THE EMPLOYEE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

AS ADOPTED BY
VAN'S LUMBER & CUSTOM BUILDERS, INC.
01/01/2015

Dear Employee:

RE: IMPORTANT INFORMATION ABOUT YOUR GROUP BENEFIT PLAN(S)

We are pleased to provide you with a health and welfare benefit plan which offers valuable financial security for you and your eligible dependents. The following summarizes the benefits provided by your employer for all eligible employees and their eligible dependents.

It is important for you to carefully study and understand your benefits so you can make the best decision regarding their use. You are encouraged to ask questions and obtain clarification on any matters about which you are uncertain.

Your benefit program has been carefully designed to provide protection against the sudden and unexpected cost of illness or injury. The program also helps you prepare for secure retirement years and it helps take care of your family in the event of your death. These are matters of concern to all of us.

The following does not include every detail and administrative procedure of the Plan. You are encouraged to discuss issues which may not be clearly or completely explained with your benefits representative before taking any actions which could result in an unreimbursed expense.

In all situations involving the interpretation or clarification of a policy, procedure or application, the decision of the Plan Administrator will be final and binding. Notwithstanding the foregoing, a claim for benefits that has been denied is subject to review pursuant to the Claims Procedure Section specified in this Summary.

This is merely a summary of the main features of the Plan and not a detailed description of all of its provisions. If, in the future, the provisions described herein should change for any reason, you will be provided with a summary of the changes.

If, for any reason, there is an omission or misstatement in this summary, or any difference between this summary and the legal documents, the legal documents will in all respects control and govern.

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Attachment

- Summary of Plan

1. IMPORTANT DEFINITIONS

As you read about your benefits, you may find terms which have specific meaning. This section lists important terms and their meanings under the Plan. Any term not included in this section, but used in this Summary shall have the same meaning as specified in the Plan.

AD&D means accidental death and dismemberment insurance.

Cafeteria Plan means a cafeteria plan under Code Section 125 established by the Company under a separate document.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985.

Company means the Plan Sponsor.

Component Benefit Program means those benefits programs specified in Section 3 of the Plan.

Dependent means a family member that meets the requirements specified in the Component Benefit Programs.

Employee means any common-law employee of the Employer who satisfies the eligibility provisions of Section 4 and who is not excluded from participation by the terms of benefits under the Component Benefit Program.

Employer means the Company and any related employers who are participating under this Plan.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Health Flexible Spending Account means the portion of the Cafeteria Plan that reimburses unreimbursed medical expenses under Code Section 213(d).

Health Reimbursement Arrangement means a health reimbursement arrangement sponsored by the Company.

HIPAA means the federal Health Insurance Portability and Accountability Act of 1996, which is far-reaching legislation designed to improve the portability of health coverage and to make other changes to the health care delivery system.

HITECH means the Health Information Technology for Economic and Clinical Health Act.

Insurer means any insurance company with whom the Company has contracted to provide one or more of the benefits under the Component Benefit Program to you and your eligible Dependents in exchange for a premium paid. It is the Insurers' duty to pay claims covered under the benefit provided under the Component Benefit Program in which you and your Dependents are enrolled.

Named Fiduciary means Named Fiduciary.

NMHPA means the Newborns' and Mothers' Health Protection Act of 1996.

Plan means this Employee Benefit Plan(s).

Plan Administrator means the individual or entity specified in Section 1 of this Summary.

Protected Health Information ("PHI") means individually identifiable health information that is maintained or transmitted by a covered entity, subject to specified exclusions as provided in federal regulations.

PPACA means the Patient Protection and Affordable Care Act.

Spouse means an individual who is legally married to a Participant and specified in each of the benefits through the Component Benefits Program.

USERRA means the Uniformed Services Employment and Reemployment Act of 1994.

2. COMPONENT BENEFIT PROGRAM INFORMATION

What benefits are offered under the Plan?

The Company maintains the Plan for the exclusive benefit of its eligible Employees and their Spouses and other Dependents to provide certain health and welfare benefits. The Plan provides these benefits through the Component Benefit Program. **See Summary of Plan.**

Some of the benefits under the Component Benefit Program require you to make an annual election to enroll for coverage. The details of such annual elections are described in the Cafeteria Plan.

Where can you find information regarding the benefits?

Each of these benefits under the Component Benefit Program is summarized in a certificate of insurance issued by an Insurer, a summary plan description or another governing document prepared by the Company. A copy of each booklet, summary or other governing document is provided in the Attachments Section to this Summary.

This document and its Attachments constitute the summary plan description for each of the Component Benefit Programs as required by ERISA Section 102.

Are the Medical Benefits provided under the Component Benefit Program Grandfathered?

See Summary of Plan.

What are the important limitations?

Benefits hereunder are provided pursuant to an insurance contract or governing written plan document adopted by the Company. If the terms of this document conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this document, unless otherwise required by law.

3. ELIGIBILITY AND PARTICIPATION REQUIREMENTS

When are you or your Dependents eligible to participate under the Plan?

An eligible Employee with respect to the Plan will be any common-law employee of the Employer who is eligible to participate in and receive one or more benefits under the Component Benefit Program. To determine whether you or your Dependents are eligible to participate in any of the benefits under the Component Benefit Program, please read the eligibility information for each benefit in the **Summary of Plan**.

How do you enroll your Dependents?

To enroll your eligible Dependents, or if you later gain Dependents, you must complete and return a new enrollment form to the Plan Administrator. They become eligible for coverage on the date they first qualify as a Dependent and if you have enrolled them to participate.

If you incur a change in family status during the Plan Year, as defined under HIPAA, you can change your tier of coverage election. **See Summary of Plan.**

Generally speaking, changes in family status include, but are not limited to: marriage, divorce, birth or adoption of a child, or death of a Dependent.

Newborn or newly adopted children are covered under the group health plans as soon as they meet the definition of a Dependent, provided that you enroll the child in the Plan within 30 days from the child's birth or placement for adoption. Coverage for a new Spouse is effective no later than the first day of the month following after the date the plan receives the completed request for enrollment. **If you do not enroll a newborn child, a newly adopted child or a new Spouse within the specified 30-day period, you must wait until the open enrollment period.** Contact your designated benefits representative to enroll newly acquired Dependents. You may need to show proof of the status change before you can elect new benefits.

Under what circumstances may you enroll yourself, your Spouse and your other Dependents in the Plan during the Plan Year when you, your Spouse and/or your other Dependents lose other coverage?

If you, your Spouse and/or your eligible other Dependents choose not to enroll in the any of the benefits specified above in the previous question at the time that you initially become eligible because you maintain coverage under another group health coverage, you may be provided with an opportunity to elect coverage in the event that your previously held coverage ends. In order to be eligible to elect coverage under this special enrollment opportunity, you must have lost coverage under one of the following circumstances:

- You and/or your Dependents lost coverage under your prior plan because you and/or your eligible Dependents became ineligible under that plan or because the Company's contribution made to coverage under the plan had ended; or

- You and/or your Dependents were enrolled in coverage under COBRA and the COBRA coverage period expired.

In either case, no special enrollment period will be provided to you and/or your Dependents where your previous coverage maintained (either COBRA or non-COBRA) ended because you and/or your Dependents failed to pay the required premiums for the coverage in a timely manner.

Are there any other situations where you can enroll yourself, your Spouse and you're other Dependents in the Plan during the Plan Year?

Yes. If you, your Spouse and/or your eligible other Dependents are eligible but did not enroll in the Medical Benefit, you and/or your eligible Dependents may enroll in these benefits under two additional circumstances, which are becoming eligible for a premium assistance subsidy in the Medical Benefit, under Medicaid or a State Child Health Insurance Plan.

You must request coverage under the Plan within 60 days of termination or the date it is determined that you or your child are eligible for assistance in order to be entitled to these special enrollment rights.

When does your participation in the Plan end?

If you terminate employment (including retirement), or you or your covered Dependents otherwise become ineligible for benefits (i.e. because of age restrictions or divorce), coverage will cease under the terms of the benefits under the Component Benefit Program. If the Company decides to terminate the Plan, coverage will end on the termination date.

Under these circumstances (unless coverage ends because your employment is terminated due to gross misconduct), you and your covered Dependents may be eligible to continue benefits under the Component Benefit Program under COBRA as provided in Section 7 of this Summary.

Note: During the 31 day period following termination of your coverage, you may be able to convert some of your benefits under the Component Benefit Program to individual policies without providing evidence of insurability. You should consult the certificate of insurance booklets, summary plan descriptions and other governing documents for the Component Benefit Programs for additional information.

If you terminate your employment for any reason, including (but not limited to) disability, retirement, reduction in force, layoff or voluntary resignation, and then are rehired. **See Summary of Plan.**

If you (whether or not a Participant) terminate employment and are not rehired within the time specified above or cease to be an eligible employee or any other reason, including (but not limited to) a reduction in hours, and then become eligible again, you must complete the waiting period described in the benefits under the Component Benefit Program before again becoming eligible to participate in the Plan, unless your collectively bargaining agreement provides otherwise.

4. SUMMARY OF PLAN BENEFITS

Who pays for the benefits under the Plan?

The cost of benefits provided through the Component Benefit Program will be funded wholly by employer contributions, in part by employer contributions, wholly by employee contributions or in part by employee contributions. These Employee contributions can be either pre-tax or post-tax depending on the terms of the Cafeteria Plan, if applicable. The Company will determine and periodically communicate your share of the cost of the benefits provided through Component Benefit Program, and it may change that determination at any time.

The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefit or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to the Insurer, or with respect to benefits that are self-funded, will use contributions to pay benefits directly to or on behalf of you or your eligible Dependents from the Company's general assets. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay the cost of such benefit.

How are the Medical Benefits coordinated with Medicare?

For active employees (or Spouses of active employees) age 65 and over, any group health coverage is primary and Medicare is secondary. You or your Spouse may elect Medicare as primary coverage, but if you do, the Employer can't offer you group medical coverage, even on a secondary basis.

What is a Qualified Medical Child Support Order?

Some benefits under the Component Benefit Program must be provided as required by any Qualified Medical Child Support Order (QMCSO). A QMCSO is an order issued by a court or by an administrative agency pursuant to state law directing an individual to provide certain Benefits for an otherwise eligible dependent child, even if the individual is the non-custodial parent.

The Plan has detailed procedures for determining whether an order qualifies as a QMCSO, and such determinations will be made by the Plan Administrator within a reasonable period of time. For an order to be qualified, it must generally include all of the following:

- The child's name and last known mailing address for which the coverage must be furnished;
- Your name and last known mailing address;
- A reasonable description of the type of health coverage to be provided for each child included in the order; and
- The period or length of time for which coverage must be furnished.

As a part of this process, the Plan Administrator may provide Plan and benefit information necessary for the preparation of a QMCSO to the custodial parents of a child and/or any state child support enforcement agencies acting on the child's behalf. Upon receipt of an order, the Plan Administrator will notify you and your child or child's custodial parent or guardian and will provide copies of the Plan's procedures for determining whether the order is qualified. You and your beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Subsequent to making its determination, you, your child or child's custodial parent or guardian, and any applicable state agencies will be notified by the Plan Administrator of its determination as to whether the order is qualified. The Plan Administrator has no obligation to determine whether the court or administrative agency issuing the order has correctly applied State law. Furthermore, the Plan has no responsibility for ensuring that the individual identified in an order as an alternate recipient is in fact your child, or that service was properly made on the parties. Finally, the child who the order requires to be covered by you must meet the eligibility requirements for a Dependent under the Plan to be enrolled into coverage.
Where a medical child support order is qualified, the eligible child must be enrolled into coverage under the applicable benefit under the Component Benefit Program at the earliest possible date following such a determination. If you are not enrolled or participating in the applicable benefit at the time an order is determined to be qualified, then the Plan Administrator

will enroll you in coverage as the same date as the child. If there is a waiting period following enrollment for coverage to begin, coverage will begin on the first possible date following the waiting period. Once the waiting period has expired, you and/or your child shall be eligible for coverage under the Plan. The Company has the discretion to add an alternate recipient to the corresponding Employee's coverage as long as the alternate recipient meets the Plan's dependent eligibility requirements.

Your child and/or child's custodial parent or guardian will be provided with a copy of all Plan related notices and communications that you would normally receive. If you are aware of a QMCSO, you may contact the Plan Administrator.

What is a Certificate of Creditable Coverage?

When you or your Dependents lose medical coverage, the Company or the Insurer will automatically mail a certificate of creditable coverage to your home.

This certificate can be used, in accordance with HIPAA, to prove you were covered under a medical plan for a certain length of time. The certificate will prove that you had coverage for up to a maximum of 18 months. You can use this certificate to offset and possibly eliminate pre-existing condition exclusions that may apply under medical coverage in which you later participate.

What are your rights under the Newborns' and Mothers' Health Protection Act of 1996?

Medical plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally doesn't prohibit the mother's or newborn's attending medical care provider from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after consulting with the mother. In any case, federal law prohibits the Plan from requiring that a medical care provider obtain authorization for a length of stay that's less than or equal to 48 (or 96) hours.

What happens to your coverage if you suffer from end stage renal disease?

You are eligible for Medicare if you require regular dialysis or kidney transplant services. Medicare coverage becomes primary and this medical coverage becomes secondary after a 30-month coordination of benefits period (This 30-month period applies if you are already enrolled in Medicare because of age or disability).

What is the coverage for a Mastectomy?

Federal law requires a medical plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- Prostheses and physical complications at all stages of mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Coverage for breast reconstruction and related services will be subject to deductibles and co-insurance amounts that are consistent with those that apply to other benefits under the Plan.

What is Pre-existing Condition and how does it affect your coverage?

Claims resulting from Pre-existing Conditions may be excluded from some of the benefits under the Component Benefit Program until you and/or your covered Dependent(s) are covered under the Plan for a time equal to 12 consecutive months (18 months in the case of a Late Enrollee) minus you and/or your Dependent's period of Creditable Coverage. Any Pre-existing conditions will be excluded for Plan Years beginning on or after January 1, 2014. For purposes of this section, "Creditable Coverage" is defined as your coverage under a medical plan, Medicare or any one of several other specified health plans that is not interrupted by a 63-day break in coverage. Please refer to the certificate of insurance, summary plan description or other summary attached to this summary benefits for the Component Benefit Program in the Attachments Section of this Summary for details.

How does a leave of absence (such as under FMLA) affect my benefits?

If your benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be entitled to re-enter such benefits, as applicable, upon return from such leave on the same basis as you were participating in the Plan before the leave, or otherwise required by FMLA. **See Summary of Plan.**

You are entitled to have coverage for such benefits automatically reinstated as long as coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave. But despite the preceding sentence, with regard to benefits under the Cafeteria Plan, if your coverage ceased, you will be entitled to elect whether to be reinstated in your benefits under the Cafeteria Plan at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which you did not pay premiums. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated benefits under the Cafeteria Plan will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, your election for non-health benefits will be treated in the same way as under the Company's policy for providing such benefits for participants on a non-FMLA leave. If that policy permits participants to discontinue contributions while on leave, Participants will upon returning from leave be required to repay the premiums not paid by the Participant during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

Non-FMLA Leaves of Absence. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the premium due for you will be paid by pre-

payment before going on leave, after-tax contributions while on leave or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If you go on an unpaid leave that affects eligibility, refer to **Summary of Plan.**

Are there any special coverage requirements if you go on military leave under USERRA?

If you are in the military and you are called up for service, you will be eligible for a leave of absence receiving protection under USERRA. Under USERRA, you may elect to continue benefits under the Component Benefit Program selected by the Company, for up to 24 months after the leave of absence begins, or the period of absence, whichever is shorter. During your leave, you will not be required to pay more than 102% of the full premium for the coverage. If the leave due to uniformed service is extended for 30 days or less, you will not be required to pay more than the normal employee share of any premium.

On your return from service and leave, benefits under the Component Benefit Program will be reinstated without any waiting period or exclusions for preexisting conditions, other than waiting periods or exclusions that would have applied even if there had been no absence for uniformed service.

To elect coverage under USERRA, please follow the same procedures for electing coverage under COBRA, explained in Section 8 below in this Summary.

What are the requirements under the Genetic Information Nondiscrimination Act of 2008 ("GINA")?

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any of the benefits under the Component Benefit Program.

GINA generally:

- prohibits the Plan from adjusting premium or contribution amounts for a group on the basis of genetic information;
- prohibits the Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;
- allows the Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements; and
- prohibits the Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual's enrollment.

What rules apply to Mental Health and Substance Abuse Benefits?

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") imposes significant new requirements on the Plan that offer mental health and substance abuse benefits. Current law prohibits health plans from imposing lower annual and lifetime limits on mental health coverage than on other types of medical coverage. The MHPAEA further limits other types of financial and non-financial limitations that plans may impose on mental health coverage and substance abuse benefits. Some of the MHPAEA's key provisions are as follows:

- financial limitations—including limitations on deductibles, copayments, coinsurance, and out-of pocket expenses—imposed on mental health and substance abuse benefits may not be higher than those imposed on other types of medical coverage;
- the Plan may not place limits on the scope or duration of treatment for mental health or substance abuse that are more restrictive than for other types of medical treatment;
- the Plan must provide, upon request, information to plan participants and providers regarding the criteria for determining whether mental health or substance abuse treatment is medically necessary, and the reasons for denial of coverage; and
- coverage of mental health and substance abuse benefits by out-of-network providers must be on par with out-of-network coverage for medical treatment;

5. PLAN ADMINISTRATION

Who administers the Plan?

The administration of the plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion.

The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. The Company will bear the incidental costs of administrating the Plan. The Company may shift from time to time certain administration costs to Participants. The Company will communicate to the Participants the details of any cost shifting arrangements.

If any benefits provided under the Component Benefit Program are insured, who provides them?

Certain benefits provided under the Component Benefit Program are fully insured. Those Insurers providing benefits and the terms of benefits provided are summarized in the copy of each booklet, summary or other governing document attached, as noted above in the Attachments section of this Summary.

Under those benefits provided by the Insurers, the Insurers are responsible for (1) determining eligibility for the amount of any benefits payable; and (2) prescribing claims procedures to be followed and claim forms to be used by Employees pursuant to their respective benefit plans.

If you have questions regarding your eligibility for or the amount of, any benefit payable under the fully-insured Component Benefit Programs, please contact the Insurer.

If any benefits provided under the Component Benefit Program are self-funded, who provides them?

The Company provides certain benefits under the Component Benefit Programs that are self-funded. Which benefits are self-funded is indicated in the Attachments Section of this Summary. They are funded by the general assets of the Company. If you have any general questions regarding the Plan or regarding your eligibility for or the amount of any benefit payable under the Component Benefit Program, please contact your benefits representative, who acts on behalf of the Plan Administrator.

6. COORDINATION OF BENEFITS

You or your Dependents may be covered by other employer sponsored health and welfare plans. If so, benefits from that plan and Benefits under the Component Benefit Program are coordinated so both plans don't pay for the same expenses.

If both you and your Spouse work at the Employer, you cannot claim each other as dependents and submit claims for benefits twice. Only one of you can claim your children as Dependents (this statement does not apply to benefits under Dependent Life Insurance).

How does coordination of benefits work?

If you are covered by two or more plans, one plan is "primary" and the others are "secondary." The primary plan pays benefits first without regard to any other plans. The secondary plans adjust their benefits so that total benefits available will not exceed allowable expenses. If the Plan is not primary, you will receive the difference between what the primary plan paid and the total amount of eligible covered expenses. However, neither plan would pay more than it would without the coordination provision.

Coordination of benefits ensures that benefits do not exceed 100% of the Reasonable and Customary charges for covered expenses. "Covered expenses" are any Reasonable and Customary charges for health care services for a non-occupational sickness or injury, at least partially covered by at least one of the plans under which you have coverage. If the plan

provides services rather than cash benefits, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

Which Plan is determined to be primary?

In general, the Plan covering the patient as an employee will be the primary plan, the plan that pays benefits first.

When the patient is an employee in more than one plan, the plan covering the individual for the longer period of time shall be the primary payer.

When the patient is an active employee of one plan and a retiree of another, the plan covering the patient as an active employee shall be the primary payer. The plan covering the patient as a retiree shall be the secondary payer.

If your Dependent child is covered under both you and your Spouse's plan, the plan of the parent whose birthday (month and day only) is earlier in the year will be primary. If you and your Spouse have the same birthday, the plan that has covered the parent for the longest time will be primary. If your Spouse's plan does not have this birth date provision, his or her plan will determine the order of payment for Dependents.

If you are legally separated or divorced, the order of payment for Dependents is:

- The plan of the parent with custody of the child.
- The plan of the Spouse of the parent with custody of the child.
- The plan of the parent without custody of the child.

However, if a court decree has given one parent financial responsibility for the child's health care expenses, that plan is primary.

If another plan does not have a Coordination provision, it will be the primary plan.

An Example:

Suppose the primary plan covers 80% for a certain expense and this Plan covers the same expense at 70%. You would receive 80% from your primary plan and 20% from this Plan. Together, 100% of covered expenses would be paid.

What information must be provided about your other coverage?

If you or your Dependents are covered under another plan, you must supply information about that plan to the Plan Administrator in order to receive benefits under this Plan. The Plan Administrator, on behalf of the Employer, has the right to release or obtain any information regarding coverage, expenses, and benefits under any other plan without your consent.

If the benefits you receive from more than one Plan exceed your total covered charges, you have been overpaid.

If an overpayment is made under this Plan because of failure to report other coverage or otherwise, the Plan Administrator on behalf of the Employer, will have the right to recover such overpayment. If payments which should have been made under this Plan have been made under other plans, the claims administrator on behalf of the Employer, will have the right to reimburse any organizations making such other payments any amounts it considers proper according to the intent of these provisions, and those amounts will be counted for all purposes as benefits paid under this Plan.

7. COBRA COVERAGE

What is COBRA coverage?

Under COBRA, the Company is required to provide you and your Qualified Beneficiaries with the opportunity to continue coverage under following benefits under the Component Benefit Program. **See Summary of Plan.**

(Such coverage will be referred to as "COBRA Coverage :) COBRA Coverage is offered for a limited period of time, unless your employment was terminated due to gross misconduct. This coverage is paid by you or your Qualified Beneficiaries when certain defined events occur that otherwise would cause you and/or your Qualified Beneficiaries to lose coverage.

Please note that COBRA coverage will not be offered if you or your Qualified Beneficiaries were not covered for these benefits prior to your qualifying event.

What other options may be available to you when you lose medical coverage under the Plan?

You may be eligible to buy individual medical insurance coverage through the Health Insurance Marketplace. By enrolling in medical insurance coverage through the Health Insurance Marketplace, you may qualify for a lower cost on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another employer group medical plan for which you are eligible (such your spouse's plan), even if that plan generally doesn't accept late enrollees.

What benefits are available through COBRA coverage?

Following a qualifying event (described below), the Company must offer you and your Qualified Beneficiaries the opportunity to continue those benefits under the Component Benefit Program you had on the day before your qualifying event. You will be responsible for the full cost of such insurance premiums for COBRA Coverage. Your participation in the Health Flexible Spending Account can also continue on an after-tax basis through the remainder of the Plan Year in which you qualify for COBRA (as explained below). The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all Qualified Beneficiaries.

The COBRA coverage that the Company offers is not fixed. If the Company changes the terms of its benefits under the Component Benefit Program for regular employees, Spouses and Dependents, these changes also apply to you and your Qualified Beneficiaries under COBRA. Also, Qualified Beneficiaries will have the same opportunity as active employees to change benefit elections during annual enrollment or special enrollment periods for benefit options previously elected.

If you make contributions to the Health Flexible Spending Account for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the Plan Year.

You may be offered to continue your coverage under the Health Flexible Spending Account if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the Qualified Beneficiary for the Plan Year (e.g., $2,500 of coverage); (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent.

You may not re-enroll in the Health Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Who is a Qualified Beneficiary?

This term refers to you and your Spouse and/or dependent child(ren) who are or were covered under one of the benefit options listed above on the day before the qualifying event, and who have experienced a qualifying event that leads to a loss of coverage. This also includes a child who is born or placed for adoption with you during the period of COBRA coverage. Whether an individual is a Qualified Beneficiary is important because each Qualified Beneficiary has a separate right to elect COBRA coverage. COBRA documents may use the term "Qualified Beneficiary" which refers to you and your qualified beneficiaries.

Please remember that if you did not enroll any of your Dependents in any of the Company's benefit options under the Component Benefit Program (for whatever reason) prior to a qualifying event, even though they were otherwise eligible, they will not be considered Qualified Beneficiaries for COBRA coverage.

What events trigger COBRA coverage?

COBRA coverage is offered to you and/or any Qualified Beneficiary when a qualifying event occurs. A qualifying event is defined as a loss of Benefit coverage due to one of the following reasons:

- Your death;
- A change in your employment status—such as your termination of employment from the Company or reduction in working hours;
- Your divorce or legal separation;
- The bankruptcy of the Company;
- You or any of your qualified beneficiaries are on military leave;
- You elect Medicare as primary coverage; or
- Your dependent child loses eligibility for coverage.

What is the maximum length of COBRA coverage?

The general rule is that following your COBRA enrollment, COBRA coverage extends for 18 months from the date of the qualifying event if the event is your termination of employment or reduction in hours. However, a special 11-month extension (for a total COBRA period of 29 months) is available to Qualified Beneficiaries who are disabled (according to Title II or XVI of the Social Security Administration Act) at the time of a qualifying event or are disabled within the first 60 days of COBRA coverage. In addition, the 29-month coverage period also applies to your non-disabled qualified beneficiaries even if they are not disabled. For all other qualifying events, COBRA coverage will be offered for 36 months.

Special "multiple qualifying event" rules allow Qualified Beneficiaries who receive COBRA coverage upon your termination of employment or reduction in hours to extend the length of their coverage if a second qualifying event—such as your divorce or death—occurs during the initial 18 month period. In no event will COBRA coverage continue for more than 36 months.

When can COBRA coverage be terminated early?

COBRA coverage may be terminated before the end of the applicable coverage period (18, 29 or 36 months) under any of the following circumstances:

- You or any Qualified Beneficiary fails to make a timely COBRA premium payment. An initial premium payment following the election of COBRA coverage is considered timely if received within 45 days of such election. Any subsequent premium is considered timely if it is paid within 30 days from the due date.

- You or any Qualified Beneficiary receives coverage under another group plan after the date of election. COBRA coverage will be terminated if a Qualified Beneficiary becomes covered under any other group health plan that contains no restrictions or limitations on coverage of "pre-existing conditions" after the date of his or her COBRA election.

- The Company terminates all medical, dental, vision and prescription drug plans.

- You or any Qualified Beneficiary becomes, after the date of election, entitled to Medicare.
- Determination is made that you or any Qualified Beneficiary are no longer disabled, but only after the initial 18 month COBRA coverage period has ended. This is applicable to disabled qualified beneficiaries that were granted 11 months of COBRA coverage in addition to the basic 18 month coverage period. COBRA coverage will terminate at the beginning of the next month after there has been a determination by the Social Security Administration that the individual is no longer disabled. You or your qualified beneficiaries are required to notify the Plan Administrator within 30 days of such determination.
- You notify the Plan Administrator you wish to cancel your coverage.
- For cause, on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA participants.

What are your or any Qualified Beneficiary notification requirements?

You or your Qualified Beneficiaries must notify the Plan Administrator if your Spouse either divorces or legally separates from you or your Dependent(s) loses his or her "eligibility status" under the plan. You are required to notify the Company of family status changes within 60 days of the event date. Your enrollment change will trigger a COBRA packet, which will be mailed to you.

If you do not make enrollment changes within 60 days or if your Qualified Beneficiaries wish to notify the Company of the qualifying event, then you, your Spouse, or your other Dependents must notify the Plan Administrator. Loss of coverage occurs on the last day worked.

Remember that the Company will not offer any Qualified Beneficiaries the opportunity to elect COBRA coverage if you or your Qualified Beneficiaries fail to provide the required written notice of a qualifying event.

To qualify for the 11-month extension of COBRA coverage, disabled Qualified Beneficiaries must notify the Plan Administrator of their disability status within 60 days of their disability determination by the Social Security Administration. Such notice must be given no later than the end of the regular 18 month COBRA coverage period that applies whenever there is a change in employment status.

When will you or any Qualified Beneficiary be given notice of your COBRA rights?

When the Plan Administrator receives notice of a qualifying event, it is required to notify you and any Qualified Beneficiary in writing of your COBRA rights. If you, your Spouse and Dependent child(ren) live together at the same address, the Plan Administrator satisfies this requirement by mailing one notice to you. The notice will be mailed to your current address on file. It is important to keep your address information current on file with the Plan Administrator. Following the Plan Administrator's receipt of notice of the qualifying event, it has forty-four (44) days from the date of receiving notice of any qualifying event to mail the notification.

When must you or any Qualified Beneficiary elect COBRA coverage?

Once you and any Qualified Beneficiary receive notice of your COBRA rights from the Plan Administrator, you have 60 days from the date of the notification, or the date your coverage terminates (whichever is later), to elect COBRA coverage. You or any Qualified Beneficiary elect COBRA coverage by completing and returning the election form sent with the notice, to the Plan Administrator at the address listed on the form by the deadline specified.
See Summary of Plan.

Qualified Beneficiaries may waive their rights to COBRA coverage rather than make a COBRA election. However, Qualified Beneficiaries are permitted to revoke such waiver at any time during the 60-day election period if they change their minds and decide to elect COBRA coverage. If Qualified Beneficiaries revoke a waiver, coverage doesn't have to be provided for any period before the revocation. Once the 60-day election period ends, the waiver cannot be revoked.

Do Qualified Beneficiaries have independent election rights under COBRA?

Yes. Each Qualified Beneficiary may independently elect or waive COBRA coverage.

For example, although you may not elect COBRA coverage on your own behalf, any Qualified Beneficiary may elect COBRA coverage independently of you. And, if there's a choice among types of coverage, each Qualified Beneficiary is entitled to make a separate election from among the different types of coverage offered under the various plan options. So, even if you elect certain coverage, your Spouse or other Dependent(s) may elect different coverages.

You or your Spouse (except in the case of your death or divorce or legal separation), are permitted to make the election on behalf of other Qualified Beneficiaries affected by the qualifying event. In such cases, you or your Spouse's decision is binding on the other qualified beneficiaries in the family and the other family members lose their right to make an independent election.

Are there other coverage options besides COBRA Coverage?

Yes. Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other employer group health plan coverage options (such as a spouses plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.healthcare.gov.

Must you keep the Plan informed of any address changes?

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

What amount do you and any Qualified Beneficiary pay for COBRA coverage?

The premium you and any Qualified Beneficiary are charged for COBRA coverage is based on the applicable total (the Company and employee) premium cost under the Benefit options for "similarly-situated" employees. The Company charges the covered employee and any Qualified Beneficiary no more than 102% of the applicable plan option premium cost. The additional 2% above the premium cost covers the Company's cost of administering COBRA.

Disabled Qualified Beneficiaries that are granted the special 11-month extension are charged up to 150% (rather than 102%) of the applicable plan premium during the 11 month period of extended coverage.

8. CIRCUMSTANCES THAT MAY AFFECT BENEFITS

When may you be denied or lose your benefits?

Your benefits (and the benefits of your Dependents) under the Component Benefit Program will cease when your participation in the Plan terminates, as indicated above in Section 4.
Your benefits will also cease upon the termination of the Plan. **See Summary of Plan.**

You should consult the certificate of insurance booklets, summary plan descriptions and other governing documents for the benefits under the Component Benefit Program attached to this Summary for additional information.

When will the Plan ask you to repay benefits paid to you?

The purpose of the Plan is to provide you and your Dependents with coverage for benefits under the Component Benefit Program that are not the responsibility of any third party. If you and/or your covered Dependents incur a claim for medical, dental and/or vision expenses as a result of injuries caused by someone else's negligence, wrongful act or omission, the Plan is not responsible to pay these expenses. If this happens, the Plan Administrator or the Insurer will contact you and ask you to sign a subrogation agreement. This means that the Company or the Insurer can take steps to recover what it paid to cover medical expenses from the third party that caused injury or illness. If you do not sign a subrogation agreement, your claims for medical expenses related to the injury or illness may be denied.

What rights does the Plan have to recover expenses it paid to you?

If the Plan pays your and/or covered Dependent's claim(s) for medical, dental and/or vision expenses, and if a third party or entity should pay the claim, you, as the Participant, agree to the following conditions:

- The Plan shall be subrogated to all of you and/or your Dependent's rights of recovery arising out of any claim or cause of action which may result or be attributable to a third party's negligent or wrongful acts or omission to the extent of amounts paid.

- You also agree to reimburse the Plan for any benefits under the Component Benefit Program paid to you if you recover any amounts from a third party for the injury or illness.

- The Plan's subrogation and reimbursement rights shall apply to any recoveries by you, your covered Dependents, or your estate because you (or your covered Dependents), suffered an injury or illness that could be attributed to a third party's negligence, wrongful act or omission. The Plan shall have first priority rights and such rights shall extend to, but not be limited to, the following recoveries by you:

  - Any payment made by or on behalf of a third party benefits, by your insurance company, such as a settlement, judgment, or arbitration award, or otherwise.

  - Any payment as a result of a settlement, judgment, arbitration award or otherwise made by an insurance company for uninsured or underinsured motorist coverage (It doesn't matter whose insurance coverage it is – yours or the other person's).

  - Any payment from any source that is intended to compensate you or your covered Dependents for the injury resulting from the negligence or alleged negligence of a third party.

  - Any payment under Workers' Compensation.

  - Any payment under no-fault or other state required motor vehicle insurance.

  - Any payment made through your automobile, school or homeowner's insurance policy to cover you for the injury.

- You will fully cooperate and do your part to ensure the Plan's right of recovery and subrogation are secured. If necessary, you will grant a lien on any money that you may receive, equal to the value of any amounts paid by the Plan. You will not take any action or be a party to agreement that does not recognize the rights of the Plan to recover expenses. You shall grant a lien on any amounts recovered from a third party and assign it to the Plan for any expenses paid. Similarly, you may not assign rights to any third party to recover money, including your minor children, without the written consent of the Plan Administrator.

- The Plan has a prior lien against all amounts that you may recover, even those amounts designated exclusively for non-benefit expense damages. You or your Dependents shall not defeat or reduce the Plan's recovery rights by the use of the "Made-Whole Doctrine", "Rimes Doctrine" or any doctrine that is intended to take away the Plan's rights to recover its expenses.

- You may not incur any expenses on behalf of the Plan to pursue a payment. You may not deduct court costs or attorney's fees from any amount reimbursed to the Plan, without written consent from the Plan Administrator. You or your Dependents cannot use the "Fund Doctrine", "Common Fund Doctrine" or "Attorney's Fund Doctrine" to use the Plan's funds for these purposes. The benefits under the Plan are secondary to any coverage under no-fault or similar insurance.

- If you and/or your covered Dependents fail or refuse to honor the Plan's recovery and subrogation rights, the Plan may recover any costs to enforce its rights. This includes, but is not limited to attorney's fees, litigation, court costs and other expenses.

9. PRIVACY RIGHTS

What disclosures of enrollment/disenrollment information are permitted?

The Plan may disclose to your Employer information on whether you are participating in medical benefits under the Component Benefit Program, or are enrolled in or have disenrolled in such benefits. For purposes of this section, "Protected Health Information" ("PHI") means individually identifiable health information that is maintained or transmitted by the Plan for medical benefits under the Component Benefit Program, subject to specified exclusions as provided in federal regulations. For purposes of this section, Electronic Protected Health Information or Electronic PHI means PHI that is transmitted by or maintained in electronic media, as provided under HIPAA and HITECH.

What uses and disclosures of summary health information are permitted?

The Plan may disclose Summary Health Information to your Employer, provided your Employer requests the Summary Health Information for the purpose of (a) obtaining premium bids from plans for providing coverage for group health benefits under the Component Benefit Program or (b) modifying, amending, or terminating the Plan for such benefits.

"Summary Health Information" means information that (a) summarizes the claims history, claims, expenses, or type of claims experienced by individuals for whom your Employer had provided group health benefits under the Component Benefit Program; and (b) from which the information has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

What required uses and disclosures of PHI are permitted for plan administrative purposes?

Unless otherwise permitted by law, and subject to the conditions of disclosure and obtaining written certification, the Plan (or an insurance company on behalf of the Plan) may disclose PHI and Electronic PHI to your Employer, provided your Employer uses or discloses such PHI and Electronic PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by your Employer on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by your Employer in connection with any other benefit or benefit plan of your Employer, and they do not include any employment-related functions.

Enrollment and disenrollment functions performed by your Employer are performed on behalf of you and your dependents, and are not Plan administration functions. Enrollment and disenrollment information held by the Employer is held in its capacity as the plan sponsor and is not PHI.

Notwithstanding the provisions of this Plan to the contrary, in no event shall your Employer be permitted to use or disclose PHI in a manner that is inconsistent with federal regulations.

Under what conditions can PHI be disclosed for plan administration purposes?

Your Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan (or an Insurer on behalf of the Plan), your Employer shall:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to your Employer with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of your Employer;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for and to notify each individual who's PHI in its possession that has been, or is reasonably believed to have been accessed, acquired, or disclosed in an unauthorized manner that compromises the privacy of such information as and when required under the federal law as recently amended by the American Recovery and Reinvestment Act of 2009;
- Make available PHI to comply with HIPAA's right to access in accordance with federal regulations;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with federal regulations;
- Make available the information required to provide an accounting of disclosures in accordance with federal regulations;
- 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 compliance by the Plan with HIPAA's privacy requirements;
- If feasible, return or destroy all PHI received from the Plan that your Employer still maintains, in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation between the Plan and your Employer (i.e. the "firewall"), required in federal regulations, is established.

Your Employer further agrees that if it creates, receives, maintains or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information and information disclosed pursuant to a signed authorization that complies with the federal requirements which are not subject to these restrictions) on behalf of the Plan, it will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and your Employer (i.e., the firewall), is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan Administrator any security incident of which it becomes aware, as follows: your Employer will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition the Employer will report to the Plan as soon as feasible any successful unauthorized access, use disclosure, modification or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

Who is permitted to disclose information?

Your Employer shall allow those classes of employees or other persons in your Employer's control designated by your Employer to be given access to PHI. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that your Employer performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by your Company for non-compliance pursuant to your Employer's employee discipline and termination procedures.

Your Employer shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

When can PHI be disclosed to your Employer?

The Plan shall disclose PHI to your Employer only upon the receipt of a certification by your Employer that the Plan has been amended to incorporate the provisions of federal regulations, and that your Employer agrees to the conditions of disclosure set forth in this summary.

10. CLAIMS PROCEDURES

What are the claims procedures for insured benefits?

For purposes of the determination of the amount of, and entitlement to, benefits under the Component Benefit Program provided under insurance contracts, the Insurer is the Named Fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the Insurer under the Component Benefit Program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the Insurer's form. In that case, the form is available from the Plan Administrator.

The Insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The Insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Insurer denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Insurer for a review of the denied claim. The Insurer will decide your appeal in accordance with its reasonable claims procedures, as required by federal law. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

After your appeal(s) has been denied by Insurer, you shall be eligible to file a request for review under the external review procedure. Please contact the Plan Administrator for further details.

What are claims procedures for self-funded benefits?

If your claim is denied, you may appeal to the Named Fiduciary for a review of the denied claim. The Named Fiduciary will decide your appeal in accordance with reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

After your appeal(s) has been denied by Named Fiduciary, you shall be eligible to file a request for review under the external review procedure. Please contact the Plan Administrator for further details. **See Summary of Plan.**

For more details regarding how to file a claim and the procedures applicable to your claim, please consult the Summary Plan Description for the benefits under the Component Benefit Program contained in the Attachments Section of this Summary.

11. ERISA RIGHTS

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

What information must you receive about the Plan and benefits?

ERISA provides that all Plan participants shall be entitled to:

- Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan 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 the summary annual report.

How must Plan fiduciaries act?

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

How do you enforce your rights?

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (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 per 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 that 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 a benefit claim, you may file suit in federal court. If it

should happen that Plan fiduciaries misused 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 the claim is frivolous.

How do you receive assistance with your questions?

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

12. MISCELLANEOUS PROVISIONS

What rights does the Company have under the Plan?

The Company reserves the right to terminate, modify, amend or change any or all benefit plans at any time and for any reason without the prior consent or agreement of you or your Dependents. Your participation in the Plan doesn't guarantee the availability of benefits in the future.

Participants will be notified of any changes through the Company's employee publications, including enrollment materials and updates to this and other relevant summaries.
The Company, the Insurer Claims Administrator and the Plan Administrator have the right to check stated facts, eligibility and benefit amounts. They can adjust benefits and/or make retroactive payroll adjustments if any relevant facts have been misstated.

The Company and each of the Employers recognize the value of providing benefits for you and the value of the benefits described in this document. However, the benefits described here are not conditions of employment. The language used in this document isn't intended to create, nor is it to be construed to constitute, a contract between Employer and any of its employees for either employment or the provision of any benefit. Employment for employees for the Employer remains at-will.

What requirements does the Plan have to comply with under State and Federal laws?

With respect to benefits under the Component Benefit Program, the Plan will comply, to the extent applicable, with the requirements of all applicable state and federal laws.

This Plan is governed by federal laws in existence at the time that this Summary Plan Description was amended and restated (or as they may be amended from time to time). In no event shall the Company guarantee any favorable tax treatment sought by this Plan. To the extent

not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State indicated for the Plan.

What if the information in this Summary Plan Description differs from other existing Plan documentation?

If the terms of this Summary Plan Description conflict with the terms of the contract with any Insurer or governing Plan document, then the terms of the contract with the Insurer or governing Plan document will control, rather than this document, unless otherwise required by law.

Can you sell or convey your benefits under the Plan to anyone else?

No. Benefits payable at any time under this Plan shall not be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment or encumbrance of any kind.

What if a provision in this Summary Plan Description is invalid or unenforceable under the law?

If any of the terms, conditions or provisions of this Plan are found to be invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions within the Summary Plan Description, and this Plan shall be construed and enforced as if such provisions had not been included.

What if a provision in this Summary Plan Description is invalid or unenforceable under the law?

If any of the terms, conditions or provisions of this Plan are found to be invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions within the Summary Plan Description, and this Plan shall be construed and enforced as if such provisions had not been included.

What happens if you become physically or mentally incapacitated while covered under the Plan?

In the event it is demonstrated to the satisfaction of the Plan Administrator that you, your Spouse and/or your other Dependents is unable to care for his or her affairs because of mental or physical incapacity, any payment due may be applied, in the discretion of the Plan Administrator, to the payment of any benefits under the Component Benefit Program for you or your Dependents or withheld until appointment of a legally-appointed guardian or representative. Payment may be made in this manner, or withheld as the case may be, unless prior to payment a claim will have been made for payment of any benefits under the Component Benefit Program by you or your Dependent's' legally-appointed guardian, committee, or other legal representative. Any payment under this section will, to the extent of payment, completely discharge the Company's or Insurer's liability with respect to your or your Dependents' interest.

What other communications is the Company required to provide to you and you're Dependents?

The Company agrees to provide additional documentation to you and your Dependents in compliance with applicable Federal and State laws and as designated within the Summary Plan Description.

Does your participation in the Plan vest you with any ownership of the rights and benefits provided under the Plan?

Nothing in this Summary Plan Description shall be construed to create any vested rights in any Employee, Spouse or other Dependent enrolled under the Plan and the Company reserves the right to terminate benefits at any time without any requirement for providing additional coverage, subject to COBRA and other applicable laws noted within the Plan document.

Can I bring a lawsuit against other Employees within the Company for errors in the Plan's administration?

The Company shall indemnify all officers and Employees of the Employer assigned fiduciary responsibility under federal law to the extent that such officers or participants incur loss or damage which may result from such officers' or participants' duties, exercise of discretion under the Plan, or any other act or omission hereunder.

VAN'S LUMBER & CUSTOM BUILDERS, INC.

DIRECTORS' ACTION

The undersigned, being the Directors of:

VAN'S LUMBER & CUSTOM BUILDERS, INC.

(the "Company"), a Wisconsin corporation does hereby declare and state that they consent to and hereby adopt the following resolutions and takes the following actions:

WHEREAS, the Company intends to adopt the VAN'S LUMBER & CUSTOM BUILDERS, INC'S Employee Benefit Plan (the "Plan") effective on 01/01/2015;

WHEREAS, the Company has the power to adopt the Plan.

NOW, THEREFORE, BE IT RESOLVED; that the Plan shall be adopted effective _01/01/2015 in substantially the form of the plan document attached herein as Exhibit A;

FURTHER RESOLVED that the proper management of the Company be and they are hereby authorized, empowered and directed, for and in the name of the Company, to perform all acts and to execute and deliver all documents, instruments and agreements in connection with the aforementioned; and to pay such fees and expenses that such officers deem necessary or desirable to carry out the intent and purposes of these resolutions; and

FURTHER RESOLVED that all of the acts and things done, whether heretofore or hereafter performed or done, by any of the proper management of the Company that are in conformity with the intent and purposes of these resolutions shall be and the same are hereby, in all respects, ratified, confirmed and approved.

IN WITNESS WHEREOF, we have signed this Directors' Action as of the date inserted below our signatures.

Directors of the Company: _____

_____

_____

Date: 3/30/15

ATTACHMENT

SUMMARY OF PLAN

GENERAL PLAN INFORMATION

Plan Name:	VAN'S LUMBER & CUSTOM BUILDERS, INC. Employee Benefit Plan
Type of Plan:	Welfare Benefit Plan
Plan Year:	Calendar Year
Plan Sponsor:	VAN'S LUMBER & CUSTOM BUILDERS, INC.
Plan Administrator:	VAN'S LUMBER & CUSTOM BUILDERS, INC.

The Laws of the State or Commonwealth of Wisconsin will apply to the administration of the Plan.

Medical Claims Administrator:	ALLIED HEALTH
Claims Administrator:	VAN'S LUMBER & CUSTOM BUILDERS, INC.
Business Address for Plan Sponsor:	E176 COUNTY ROAD S
City, State, Zip:	LUXEMBURG, WI 54217
Business Telephone #:	920-866-2351
Employer ID # for Plan Sponsor:	39-0962324
Plan Number:	501
Legal Agent:	JEAN WILLIS

Service of legal process may be made to the Plan Administrator or the legal agents at the business address listed above

Effective Date of the Plan:	01/01/2015
Date of the Summary Plan Description:	01/01/2015

Named Fiduciary

The Company sponsoring the Plan

For any benefits that are self-funded:

Allied Health - Medical

For any benefits provided under the Plan that are insured, the Insurer shall be the Named Fiduciary.

Benefits offered under Plan

- Medical Benefits
- Dental Benefits
- Vision Benefits
- Short-Term Disability Benefits
- Long-Term Disability Benefits
- AD&D Benefits
- Group Term Life Insurance Benefits

Grandfathered Medical Benefits provided under the Component Benefit Program

The Company believes the Medical Benefits provided under the Component Benefit Program is not a "grandfathered health plan" under PPACA.

Family Status Change

Medical
Dental
Vision

Ending Participation in the Plan

If you terminate your employment for any reason, including (but not limited to) disability, retirement, reduction in force, layoff or voluntary resignation, and then are rehired, you will be treated as a new employee and have to satisfy a new waiting period.

FMLA

FMLA does apply

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by FMLA, your Company will continue to maintain all benefits under the Plan.

If so, the employee will pay his or her share of the premiums:

During the leave

COBRA

Under COBRA, the Company is required to provide you and your Qualified Beneficiaries with the opportunity to continue coverage of benefits under the Component Benefit Program:

Medical
Dental
Vision
Health Flexible Spending Account

Election of COBRA coverage

When you or your Qualified Beneficiary elect COBRA coverage, you or each of your Qualified Beneficiaries will have a separate election for each benefit.

Termination of COBRA coverage

Other circumstances can result in the termination of coverage and they include:

Termination of employment
Reduction of hours
Submits false claims
Transfer to a non-eligible employee group
The loss or eligibility in one or all of the benefits under the Component Benefit Program

Claims procedures for self-funded benefits

For purposes of determining the amount of, and entitlement to benefits under the Component Benefit Program provided through the Employer's general assets, the Claim Administrator, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must complete, execute and submit to the Claim Administrator, a written claim.

The Claim Administrator, has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

The Claim Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA.

If the Claim Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

Appeal
The Claim Administrator shall be designated as the Name Fiduciary.