SUMMARY OF MATERIAL MODIFICATIONS

HEALTH AND WELFARE PLAN FOR BERRIEN RESA

The Health and Welfare Plan has been amended. The following two changes affecting the Plan are set forth in this Summary of Material Modifications and are effective as of July 1, 2016.

1. In the **BENEFITS** section of the Plan document, paragraph A. of the **HEALTH CARE REFORM** subsection shall be deleted in its entirety and replaced with the following:

   The Plan allows eligible Dependent children to continue to participate in the Plan through the end of the month in which the child's 26th birthday occurs.

2. In the **DEFINITIONS** section of the Plan document, paragraph B.2. of the *DEPENDENT* definition shall be deleted in its entirety and replaced with the following:

   Is less than 26 years of age. Coverage will continue through the end of the month in which the child's 26th birthday occurs. The age requirement above is waived for any child who is developmentally disabled or who has a physical handicap(s) before age 26 who is incapable of self-sustaining employment, and who could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code. Proof of incapacity must be furnished to the satisfaction of the Plan Administrator upon request, and the Plan Administrator may request additional proof from time to time.

The Health and Welfare Plan has been amended. The following six changes affecting the Plan are set forth in this Summary of Material Modifications and are effective as of October 1, 2016.

1. The following benefit shall be added to the **PLAN A SCHEDULE OF MEDICAL BENEFITS – PROFESSIONAL EMPLOYEES, PLAN B SCHEDULE OF MEDICAL BENEFITS – PARAPROFESSIONAL AND NON-BARGAINING EMPLOYEES**, and **PLAN C SCHEDULE OF MEDICAL BENEFITS – PARAPROFESSIONAL AND NON-BARGAINING EMPLOYEES** sections of the Plan document:

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
ROUTINE IMMUNIZATIONS ADMINISTERED IN A PHARMACY OR AT THE DEPARTMENT OF COMMUNITY HEALTH *(including any injection fee charge or other immunization-related charges)*	100%; Deductible waived	100%; Deductible waived

NOTE: The Covered Person may have to initially pay for these charges in full and then submit the expense directly to the Claim Administrator for reimbursement.

2. The following shall be added to the ***PRESCRIPTION DRUGS*** benefit found in the **PLAN A SCHEDULE OF MEDICAL BENEFITS – PROFESSIONAL EMPLOYEES, PLAN B SCHEDULE OF MEDICAL BENEFITS – PARAPROFESSIONAL AND NON-BARGAINING EMPLOYEES,** and **PLAN C SCHEDULE OF MEDICAL BENEFITS – PARAPROFESSIONAL AND NON-BARGAINING EMPLOYEES** sections of the Plan document:

- *Specialty Prescription Drug Program*

Co-payment per generic specialty prescription drug	$20
Co-payment per formulary brand-name specialty prescription drug	$50
Co-payment per non-formulary brand-name specialty prescription drug	$100

The term "specialty prescription drug" means a drug identified on the drug list maintained by the Pharmacy Benefits Manager (PBM) that includes drugs typically used to treat complex medical conditions. Specialty prescription drugs may be injectable medications, high-cost medications, or have special delivery and storage requirements (e.g., they may require refrigeration). Specialty prescription drug purchases will be limited to a 30-day supply, and prescriptions for such drugs must generally be filled through Lumicera Health Services specialty pharmacy or the drug will not be eligible for coverage under the Plan. For additional information about specialty prescription drugs, including information about which drugs are currently on the PBM's specialty drug list, the Covered Person can contact the PBM at the number on the front of the identification card.

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3. The following provision shall be added to the Plan document. In the event that this provision conflicts or appears to conflict with any existing language pertaining to the payment of claims arising out of Motorcycle accidents, the terms of this amendment will rule:

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF MOTORCYCLE ACCIDENTS

Notwithstanding the Payment Priorities rules set forth in the General Provisions section, the following special coordination rule applies regarding Motorcycle accidents.

If a Covered Person is injured in an accident that involves a Motor Vehicle, claims will be processed in accordance with the Plan's position on Motor Vehicle accidents.

If a Covered Person is operating a Motorcycle and is injured in an accident that does not involve a Motor Vehicle, this Plan will exclude coverage for the first $20,000 in eligible charges or, if greater, the amount of health benefits payable by the Motorcycle insurance policy. It is the responsibility of any Covered Person who operates a Motorcycle to ensure that he or she is covered under a Motorcycle insurance policy that will pay at least $20,000 in health benefits for him or her per accident. This requirement applies even if the Covered Person is not legally required to have such health benefit coverage. If the Covered Person fails to maintain $20,000 of coverage through a Motorcycle insurance policy, the difference between the policy's maximum payout per accident (if any) and $20,000 will be the Covered Person's responsibility.

A Covered Person who is riding a Motorcycle as a passenger and is injured in an accident that does not involve a Motor Vehicle will not be subject to this provision and will not have his or her otherwise eligible claims excluded from Plan coverage as described above.

4. The following two changes shall be made to the **PRESCRIPTION DRUG BENEFIT** section of the Plan document:

A. The following subsection shall be added:

SPECIALTY PRESCRIPTION DRUG PROGRAM

The Specialty Prescription Drug Program is specifically designed to provide the Covered Person with medications and expert support for certain complex and chronic conditions. Charges are covered under this benefit for eligible specialty prescription drugs that are provided through the specialty pharmacy vendor designated in the Schedule of Benefits and that are prescribed in writing by a Physician, Physician's Assistant, or Nurse Practitioner within the legally appointed scope of his/her license. Specialty prescription drug purchases will be limited to a 30-day supply and subject to the applicable co-payment per prescription listed in the Schedule of Benefits. In general, if a prescription for a specialty prescription drug is not filled through the designated specialty pharmacy vendor, that drug purchase will not be eligible for coverage under the Plan. Contact the PBM for more information about this program.

B. Flu shots and other routine vaccines / immunizations designated as covered by the PBM ($-0- co-payment applies) and self-administered injectables and shall all be added to the list of ***COVERED PRODUCTS***. These items shall no longer be excluded from coverage under the Plan's prescription drug benefit.

5. The following term shall be added to the **DEFINITIONS** section of the Plan document:

MOTORCYCLE

The term "Motorcycle" means a two- or three-wheeled vehicle that is equipped with a motor that exceeds 50 cubic centimeters (cc) engine displacement. The number of wheels on any attachment to the vehicle will not count toward the number of wheels on the vehicle. A vehicle that is commonly recognized as an "off-road vehicle" (ORV) or "all-terrain vehicle" (ATV) shall not be deemed to be a Motorcycle, nor will the off-road operation of a Motorcycle cause it to be deemed instead an ORV or ATV.

6. The *DEPENDENT* definition shall be revised to read as follows:

DEPENDENT

The term "Dependent" means the following:

A. The Participant's legal spouse who is a resident of the same country in which the Participant resides. The spouse must have met all of the requirements of a valid marriage contract in the state of marriage of the parties.

B. A child who meets all of the following conditions:

1. May be identified in one of the following categories:

a. The Participant's natural child, the Participant's stepchild, the Participant's legally adopted child, or a child who is being placed for adoption with the Participant.

b. A child who is under the legal guardianship of the Participant and could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code.

c. A child to whom the Participant is obligated to provide medical care coverage under an order or judgment of a court of competent jurisdiction and could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code.

2. Is less than 26 years of age. Coverage will continue through the end of the month in which the child's 26th birthday occurs. The age requirement above is waived for any child who is developmentally disabled or who has a physical handicap(s) before age 26 who is incapable of self-sustaining employment, and who could be considered a "dependent" of the Participant for tax

exemption purposes under Section 152 of the Code. Proof of incapacity must be furnished to the satisfaction of the Plan Administrator upon request, and the Plan Administrator may request additional proof from time to time.

C. A child for whom the Participant is obligated to provide medical coverage under a QMCSO, notwithstanding the above.

NOTE: **For Medical and Prescription Drug Benefits:** If both parents are Employees of the Employer, children will be covered under this Plan as Dependents of only one parent.

For Dental and Vision Benefits: If both spouses are Employees of the Employer who meet the Participant Eligibility Requirements, each may be covered as a Participant and as a Dependent of the other. If both parents are Employees of the Employer who meet the Participant Eligibility Requirements, children may also be covered under both parents as Dependents.

The Participant may be asked to certify the status of the persons for whom the Participant is claiming Dependent status, and benefits shall be terminated and the Participant shall be asked to reimburse the Plan if it is discovered that he/she has provided false information.

The term "Dependent" excludes these situations:

A. A spouse or former spouse who is legally separated or divorced from the Participant, pursuant to a valid separation or divorce in the state granting the separation or divorce.

B. Any person who is covered under this Plan as an individual Participant (medical and prescription drug benefits only).

C. Any person who would otherwise qualify as a Dependent, but who is not properly enrolled in the Plan.

All other provisions of the Plan shall remain in effect and unchanged.

NOTE: If your health plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact ASR Health Benefits at (800) 968-2449.

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact ASR Health Benefits at (800) 968-2449.