## SECTION 1
## INTRODUCTION

The Universal Truckload Services, Inc. Welfare Benefit Plan ("Plan") is maintained for eligible employees who perform services for Universal Truckload Services, Inc. ("Company") and employees of participating employers who have adopted the Plan. Collectively, Universal Truckload Services, Inc. and the participating employers who have adopted the Plan, listed on Appendix A, are referred to as "Employer" in the Plan. The Plan is effective January 1, 2010 and is being amended and restated effective January 1, 2015, unless otherwise provided in the Plan.

The insurance contracts, booklets, guides and policies published by the insurers are intended to provide additional information about the benefits under the Plan and are incorporated into the Plan document by reference. This document is intended to constitute a "plan document" and "summary plan description" under the Employee Retirement Security Act of 1974 ("ERISA").

The Plan offers various welfare benefits, as described in Appendix B. Different coverage levels allow you to select the benefits and coverage that best meet your needs. In addition, unless your employer group does not participate in these benefits, as described on Appendix A, the Plan provides you with an opportunity to pay for uninsured healthcare and dependent care expenses on a pre-tax basis, and to pay your portion of the cost of benefits on a pre-tax basis.

The Plan is intended to comply with Sections 79, 105, 106, 125, 127, 129, and 152 of the Internal Revenue Code of 1986 and with the regulations and guidance promulgated thereunder. Where not governed by federal law, the Plan is administered and construed in accordance with Michigan law.

You may examine the Plan's insurance contracts, booklets, guides and policies during regular business hours in the Human Resources Department. If you have any questions about the Plan, you may contact the Human Resources Department.

## SECTION 2
## EMPLOYEE ELIGIBILITY

> **Eligible Employees**. You will be eligible to participate in the Plan if you are a full-time employee of the Employer who works a minimum of 30 hours per week, and you are not otherwise an excluded employee, as described below.

The benefits offered under the Plan may have additional eligibility requirements. Please see the benefit booklets referenced in the Appendix for further information.

> **Exclusions**. The following employees are not eligible to participate in the Plan: (1) part-time employees (i.e., those working less than 30 hours per week); (2) employees whose employment is covered by a collective bargaining agreement; and (3) independent contractors even if they are later found to be employees.

> **Commencement of Participation**. You will begin to participate in the Plan on the first day after completion of 90 consecutive days of employment with the Employer.

However, participation in certain benefits offered under the Plan may begin on an earlier or later date, and in some cases your employment group may be excluded from participation in certain benefits. See the Appendices and the benefit booklets referenced in the Appendix for further information.

In order to actually participate in the Plan, you must enroll in the benefits offered under the Plan during the allotted time frame by following the instructions you receive with your enrollment materials.

> **Terminated Employees**. If you terminate employment with the Employer during a Plan Year, your benefits under the Plan generally will stop as of the date described in the section called Termination of Participation.

> **Re-hired Employees**. In the event that you are re-employed by the Employer, you will be treated as a new employee, and you will be required to complete the eligibility and participation requirements set forth above prior to participating in the Plan.

## SECTION 3
## DEPENDENT COVERAGE

> **Effective through December 31, 2010, your eligible dependents are:**

- Your lawful and legal spouse, as determined by the laws of Michigan.

- Your "qualifying children" include your biological children, legally adopted children, children placed with you for adoption, your step children, and in certain cases your foster children. To be eligible for coverage as a "qualifying child," the child must be unmarried, reside with you for more than half of the year and may not provide over one-half of his or her own support. The residence requirement does not apply when your child does not live with you under a decree of divorce, separation or paternity which provides that you may be entitled to a deduction for such child.

  "Qualifying children" include: (1) children under age 19, or (2) a child under age 22 if the child is a full-time student at an accredited school, college, or university, which may require ongoing proof of full-time student status, or (3) a child who became permanently and totally disabled before age 19, and you notify the Human Resources Department in writing of the child's condition before age 19. In this case, the child may be covered up to the end of the year in which the child turns age 22. The Employer reserves the right to require at its expense an independent medical examination in connection with any annual review of the child's disabled status.

  Coverage will continue for dependent students who leave a postsecondary educational institution for a period of not more than one year due to a medically necessary leave of absence for a serious illness or injury certified by a physician.

> **Effective beginning January 1, 2011, your eligible dependents are:**

- Your lawful and legal spouse, as determined by the laws of Michigan.

- Your "qualifying children", which include your biological children, legally adopted children, children placed with you for adoption, your stepchildren, and your foster children.

- Your "qualifying child" will be considered a dependent eligible for coverage described on Appendix B until the child's 26th birthday, on which date coverage ends. However, if the child has access to other employer-based coverage when the child turns 19, then coverage under the Plan ends on the child's 19th birthday or ends on any date between the child's 19th and 26th birthday that the child becomes eligible for other employer-based health coverage. You must notify the Employer in writing as soon as you learn that your child is eligible for other health coverage.

The applicable insurance contracts and/or booklets published by the insurers may have additional requirements for dependent coverage.

Coverage for your dependents generally will be effective on the date that your coverage is effective if you apply for dependent coverage when you enroll in the Plan.

You are required to notify the Human Resources Department if any of your dependents no longer satisfy the requirements for eligibility as a dependent.

## SECTION 4
## ENROLLMENT AND BENEFIT ELECTIONS

> **New Employees**. New employees and newly eligible employees will be given the opportunity to enroll when they are employed. If you fail to enroll when you are initially eligible for benefits, you must wait until the following open enrollment period to enroll in the Plan (unless one of the exceptions described below applies).

> **Open Enrollment**. You must enroll in the Plan each year during the open enrollment period, which is typically held during the month of December. Elections made during the open enrollment period will be effective on the following January 1.

If you fail to return a completed election form to the Plan Administrator on or before the specified due date for the following Plan Year, you will be deemed to have elected the same options as you had in effect for the prior Plan Year. However, you will be deemed to have elected not to participate in the health care or dependent care reimbursement accounts for the following Plan Year.

> **Enrollment Procedures**. To enroll in the benefits, you must complete and return the enrollment forms that are required by the Plan Administrator and insurers by the date requested. Enrollment procedures will be included with your enrollment materials.

> **Changes in Elections**. Generally, the benefit elections that you make during the enrollment period will be in effect for the entire Plan Year following your election, and you will not be permitted to change your elections during the Plan Year. However, as explained below, there are exceptions to these general rules:

■ New Dependents - If you acquire a new dependent during the Plan Year as a result of marriage, birth, adoption, or placement for adoption, you generally will be able to enroll that dependent during the Plan Year. However, you must give notice to the Human Resources Department within 30 days of the event. If you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, coverage will be effective retroactive to the date of the event. Contributions to the Plan for retroactive coverage as a result of a mid-year election change due to marriage are made with after-tax dollars. If you fail to request enrollment within 30 days after the event, you must wait until the following open enrollment period to elect coverage for the new dependent.

 Change in Status - Benefit elections may be changed during the Plan Year only if done so within 30 days of a change described below, and the changes in your status are acceptable under rules and regulations adopted by the Department of Treasury, the provisions of which are incorporated by reference, as described below:

(1) If you have 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 you may revoke an election and make a new election for the remaining Plan Year.

(2) 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.

(3) In the event that coverage is significantly curtailed or ceases during a Plan Year, all affected participants may revoke their elections and instead elect similar coverage on a prospective basis under another benefit package option providing similar coverage. If there is no option providing similar coverage, affected participants may be permitted to drop coverage on a prospective basis. For health coverage, coverage is considered significantly curtailed only if there is an overall reduction in coverage provided to participants. This paragraph does not apply to health care reimbursement accounts.

(4) You 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 (marriage, divorce, legal separation, annulment or death of spouse); (2) change in number of dependents (death of a dependent; birth, adoption, or placement for adoption of a child); (3) change in employment status of you, your dependent or your 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) a change in the place of residence of you, your spouse or dependent. In addition, for purposes of the dependent care reimbursement account, a dependent becoming or ceasing to be a "qualifying dependent" as defined under Internal Revenue Code Section 21(b) will be considered a change in status.

(5) If the Plan receives an order requiring you to provide medical coverage for your child, the Plan must permit you to change your election in a manner consistent with an increase or decrease in your responsibility to provide medical coverage to the child.

(6) If you, your spouse or your dependent becomes covered under Medicare or Medicaid, or loses eligibility for Medicare or Medicaid, or if Medicare becomes primary for you, your spouse or your dependent, the Plan may permit you to cancel or reduce medical coverage prospectively, to commence or increase coverage prospectively, or to change your election to a medical plan that coordinates with Medicare.

(7) If you take an unpaid leave under the Family and Medical Leave Act, you may revoke existing medical elections at the beginning of the leave for the duration of the leave in accordance with the Family and Medical Leave Act.

(8) 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 you to elect the newly-added option (or elect another option if an option has been eliminated) prospectively. This paragraph does not apply to the health care reimbursement accounts.

(9) If the plan of your spouse, former spouse 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 you to make a prospective election change that is on account of or corresponds with a change made under the plan of your spouse, former spouse, or dependent's employer. This paragraph does not apply to the health care reimbursement accounts.

(10) You may make a prospective election change in your dependent care reimbursement account election that is on account of and corresponds with a change in the dependent care provider. You may change your participation or contribution amount if the fee for dependent care increases or decreases, if you make a provider change, if your eligible dependent enters or leaves school and it changes the need for dependent care, or if there is an employment status change for you or your spouse that changes the need for dependent care.

(11) You or your dependents will be permitted to enroll or drop coverage because you or your dependent's Medicaid or state Children's Health Insurance Program (CHIP) coverage is cancelled due to a loss of eligibility, or because you or your dependents enroll in Medicaid or the state CHIP. It is your responsibility to notify the Human Resources Department within 60 days after one of these changes in Medicaid or CHIP.

**If you have a change in status you generally must notify the Human Resources Department within 30 days of the event in order to change your election**. If you provide timely notice of the change in status, your election change will be effective prospectively from the date of the notice. However, if the request to enroll is to add a new dependent due to the birth or adoption of a child, result of marriage or as required by the Health Insurance Portability and Accountability Act of 1996, the effective date of coverage will be retroactive to the date of the event. If you fail to notify the Human Resources Department timely, you will need to wait until the following open enrollment period to change your coverage.

 Waiver of Medical Coverage If you waive medical coverage under the Plan for yourself or your dependents as a result of being covered under another employer's medical plan, you may elect medical coverage under this Plan upon termination of the other coverage if you request enrollment in this Plan within 30 days of the termination and one of the three following requirements is met:

(1) The other coverage was COBRA continuation coverage that was exhausted. COBRA coverage is considered exhausted when an individual's COBRA coverage ceases for any reason other than either the failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA coverage if such coverage ceases (2) (a) due to the failure of the employer or other responsible entity to remit premiums on a timely basis, (b) when the individual no longer resides, lives or works in the service area of an HMO or similar program and there is no other COBRA coverage available to the individual, or (c) when the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA coverage available to the individual.

(2) The other coverage terminated because you no longer are eligible under the terms of the other plan. This does not include a loss of coverage due to the failure to pay premiums on a timely basis or the termination of coverage for cause. It does include the loss of coverage (a) due to divorce, cessation of dependent status, death, or termination of employment, (b) when the individual no longer resides, lives or works in the service area of an HMO or similar program, or (c) when the individual incurs a claim that would meet or exceed a lifetime limit on all benefits.

(3) The other coverage terminated due to the termination of employer contributions. If you request enrollment within 30 days of the termination of the other coverage, the coverage under this Plan will be effective no later than the first payroll date following receipt of the request for coverage.

 Nondiscrimination Rules The Company may alter or revoke your election if you are a highly compensated or key employee if revocation is required in order to satisfy restrictions imposed by the Internal Revenue Code. You will be notified if you are affected by these restrictions.

## SECTION 5
## BENEFITS

Prior to the beginning of each Plan Year, the Plan Administrator will notify each eligible employee of the benefits available for selection for the following Plan Year. The benefits that are currently available for selection are described in Appendix B and the insurance contracts and/or booklets issued by the insurers and administrators of benefits.

## SECTION 6
## HEALTH CARE REIMBURSEMENT ACCOUNTS

> **General**. This benefit permits you to pay eligible "Medical Expenses" that are incurred by you, your legal and lawfully married spouse, or your dependents, with pre-tax dollars. If you elect this benefit, a health care reimbursement account is established for you from which eligible Medical Expenses

are reimbursed. You decide how much money to put into the account based upon your anticipated eligible Medical Expenses. As you incur eligible Medical Expenses, you submit claims to the Plan Administrator, as summarized below.

> **Definitions**. For the purposes of this section, the terms below have the following meaning:

 Dependent means an individual who is a dependent of a participating employee within the meaning of Section 152(a) of the Internal Revenue Code, without regard to subsection 152(b)(I), (b)(2) and (d)(I)(B) (this includes your children who meet the definition of a "qualifying child" as defined in Section 3 of the Plan, as well as your children who are not considered qualifying children, your siblings, parents, nieces or nephews, aunts or uncles, in-laws, or any other individual who receives over half of his or her support from you.

 Health Care Reimbursement Account means the account which your pre-tax contributions may be allocated and from which all allowable Medical Expenses may be reimbursed.

 Medical Expenses means any expense for medical care within the meaning of the term "medical care" or "medical expense" as defined in Internal Revenue Code Section 213 and the rulings and Treasury regulations thereunder. To be an eligible Medical Expense, the expense must meet several requirements:

(1) Effective January 1, 2011, a physician prescription is required for certain over-the-counter drugs and medicines.

(2) The expense may not be claimed as a deduction on your federal income tax return.

(3) The expense must be *incurred* by you or your dependent or legal spouse while you are a participant in the Plan. An expense is incurred on the date when the underlying services giving rise to the medical expenses are performed, and not on the date that the services are billed by the service provider or paid.

(4) The expense can not be covered by other health insurance or reimbursed by any other means.

(5) The following expenses are not eligible Medical Expenses: (a) the cost of other health coverage such as premiums paid under plans maintained by the employer of your spouse or individual policies maintained by you or your spouse or dependent, (b) expenses for 'qualified long-term care services' as defined in Internal Revenue Code Section 7702B(c), and (c) effective January 1, 2011, certain over-the-counter drugs and medicines.

A complete list of eligible Medical Expenses is available upon request from the Human Resources Department.

> **Contributions**. The maximum amount that you may contribute to your health care reimbursement account is listed on Appendix B. The limit is reviewed annually and adjusted in the discretion of the Company. The amount that you elect will be withheld automatically from your pay in equal installments.

> **Reimbursement of Eligible Expenses**. You may claim reimbursement of Medical Expenses by filing a completed claim form with the Human Resources Department. You may receive up

to the maximum amount that you elected to contribute to your health care reimbursement account for the Plan Year at any time during the Plan Year.

You may be required to provide supporting documentation with your claim to show that your expense is a qualified Medical Expense.

All expenses incurred during a Plan Year must be submitted for reimbursement no later than 60 days after the end of the Plan Year. If you terminate employment during the Plan Year, you must submit your claims within 60 days after the end of the Plan Year in which you terminate employment. Otherwise, any money left over in your account will be forfeited, as described below.

If you are a participant in the health care reimbursement account and you change your election mid-year due to a change in status event, you will be permitted to continue to participate in the health care reimbursement account for the remainder of the Plan Year. Any change in election affecting annual contributions to the health care reimbursement account also will change the maximum available reimbursement for the period of coverage remaining in the Plan Year. The maximum available reimbursement for the period of coverage following an election change will be calculated by adding the balance (if any) remaining in your account as of the end of the portion of the Plan Year immediately preceding the change in election to the total contributions scheduled to be made during the remainder of such Plan Year to the health care reimbursement account. For example, assume you have a change in status event that permits you to change your election effective July 1. On June 30, you had a total of $800 remaining in the health care reimbursement account. You then reduce the monthly contribution to $50 ($250 for remainder of year). The total amount that is available for reimbursement for the remainder of the Plan Year is $1,050 ($800 + $250).

> **Reservists.** Reservists called to active duty for at least 180 days or on an indefinite basis may apply for a distribution of cash from their health care reimbursement account. Requests must be documented and substantiated and must be made after the date of the order and before the last day of the Plan Year during which the order occurred. The distribution (minus COBRA payments) is taxable as wages.

> **Forfeiture of Benefits**. You are required to forfeit the amount remaining in your health care reimbursement account as of the end of any Plan Year (and after the processing of all claims for such Plan Year as described above). Forfeitures of benefits under the Plan will be applied towards the cost of administering the Plan. In such event, you will have no further claim to unused money for any reason.

## SECTION 7
## DEPENDENT CARE REIMBURSEMENT ACCOUNTS

> **General.** This benefit enables you to use pre-tax dollars to pay Employment-Related Dependent Care Expenses incurred for the care of a Qualifying Dependent. A dependent care reimbursement account is established for you if you choose this benefit. You decide how much to contribute to the account based upon your anticipated dependent care expenses. You submit claims to the Human Resources Department for reimbursement, as described below.

> **Definitions**. For the purposes of this section, the terms below will have the following meaning:

 Dependent Care Reimbursement Account means the account established for you to which your pre-tax contributions may be allocated and from which all allowable Employment-Related Dependent Care Expenses may be reimbursed.

 Employment-Related Dependent Care Expenses means expenses incurred by you for the care of a Qualifying Dependent or for related household services that would be considered employment related expenses under Internal Revenue Code Section 21(b)(2). Generally, they will include expenses for household services or for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable you to be gainfully employed for any period for which you have Qualifying Dependents. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense will be made subject to the following rules:

(1) If the expense is incurred outside your home at an eligible day care center facility that provides care for a fee for more than 6 individuals who do not regularly reside at the facility and the facility complies with all applicable state and local laws and regulations, including licensing requirements, if any; and

(2) The expense may not include amounts paid to your dependent, your spouse, or your nondependent child who is under age 19.

(3) The following are examples of Employment-Related Dependent Care Expenses:

(a) School. The full amount paid to a nursery school qualifies as an Employment-Related Dependent Care Expense; programs at the level of kindergarten and above do not qualify, unless the program is before- or after-care for a child in school.

(b) Camps. The full amount paid for a day camp or similar program qualifies as an Employment-Related Dependent Care Expenses; expenses for overnight camps do not qualify.

(c) Transportation. The cost of transportation furnished by a dependent care provider may be an Employment-Related Dependent Care Expense.

(d) Employment Taxes. Employment taxes that you pay qualify as an Employment-Related Dependent Care Expenses if the related wages are Employment-Related Dependent Care Expenses.

(e) Room and Board and Indirect Expenses. Indirect costs exceeding usual expenditures for a provider's room and board qualify as Employment-Related Dependent Care Expenses. Indirect expenses such as application and agency fees qualify as Employment-Related Dependent Care Expenses if you are required to pay the expenses to obtain the care.

(f) Household Services. Expenses for household services may be Employment-Related Dependent Care Expenses if the services are provided in connection with the care of the Qualifying Dependent.

 Qualifying Dependent means:

(1) your dependent as defined in Internal Revenue Code Section 152(a)(1) who is under the age of 13; or

(2) your dependent or legal spouse who is physically or mentally incapable of caring for himself or herself (for example, a disabled spouse or parent) and who resides with you. An adult dependent must have gross income that is less than a certain dollar amount as specified in Code Section 151(d) and must receive more than one half of his or her support from you. If services are provided outside of your home, the dependent or spouse must spend at least 8 hours per day in your household (therefore, full-time care for a dependent parent in a nursing facility would not qualify).

> **Contributions**. The amount that you may contribute to your dependent care reimbursement account is limited to the lesser of: (a) $5,000 ($2,500 if you are married and file a separate return), (b) your earned income, or (c) your spouse's earned income. If two married employees both participate in a dependent care reimbursement account, the combined maximum amount is $5,000. This limit will be reviewed annually and adjusted in accordance with the law and in the discretion of the Plan Administrator.

If you are married and your spouse does not work, you generally are not entitled to dependent care reimbursement. However, if your spouse is a full-time student or incapable of caring for himself or herself, then you will be allowed a limited benefit under the Plan. Contact the Human Resources Department if this applies to you.

The amount that you elect to put into your dependent care reimbursement account will be withheld on a pre-tax basis automatically from your pay in equal installments.

> **Reimbursement of Eligible Expenses**. You may claim reimbursement of dependent care expenses by filing a completed claim form with the Human Resources Department. You may be required to provide supporting documentation form to show that your expense is a qualified Employment-Related Dependent Care Expense. At a minimum, the form will include a statement from an independent third party as proof that the expense has been incurred and the amount of such expense. In addition, you must furnish the name, address and tax identification number (Social Security or corporate tax ID) for the provider of dependent care services. The Plan Administrator may require additional information.

All expenses incurred during a Plan Year must be submitted for reimbursement no later than 60 days after the end of the Plan Year. If you terminate employment during the Plan Year, you must submit your claims within 60 days after the end of the Plan Year in which you terminate employment. Otherwise, any money left over in your account will be forfeited, as described below.

Employment-Related Dependent Care Expenses are reimbursable as incurred. The dependent care reimbursement account cannot reimburse you for more money than has been contributed to your account as of the date you make a claim. If there is not enough money in the account to pay the full amount of your claim, a partial payment will be made and the unpaid amount will be held until there are sufficient funds in your account.

> **Tax Credit**. Expenses that are eligible for the dependent care reimbursement account also are eligible for a tax credit under federal tax laws. The amount of federal income taxes you owe may be reduced by a percentage of the money you have spent on eligible dependent care expenses. The percentage varies depending on the combined income of you and your spouse. You are not permitted to use both the tax credit and the dependent care reimbursement account for the same expenses. You should consult with your tax advisor to determine if you should participate in the dependent care reimbursement account or take the tax credit on your federal income tax return.

> **Annual Statement of Benefits**. By January 31st of each calendar year, the Plan Administrator will furnish a statement of dependant care reimbursement amounts made to you during the prior calendar year.

> **IRS Filing**. If you receive dependent care reimbursements, you are required to file IRS Form 2441 with your federal income tax return.

> **Forfeiture of Benefits**. You are required to forfeit the amount remaining in your dependent care reimbursement account as of the end of any Plan Year (and after the processing of all claims for such Plan Year as described above). Forfeitures of dependent care reimbursement accounts will be applied towards the cost of administering the Plan. In such event, you will have no further claim to unused amounts for any reason.

## SECTION 8
## PAYING FOR BENEFITS

Both you and the Employer may share in the cost of benefits. Prior to the beginning of each Plan Year, the Plan Administrator will announce the cost to you (if any) of each of the benefit options offered under the Plan. You generally will pay your portion of the cost for benefits with pre-tax dollars. Pre-tax dollars are not subject to withholding for federal income or FICA taxes. Consequently, the amount withheld from your pay for taxes is reduced. This means a higher take-home pay for you than if you purchased benefits with after-tax dollars. Because your taxes are reduced, your Social Security benefits may be less upon retirement or disability.

All contributions to the Plan will be used to provide benefits in accordance with your benefit elections. Benefits are 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.

## SECTION 9
## TERMINATION OF PARTICIPATION

> **General Date of Termination**. Except as described below, participation in the benefits offered under the Plan generally will terminate on the earlier of (1) the date you terminate your employment with the Employer, (2) the date the Plan is terminated, (3) the date you are no longer an eligible employee, or (4) the date described in the applicable contracts and/or booklets published by the insurers or administrators of benefits. In addition, participation in a specific benefit may terminate upon the failure to pay any contributions under the Plan which may be required from time to time.

A dependent's coverage terminates when your coverage terminates or when the dependent no longer qualifies as a dependent under the Plan, whichever occurs first.

> **Benefit Continuation During Leaves of Absence**. Benefits will continue in accordance with the requirements of the Family Medical Leave Act.

## SECTION 10

## COBRA CONTINUATION COVERAGE

If you lose *health* coverage under the Plan, you and your family may be entitled to elect a temporary extension of the coverage under COBRA (continuation coverage allowed by the Consolidated Omnibus Budget Reconciliation Act of 1985) continuation coverage. For purposes of this section, the term health coverage means medical, prescription drug and dental benefits. Special rules apply to the health care reimbursement account, and are explained below. This section describes the continuation coverage rules.

If you are an employee of the Employer covered by the Plan you have a right to choose COBRA continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct).

If you are the spouse of an employee covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following reasons:

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

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

- Your death;
- A termination of the your employment (for reasons other than gross misconduct) or reduction in the your hours of employment with the Employer;
- Your divorce or legal separation;
- You become entitled to Medicare; or
- The dependent child ceases to be a Adependent child@ under the Plan.

You or your family member has the responsibility to inform the Human Resources Department in writing, 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 COBRA Administrator of your death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

When the COBRA Administrator is notified in writing that one of these events has happened, the COBRA Administrator will in turn notify you that you have the right to choose continuation coverage.

You will have 60 days from the later of the date you would lose coverage because of one of the events described above or the date you are notified of your right to continue coverage to inform the COBRA Administrator, in writing, that you want continuation coverage.

If you do not choose continuation coverage on a timely basis, your health coverage will end on the date specified earlier in this booklet under the section titled ATermination of Participation.@

If you choose continuation coverage, the Employer is required to give you 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 you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. 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. 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, but only if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred; a qualified beneficiary must notify the Human Resources Department, in writing, within 60 days after the second qualifying event occurs if he wants to extend his continuation coverage. 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 you are 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 COBRA 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 COBRA Administrator 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 you during a period of COBRA coverage will be eligible to become a qualified beneficiary upon proper notification to the COBRA Administrator 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 that does not contain any exclusion or limitation with respect to any preexisting condition he or she 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.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible. In addition, the Plan Administrator reserves the right to terminate COBRA coverage if a qualified beneficiary makes a fraudulent claim in connection with the Plan.

You will have to pay all of the premium for your continuation coverage, plus a two percent administrative fee. There is a grace period of 30 days for payment of the regularly scheduled premium; if you fail to pay the premium by the end of the 30 day grace period, your coverage will end.

Special COBRA rights apply to qualified beneficiaries who lose group health plan coverage due to involuntary termination at any time from September 1, 2008 through December 31, 2009 and employees who are terminated from employment or whose hours are reduced because of a trade-related reason. If you think you are included in one of these groups of employees, you should contact the Plan Administrator for further information.

Special COBRA rules apply if you lose coverage under the health care reimbursement account for one of the reasons described in this section. If you elect COBRA continuation coverage under the health care reimbursement account, the coverage will last only until the end of the current Plan Year. See the Human Resources Department if this applies to you and you wish to continue your coverage under the health care reimbursement account.

Your election and payment due dates will be specified in the COBRA notice that you receive from the COBRA Administrator. If you fail to make an election and/or premium payment on a timely basis, COBRA coverage will stop.

All notices must be in writing and addressed to the COBRA Administrator.

## SECTION 11
## CLAIMS PROCEDURES

**> Insured Benefits.** The Employer provides benefits through its purchase of insurance. The insurance companies provide coverage only under the terms of the insurance contracts. The insurance companies are responsible for determining your eligibility for benefits and paying claims. If you have a claim, you should contact the insurance company directly. The procedures for submitting claims and appealing denied claims for benefits generally are described in the applicable benefit booklets published by the insurers.

**> Reimbursement Accounts**. This section will apply to appeals of denied claims under the reimbursement accounts, and to the other benefits offered under the Plan only to the extent the claims procedures are not otherwise described in the applicable insurance contracts and/or booklets.

**> Definitions**. The following terms have the meanings specified in this section.

 "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.

 "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.

 "Post-Service Claim" means any claim for a benefit under the Plan that is not a Pre-Service Claim.

 "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.

> **Notification of Benefit Determination**. The Plan Administrator (or it=s designee) will notify the claimant of the Plan's benefit determination as follows:

 Medical Care Expense Claim.

(1) 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 it's 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 it's 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.

(2) 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.

(3) 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.

(4) Concurrent Care Decision.. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or

termination of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments, shall constitute an adverse benefit determination. The claimant will be notified at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided as soon as possible, taking into account the medical exigencies, and the claimant will be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

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

 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.

> **Review of Denied Claims**. A claimant whose claim for benefits has been wholly or partially denied by the Plan Administrator (or it's 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 it's 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 it's designee). Prior to submitting his request, the claimant shall be entitled to review such documents as the Plan Administrator (or it's 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 it's designee's) decision with respect to any such review shall be set forth in writing and shall be provided to the claimant as follows:

 Medical Care Expense Claim.

(1) 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.

(2) 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.

(3) 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.

- 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.

- 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.

## SECTION 12
## AMENDMENT AND TERMINATION OF PLAN

The Plan, the contracts incorporated into the Plan by reference, and the underlying Plan benefits are subject to alteration, amendment, or termination in whole or in part, at any time by a written resolution adopted by the Company's Board of Directors, or by any person or persons authorized by resolution of the Company's Board of Directors. Generally, if the Plan is terminated, you will be entitled to receive payment for covered expenses incurred before the Plan termination, but will not have any further rights under the Plan.

## SECTION 13
## HEALTH LAW INFORMATION

> **Family and Medical Leave Act**. If you are on a leave of absence covered by the Family and Medical Leave Act (FMLA), you are entitled to maintain your medical coverage. If you take an unpaid leave, you may either (1) revoke medical coverage or (2) continue medical coverage.

If you elect to continue your coverage, you will be required to pay your share of the premium cost during the leave. You have the following payment options while on an FMLA leave:

- Pre-pay. You can pay, before the unpaid FMLA leave begins, the contribution amounts for the FMLA leave period. Contributions under the pre-pay option may be made on a pre-tax basis or an after-tax basis. However, you may not pre-pay FMLA leave period contributions for a subsequent plan year on a pre-tax basis.

- Pay as you go. You may pay your share of the premium payments on the same schedule as payments would have been made by employees not on leave on either a pre-tax basis (if you continue to receive pay from your Employer) or an after-tax basis.

- Catch up. You and the Employer may arrange a schedule for you to catch up your payments when you return to work from your leave.

If you revoke coverage, upon return from leave, you will reinstated in the medical coverage on the same terms as prior to taking FMLA leave, subject to any changes in benefit levels that may have taken place during the period of FMLA leave.

Special rules apply to the health care reimbursement account. If you continue coverage during your leave, the full amount of the elected health coverage, less any prior reimbursements, will be available to you at all times, including the FMLA period. If you revoke coverage during the leave, upon return from the leave, you may resume coverage at the level in effect before the FMLA leave and make

up the unpaid contributions, or resume coverage at a level that is reduced and resume contributions at the level in effect before the FMLA leave. If your coverage under the health care reimbursement account terminates while on FMLA leave, you are not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Further, if you subsequently elect to be reinstated in the Health care reimbursement account upon return from FMLA leave for the remainder of the Plan Year, you may not retroactively elect Health care reimbursement account coverage for claims incurred during the period when coverage was terminated.

If you do not return to work after your FMLA leave, you must reimburse your Employer for any premium amounts it paid to maintain your benefits during your leave within 30 days from the last day of the leave period.

The Employer is not required to maintain your non-medical benefits during FMLA leave. However, the Employer may continue your non-medical benefits while you are on FMLA leave in order to ensure that the Employer can meet its responsibility to provide equivalent benefits upon return from unpaid FMLA.

See the Employer for more details if this applies to you.

> **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 your prior health coverage. If you terminate your employment and become covered under another employer's plan, or if your 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 and dependent who is covered under the medical benefits offered under the Plan with a certificate describing the individual's coverage under this Plan at the following times:

- if the individual is a qualified beneficiary for COBRA purposes, upon the occurrence of a qualifying event,
- at the time the individual ceases to be covered under the Plan,
- at the time the individual's coverage ceases due to the operation of a lifetime limit on all benefits, and/or
- if an individual elects COBRA, when COBRA coverage ceases.

The Employer may contract with the medical benefits insurer to provide this certificate. You may also request a certificate of coverage within 24 months of loss of coverage by making a written request for such certification to the Human Resources Department.

> **Qualified Medical Child Support Orders**. If the Plan receives an order that is a Qualified Medical Child Support Order (AQMCSO@) requiring you to provide medical coverage for your child, the child will be enrolled in coverage in accordance with the QMCSO.

(a) Definitions. For purposes of the QMCSO requirements, the following terms have the meanings indicated:

(i) Alternate Recipient means any child of an employee who is recognized under a medical child support order as having a right to enroll in a group health plan with respect to the employee.

(ii) Medical Child Support Order means any court judgment, decree or order (including approval of settlement agreement) or state administrative order that: provides for child support for a child of a Participant under the group health plan, or provides for health coverage to such a child under state domestic relations law, and relates to benefits under this Plan.

(iii) Qualified Medical Child Support Order means a medical child support order that creates or recognizes an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or beneficiary is eligible under a group health plan, and which the Plan Administrator has determined meets the qualification requirements of these procedures. To be qualified, a medical child support order must clearly: specify the name and the last known mailing address (if any) of the employee and the name and mailing address of each Alternate Recipient covered by the order; include a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and specify each period to which such order applies.

To be qualified, a medical child support order must not require the Plan to provide any type or form of benefits or any option not otherwise provided under the Plan except to the extent necessary to meet the requirements described in Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

A properly completed state administrative order issued under the Child Support Performance and Incentive Act of 1998 (ACSPIA@) automatically is deemed to be qualified.

(b) Procedures. ERISA and CSPIA require the Employer to take certain actions to help enforce state administrative and court orders for medical child support. Pursuant to ERISA, the Employer adopts the following procedures for determining whether medical child support orders are qualified in accordance with ERISA's requirements. The Plan Administrator also adopts these procedures to administer payments and other provisions under Qualified Medical Child Support Orders.

Upon receipt of a medical child support order, the Plan Administrator shall:

(i) Promptly notify in writing the employee, each Alternate Recipient covered by the order and each representative for these parties of the receipt of the medical child support order. Such notice shall include a copy of the order and these QMCSO procedures for determining whether such order is a QMCSO.

(ii) Permit the Alternate Recipient to designate a representative to receive copies of notices sent the Alternate Recipient regarding the medical child support order.

(iii) Within a reasonable period after receiving a medical child support order, determine whether it is a qualified order and notify the parties indicated in subsection (i) of such determination.

(iv) Ensure the Alternate Recipient is treated by the Plan as a Beneficiary for ERISA reporting and disclosure purposes, such as by distributing to the Alternate Recipient a copy of the summary plan description and any subsequent summaries of material modifications generated by a plan amendment.

If the Plan receives a state administrative or court medical child support order under SCPIA requiring the Employer to withhold employee contributions for group health coverage for a child, the Plan Administrator will determine whether the employee is covered or eligible under the Plan, and whether the child is eligible under the Plan. After the Plan Administrator determines the employee is subject to income withholding to pay for the child's coverage, the Plan Administrator will then notify the employee and the child's custodial parent (when that is not the employee) that coverage is or will become available. The Plan Administrator will furnish the custodial parent a description of the coverage available, the effective date of the coverage and any forms, documents or other information needed to put the coverage into effect, as well as information needed to submit claims for benefits. If employee contributions are available to pay for the children's coverage, the Plan Administrator will withhold contributions from employee income and notify the employee to that effect.

> **Maternity and Newborn Coverage**. The Plan offers maternity and newborn coverage. Under federal law, group health plans and health 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).

> **Breast Reconstruction Benefit**. If you or a 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 applicable insurance contracts and related material.

> **Military Duty.** Your 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). Special continuation rules apply if you leave employment to undertake military service and would lose health coverage under the Plan. If you leave your job to perform military service, you have the right to elect to continue your existing employer provided health plan coverage for yourself and your dependents for up to 24 months while in the military service. If you elect to continue coverage, you must pay for that coverage. If your military leave period is 30 or fewer days, you will be charged the employee share of the premium for that period of coverage. If your military service lasts more than 30 days, the Plan will charge you 102 percent of the applicable total premium for the coverage. The COBRA coverage period and the USERRA coverage period run concurrently. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are re-employed, generally without any waiting periods or exclusions except for service connected illnesses or

injuries. The Employer has adopted written procedures relating to the election of and payment for continued coverage while on a military leave of absence. If this Section applies to you, please contact the Human Resource Department for further information.

> **Managed Care**. You or your dependent, together with your doctor, are responsible for determining the appropriate course of medical treatment in any given case, regardless of whether the Plan will pay for all or a portion of the cost of such care. Neither the Company nor the Employer is responsible for the quality of care that may be rendered by any provider.

> **Coordination of Benefits and Subrogation.** The insurance contracts and related materials describe the coordination of benefits provisions and the subrogation and reimbursement provisions that apply to insured medical benefits.

> **Privacy under the Health Insurance Portability and Accountability Act of 1996**.

 General Obligations of the Plan Administrator. The Plan Administrator will adopt procedures to ensure the privacy of Protected Health Information (APHI@) in accordance with the Health Insurance Portability and Accountability Act of 1996 (AHIPAA@). Such procedures will comply with the requirements of HIPAA and any other applicable law.

 Application of this Section. HIPAA privacy applies only to the medical, prescription drug and dental benefits and the health care reimbursement accounts offered under the Plan to the extent required by HIPAA.

 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 health care treatment, payment for health care, and health care operations, as more fully described below. In addition, the Plan may permit an insurance company, insurance service, insurance organization, business associate 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 implements 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 Acovered entity@ under HIPAA or, following completion of the sale or transfer, will become a covered entity.

 Disclosure of Summary Health Information and Information on Enrollment.

(1) The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor 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 Plan Sponsor 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.

 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 Plan Sponsor's life and disability carriers and workers compensation insurer for purposes related to the administration of these plans.

 Certification of Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that this Amendment has been adopted and that the Plan Sponsor 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 Plan Sponsor 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 Plan Sponsor;

(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 Plan Sponsor 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 Plan Sponsor will return or destroy all PHI that the Plan Sponsor received from the Plan and that the Plan Sponsor no longer needs for the purpose for which disclosure was made, except that if such return or destruction is not feasible, the Plan Sponsor 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.

 Adequate Separations. The Plan Sponsor will ensure that the following adequate separations are established between the Plan and the Plan Sponsor:

(1) Only the following employees or classes of employees may be given access to PHI:

(a) The Human Resources Director, and
(b) Any staff designated by the Human Resources Director;

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

**> Security under the Health Insurance Portability and Accountability Act of 1996.**

 Application. This Section does not apply to the Plan and/or the Employer, if the only *electronic* Protected Health Information (APHI@) disclosed to the Employer by the Plan, health insurance issuer or HMO, is (a) summary health information disclosed to the Employer if the Employer requests the information for the purpose of: (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan, or (b) 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, or (c) information disclosed 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.

 Security Requirements. To the extent that this Section applies, the Plan Sponsor will reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan, as follows. In accordance with the HIP AA security provisions and 45 CFR 164.314, the Employer agrees to:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that the adequate separation required by 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(4) Report to the Plan any security incident of which it becomes aware.

If a Business Associate (as defined under HIPAA) learns of a pattern of activity or practice that constitutes a material breach or violation of the obligations relating to PHI, the Business Associate will notify the covered entity promptly, and cooperate with the covered entity in curing the breach or ending the violation. In the even the breach or violation remains, the Business Associate will take reasonable steps to cure the breach or end the violation, as applicable, and if the steps are unsuccessful, the Business Associate will terminate the business associate agreement if feasible, or if not, report the breach or violation to the U.S. Secretary of Health and Human Services.

## SECTION 14
## ADDITIONAL INFORMATION

> **Employer's Rights**. While the Employer believes in the benefits, policies and procedures described in the Plan, the language in the Plan is not intended to create, nor is it to be construed to constitute, a contract of employment between the Employer and any of its employees. The Employer retains all of its rights to discipline or discharge employees or to exercise its rights as to incidents and tenure of employment. You continue to have the right to terminate your employment at any time and for any reason, or no reason at all, and the Employer retains a similar right with regard to terminating your employment.

> **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.

> **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.

> **Facility of Payment**. Whenever payments which should have been made under this Plan in accordance with its provisions have been made under any other plans, the Plan shall have the right, exercisable alone and in its full discretion, to pay over to any organizations making such other payments any amounts it shall deem to be warranted in order to satisfy the intent of this provision, and any amount so paid shall be deemed to be benefits paid under this Plan and the extent of such payments, the Plan shall be fully discharged from liability under this Plan.

## SECTION 15
## PLAN ADMINISTRATION

> **Plan Administration**. The Company (or such person or entity as it shall designate) is the Plan Administrator and will administer the Plan in accordance with its terms. The Plan Administrator (or such person or entity as it shall designate) has the sole and discretionary authority and responsibility to review and make final decisions on Plan matters such as eligibility for coverage determinations and construing Plan terms. Any interpretation of any provision of this Plan made in good faith by the Plan Administrator is final and will be binding. The insurers of benefits have complete discretion to interpret and administer the provisions of the respective insurance contracts and benefits booklets, including all decisions regarding claims. The Plan Administrator (or such person or entity as it shall designate) has such powers and duties as may be necessary to discharge its functions under the Plan, including, but not limited to the following:

(a) Construction: to construe and interpret the Plan and decide all questions of eligibility to participate in the Plan;

(b) Forms: to require participants (1) to complete and file with it such forms as the Plan Administrator finds necessary or desirable for the administration of the Plan, and (2) to furnish all pertinent information requested by the Plan Administrator, and to rely upon all such forms and information furnished, including each participant's mailing address;

(c) Procedures: to prescribe procedures to be followed by participants in electing benefits and filing claims for benefits;

(d) Rules: to promulgate uniform rules and regulations whenever in the opinion of the Plan Administrator such rules and regulations are required by the terms of the Plan or would facilitate the effective operation of the Plan;

(e) Information: to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan, and to receive from participants such information as shall be necessary for the proper administration of the Plan;

(f) Annual Reports: to prepare, furnish, and file such annual reports with respect to the administration of the Plan as are required by law or as are reasonable and appropriate;

(g) Insurers: to appoint and remove insurance carriers;

(h) Records: to prepare, receive, review, and keep on file (as it deems convenient and proper) records of benefit payments and disbursements for expenses; and

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

(ii)

> **Fiduciaries**. The Company is a "named fiduciary" of this Plan. The Company has 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 Company has the sole responsibility for making contributions or purchasing insurance in order to provide the benefits available under the Plan. The Company may allocate its fiduciary duties under the Plan to other Plan fiduciaries (such as Employers) by written agreement between the Company and such other fiduciaries. The Company is deemed to have properly exercised such fiduciary authority unless it has abused its discretion by acting arbitrarily and capriciously.

The insurers of benefits are a named fiduciary of this Plan with respect to claim determinations relating to the respective benefits offered under the Plan.

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

> **Employment of Advisers**. The Company has the authority to employ such legal, accounting, and financial counsel and advisers as it deems 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.

> **Delegation to Officers or Employees**. The Company has the power to delegate its fiduciary duties under the Plan or under any benefit available under the Plan to officers or employees of the Company or Employers and to other persons, all of whom, if employees of the Company shall serve without compensation other than their regular remuneration from the Company.

> **Fees and Expenses**. All expenses incurred in the operation and administration of the Plan, including the fees and expenses of counsel and other advisors and the compensation, if any, of the fiduciaries, agents, and administrators shall be paid or reimbursed by the Company or Employer unless the Company determines that such fees and expenses will be paid in whole or in part by the Plan or by participants.

## SECTION 16
## YOUR 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. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**

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

**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 U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Washington D.C. 20210, telephone (202) 693-8673.

## SECTION 17
## ADMINISTRATIVE INFORMATION

> **Plan Sponsor**. The Plan Sponsor is Universal Truckload Services, Inc. 12755 E. Nine Mile Rd., Warren, MI , 48089; telephone number (586) 920-0100.

> **Plan Administrator**. Universal Truckload Services, Inc. is also the Plan Administrator. The address and telephone are the same as given in 1 above.

> **Plan Number**. The Plan number assigned to this Plan is 503.

> **Type of Plan**. Welfare benefit plan and cafeteria plan including medical, prescription drug, dental, and life insurance, with optional long term disability benefits, and if adopted by Employer, health care and dependent care reimbursement accounts.

> **Type of Administration**. Insured 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 insurance companies that insure benefits are listed on Appendix B. The addresses and telephone numbers of the insurers are provided in the applicable benefit booklets.

Some benefits are self-insured, such as the health care and dependent care reimbursement accounts. The Plan Administrator processes reimbursement account claims.

> **COBRA Administrator**. The COBRA administrator is Cherokee Insurance Company, 34200 Mound Road, Sterling Heights, MI 48310.

> **Agent for Service of Process**. The person currently named as the Agent for Service of Process is: Universal Truckload Services, Inc. 12755 E. Nine Mile Rd., Warren, MI , 48089. Process also may be served upon the Plan Administrator at the address given above.

> **Plan Year**. The Plan Year is the calendar year.

Universal Truckload Services, Inc. has caused this amended and restated Plan to be effective as of January 1, 2010, with amendments effective January 1, 2015.

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**UNIVERSAL TRUCKLOAD SERVICES, INC.**
**WELFARE BENEFIT PLAN**

**APPENDIX A**
**PARTICIPATING EMPLOYERS**
**Effective January 1, 2015**

| PARTICIPATING EMPLOYER NAME | |
|---|---|
| Universal Dedicated, Inc. | |
| Universal Intermodal Services, Inc. | |
| Universal Management Services, Inc. | |
| Universal Truckload, Inc. | |
| Universal Logistics Solutions International Inc. | |
| Universal Specialized, Inc. | |
| Logistics Insight Corp. | |
| Cavalry Logistics, LLC | |
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**UNIVERSAL TRUCKLOAD SERVICES, INC.**
**WELFARE BENEFIT PLAN**

**APPENDIX B**
**BENEFITS**
**Effective January 1, 2015**

| BENEFIT | BENEFIT DESCRIPTION/ INSURER | DEPENDENT ELIGIBILITY | EMPLOYEE COST | ADDITIONAL INFORMATION |
|---|---|---|---|---|
| **MEDICAL INSURANCE** | Cherokee Insurance Company, using various PPOs<br>MEDCO for prescription drugs | Dependent coverage is available. | Employees pay a portion of the premium cost on a pre-tax basis. The Employee portion is announced prior to the beginning of the Plan Year. Employees are responsible for deductibles and co-pays. | See the benefit booklets published by Cherokee Insurance Company and MEDCO. |
| **DENTAL INSURANCE** | Cherokee Insurance Company | Dependent coverage is available. | Employees pay a portion of the premium cost on a pre-tax basis. The Employee portion is announced prior to the beginning of the Plan Year. Employees are responsible for any deductibles and co-pays. | See the benefit booklet published by Cherokee Insurance Company. |
| **EMPLOYEE LIFE INSURANCE** | Reliance Standard Life Insurance Co.<br><br>Life insurance pays a maximum of $50,000. | Dependent coverage is not available. | The Employer pays the full premium cost for coverage. | See the benefit booklet published by Reliance Standard Life Ins. Co. |
| **LONG TERM DISABILITY INSURANCE** | Coverage is voluntary. Benefits are provided by and are insured through Cherokee Insurance Company. | Dependent coverage is not available. | Employees pay the full cost of coverage on an after-tax basis. | See the benefit booklet published by Cherokee Insurance Company. |

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|---|---|---|---|---|
| **HEALTH CARE REIMBURSEMENT ACCOUNT** | Maximum annual benefit $2,500. | N/A | Employees pay the full cost of coverage on a pre-tax basis. | N/A |
| **DEPENDENT CARE REIMBURSEMENT ACCOUNT** | Maximum annual benefit $5,000 ($2,500 if married and filing jointly) | N/A | Employees pay the full cost of coverage on a pre-tax basis. | N/A |

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**WELFARE BENEFIT PLAN**

**PLAN DOCUMENT/**
**SUMMARY PLAN DESCRIPTION**

**EFFECTIVE JANUARY 1, 2010 and**
**AMMENDED JANUARY 1, 2015**

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