressive Tooling Inc coverage will be affected. For those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Aggressive Tooling Inc coverage, be aware that you and your dependents will be able to get this coverage back as long as you are still eligible under the plans guidelines.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Aggressive Tooling Inc and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information
Kelly Draper at (616) 754-1404.
NOTE: You'll get this notice each year. You also may request a copy of this notice at any time.

OMB 0938-0990 **CMS Form 10182-CC Updated April 1, 2011**

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
Visit www.medicare.gov
Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Summary Plan Description

of the

Aggressive Tooling Inc

GROUP INSURANCE PLAN

To Our Employees

This document is called a "Summary Plan Description." Its purpose is to explain the provisions of Employer's Group Insurance Plan ("Plan"). You are urged to read this Summary Plan Description carefully and to acquaint your family with its provisions.

The Plan is comprised of various fully insured benefits. Generally, the terms and conditions under which you may be eligible for and receive the benefits are set forth in the terms of each applicable insurance policy. Since the benefits under the Plan are provided solely through insurance coverages, Employer is not an insurer of any benefits. The sole source for benefits is each insurance company.

This document does not replace the provisions of the insurance policy(ies). Every effort has been made to make this Summary Plan Description as complete and accurate as possible. In the event of any difference between the Summary Plan Description and one of the insurance policies, the terms of the policy will control.

If you have any questions about your benefits under the Plan, please contact your Employer.

GROUP INSURANCE PLAN

Employer provides various types of group insurance benefits to eligible employees. These insurance benefits are provided through a policy with each insurance carrier. Each insurance carrier is to provide you with a booklet or certificate describing the insurance benefits provided by that carrier.

The booklet or certificate will contain the following information:

- The eligibility conditions for any dependent coverage.
- A summary of benefits.
- A description of any deductibles, coinsurance or copayment amounts.
- A description of any annual or other limits on benefits.
- Whether and under what circumstances preventive services are covered.
- Whether and under what circumstances prescription drugs are covered.
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures.
- Provisions governing the use of network providers (if any). If there is a network, the booklet or certificate will contain a general description of the provider network and you will be entitled to obtain a list of providers in the network from the insurer.
- Whether and under what circumstances coverage is provided for any out-of-network services.
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care.
- Any conditions or limits applicable to obtaining emergency medical care.
- Any provisions requiring preauthorization or utilization as a condition to obtaining a benefit service.
- A summary of the claims procedures.

ELIGIBILITY AND PARTICIPATION

See the last section of this Summary Plan Description entitled "OTHER BASIC INFORMATION ABOUT THE PLAN" for a description of the eligibility and participation rules.

OTHER BASIC INFORMATION ABOUT THE PLAN

1.	Name of Plan Sponsor/Plan Administrator:	Aggressive Tooling Inc
2.	Name, Address, Telephone Number	Aggressive Tooling Inc 608 Industrial Park Drive Greenville MI 48838 616-754-1404
	Taxpayer Identification Number Employer/Plan Sponsor:	38-2876127
3.	Insurance Company:	Blue Care Network 86 Monroe Center NW Grand Rapids MI 49503
6.	Type of Plan:	Group HMO insurance plan providing health and welfare benefits
7.	Eligibility and Participation:	Each regular employee of Employer who is classified as full-time is eligible for the insurance coverage's described in this Summary Plan Description 60 days following the date of hire/rehire.
8.	Termination of Coverage:	Coverage generally ends date of termination. [However, coverage can be continued for an employee in certain situations such as during a medical leave of absence or a layoff. See Employer for details.]
9.	Type of Administration:	Insurer Administration
10.	Agent for Service of Legal Process:	Kelly Draper 608 Industrial Park Dr Greenville MI 48838
11.	Plan Fiscal Year End:	November 30, 2018