AMENDMENT # 2 TO: BERRIEN RESA, G-731

AMENDMENT TO THE HEALTH AND WELFARE PLAN

IT IS UNDERSTOOD AND AGREED THAT THE FOLLOWING MODIFICATIONS SHALL BE MADE:

1. Effective January 1, 2015, the Plan no longer has to provide Certificates of Creditable Coverage. Therefore, all associated references, including the Certificates of Creditable Coverage section and the Creditable Coverage definition, will be deleted from the Plan document.

2. The following changes will be made to the **PLAN A SCHEDULE OF MEDICAL BENEFITS – PROFESSIONAL EMPLOYEES** section of the Plan document:

   A. The ***COMPREHENSIVE MEDICAL*** benefit will be revised to read as follows:

BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
COMPREHENSIVE MEDICAL		
Deductible per Plan Year	$250/Covered Person $500/Family	$500/Covered Person $1,000/Family
Benefit Percentage Paid (all Covered Expenses, unless specifically stated otherwise)	100% after Deductible (0% Coinsurance)	80% after Deductible (20% Coinsurance)
Coinsurance Maximum Out-of-Pocket per Plan Year (includes Coinsurance only)	$-0-/Covered Person $-0-/Family	$1,000/Covered Person $2,000/Family

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
COMPREHENSIVE MEDICAL, cont.		
Total Maximum Out-of-Pocket per Plan Year (includes Deductible, Coinsurance, and medical co-payments)	$3,000/Covered Person $6,000/Family	Not applicable

NOTE:

1. The Deductible and Coinsurance Maximum Out-of-Pocket do not include co-payments of any type or expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed the limits in the Schedule of Benefits, or are otherwise excluded under the provisions of the Plan. The Deductible and Coinsurance Maximum Out-of-Pocket amounts are intended to limit the amount of Deductible and Coinsurance that has been designated as the Covered Person's or Family's responsibility; however, in certain cases, the total amount that is paid in co-payments may decrease the amount of Coinsurance or Deductible that a Covered Person or Family has to pay. That is, once the Plan's Total Maximum Out-of-Pocket has been satisfied by any combination of Deductible, Coinsurance, and co-payments paid by the Covered Person or Family, the Plan will no longer charge such amounts for the remainder of the Plan Year. Amounts applied toward the Deductible or Coinsurance Maximum Out-of-Pocket for In-Network services will also accrue toward the Deductible or Coinsurance Maximum Out-of-Pocket for Out-of-Network services, and vice versa. In no event shall the Deductible or Coinsurance Maximum Out-of-Pocket for all In-Network and Out-of-Network services combined exceed the Out-of-Network amounts shown above.

2. The Total Maximum Out-of-Pocket for medical services does not include prescription drug co-payments or expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed the limits in the Schedule of Benefits, or are otherwise excluded under the provisions of the Plan. Prescription drug co-payments track toward a separate Prescription Drug Maximum Out-of-Pocket to the extent required by Health Care Reform (see the Prescription Drugs benefit in this Schedule of Benefits for more information).

B. The $1,000 maximum benefit payable per Covered Person per Plan Year for allergy testing will be discontinued.

C. The following will be added to the ***PRESCRIPTION DRUGS*** benefit:

Prescription Drug Maximum Out-of-Pocket per Plan Year (includes prescription drug co-payment amounts paid for eligible purchases made through the Prescription Drug Card Program or the Mail Service Program)	$3,600/Covered Person* $7,200/Family*

*Does not include amounts attributed to the Total Maximum Out-of-Pocket for medical services, any optional additional amount that the Covered Person must pay over and above the co-payment, or the cost of any drug or service that is not covered under the Plan.

3. The following changes will be made to the **PLAN B SCHEDULE OF MEDICAL BENEFITS – PARAPROFESSIONAL AND NON-BARGAINING EMPLOYEES** section of the Plan document:

A. The ***COMPREHENSIVE MEDICAL*** benefit will be revised to read as follows:

BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
COMPREHENSIVE MEDICAL		
Deductible per Plan Year	$500/Covered Person $1,000/Family	$1,000/Covered Person $2,000/Family
Benefit Percentage Paid (all Covered Expenses, unless specifically stated otherwise)	100% after Deductible (0% Coinsurance)	80% after Deductible (20% Coinsurance)

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
COMPREHENSIVE MEDICAL, cont.		
Coinsurance Maximum Out-of-Pocket per Plan Year (includes Coinsurance only)	$-0-/Covered Person $-0-/Family	$3,000/Covered Person $6,000/Family
Total Maximum Out-of-Pocket per Plan Year (includes Deductible, Coinsurance, and medical co-payments)	$3,000/Covered Person $6,000/Family	Not applicable

NOTE:

1. The Deductible and Coinsurance Maximum Out-of-Pocket do not include co-payments of any type or expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed the limits in the Schedule of Benefits, or are otherwise excluded under the provisions of the Plan. The Deductible and Coinsurance Maximum Out-of-Pocket amounts are intended to limit the amount of Deductible and Coinsurance that has been designated as the Covered Person's or Family's responsibility; however, in certain cases, the total amount that is paid in co-payments may decrease the amount of Coinsurance or Deductible that a Covered Person or Family has to pay. That is, once the Plan's Total Maximum Out-of-Pocket has been satisfied by any combination of Deductible, Coinsurance, and co-payments paid by the Covered Person or Family, the Plan will no longer charge such amounts for the remainder of the Plan Year. Amounts applied toward the Deductible or Coinsurance Maximum Out-of-Pocket for In-Network services will also accrue toward the Deductible or Coinsurance Maximum Out-of-Pocket for Out-of-Network services, and vice versa. In no event shall the Deductible or Coinsurance Maximum Out-of-Pocket for all In-Network and Out-of-Network services combined exceed the Out-of-Network amounts shown above.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
COMPREHENSIVE MEDICAL, cont.		
2. The Total Maximum Out-of-Pocket for medical services does not include prescription drug co-payments or expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed the limits in the Schedule of Benefits, or are otherwise excluded under the provisions of the Plan. Prescription drug co-payments track toward a separate Prescription Drug Maximum Out-of-Pocket to the extent required by Health Care Reform (see the Prescription Drugs benefit in this Schedule of Benefits for more information).		

B. The $1,000 maximum benefit payable per Covered Person per Plan Year for allergy testing will be discontinued.

C. The following will be added to the ***PRESCRIPTION DRUGS*** benefit:

Prescription Drug Maximum Out-of-Pocket per Plan Year (includes prescription drug co-payment amounts paid for eligible purchases made through the Prescription Drug Card Program or the Mail Service Program)	$3,600/Covered Person* $7,200/Family*

*Does not include amounts attributed to the Total Maximum Out-of-Pocket for medical services, any optional additional amount that the Covered Person must pay over and above the co-payment, or the cost of any drug or service that is not covered under the Plan.

4. The following changes will be made to the **PLAN C SCHEDULE OF MEDICAL BENEFITS – PARAPROFESSIONAL AND NON-BARGAINING EMPLOYEES** section of the Plan document:

A. Paragraph 1. of the note in the ***COMPREHENSIVE MEDICAL*** benefit will be revised to read as follows:

The Deductible and Coinsurance Maximum Out-of-Pocket do not include co-payments of any type or expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed the limits in the Schedule of Benefits, or are otherwise excluded under the provisions of the Plan. The Deductible and Coinsurance Maximum Out-of-Pocket amounts are intended to limit the amount of Deductible and Coinsurance that has been designated as the Covered Person's or Family's responsibility; however, in certain cases, the total amount that is paid in co-payments may decrease the amount of Coinsurance or Deductible that a Covered Person or Family has to pay. That is, once the Plan's total out-of-pocket limit has been satisfied by any combination of Deductible, Coinsurance, and co-payments charged and paid by the Covered Person or Family, the Plan will no longer charge such amounts for the remainder of the Plan Year. Amounts applied toward the Deductible or Coinsurance Maximum Out-of-Pocket for In-Network services will also accrue toward the Deductible or Coinsurance Maximum Out-of-Pocket for Out-of-Network services, and vice versa. In no event shall the Deductible or Coinsurance Maximum Out-of-Pocket for all In-Network and Out-of-Network services combined exceed the Out-of-Network amounts shown above.

B. The $1,000 maximum benefit payable per Covered Person per Plan Year for allergy testing will be discontinued.

5. In the **BENEFITS** section of the Plan document, the *Allergy Services* provision in the list of ***COVERED CHARGES*** will be revised to read as follows:

Allergy Services

Charges for allergy services, including injections, serum, and testing.

6. In the **PRESCRIPTION DRUG BENEFIT** section of the Plan document, the following sentence will be deleted from the ***PRESCRIPTION DRUG CARD PROGRAM*** and ***MAIL SERVICE PROGRAM*** subsections:

This co-payment will not apply toward the Comprehensive Medical Out-of-Pocket maximum.

7. In the **SCHEDULE FOR ELIGIBILITY AND PARTICIPATION** section of the Plan document, the ***PARTICIPANT ELIGIBILITY REQUIREMENTS*** subsection will be deleted in its entirety and replaced with the following two subsections:

PARTICIPANT ELIGIBILITY REQUIREMENTS: FULL-TIME AND PART-TIME EMPLOYEES

In order to be eligible to participate in this Plan, an individual must satisfy one of the following requirements:

A. Be currently employed by the Employer in Full-Time Employment for 30 or more hours per week.

B. Be currently employed by the Employer in Part-Time Employment for at least 20, but less than 30, hours per week.

NOTE:
1. An individual who is eligible to participate in the Plan as both a Participant and a Dependent may enroll as a Participant or as a Dependent, but not as both.

2. An individual will remain eligible for the Plan during any period when school is not in session if the individual remains employed by the Employer for the duration of the break and also returns to the regular assignment when the break has ended. U.S. Employees working in other countries and foreign nationals working for the Employer are not eligible to participate in the Plan unless otherwise stated.

PARTICIPANT ELIGIBILITY REQUIREMENTS: ALL OTHER EMPLOYEES

Beginning on October 1, 2015 and as permitted under Health Care Reform, the Employer will use the Measurement Period/Stability Period Safe Harbor method to determine whether or not an Employee who does not meet the Participant Eligibility Requirements in the subsection above but who does work an average of 30 or more hours over the course of the Initial Measurement Period or Standard Measurement Period will be eligible to participate in the Plan for the period of time required by law.

An Employee's schedule will be monitored over the course of a 12-month Initial Measurement Period that will begin on the first of the month following the Employee's hire date. Immediately following the end of the Initial Measurement Period, there will be a one-month Initial Administrative Period during which the Employer will evaluate the results of the monitoring and conduct other administrative tasks. If the results show that the Employee averaged 30 or more hours per week over the course of the Initial Measurement Period, he or she will be eligible for Participant Coverage during a 12-month Initial Stability Period that will begin immediately after the expiration of the Initial Administrative Period. Barring any event that would cause it to terminate, Participant Coverage will remain in effect during the entire Initial Stability Period even if the Employee averages fewer than 30 hours per week during that time.

If an Employee transfers to Full-Time or Part-Time Employment and meets the Participant Eligibility Requirements for Full-Time or Part-Time Employees stated above during the Initial Measurement Period, the Employee will be eligible for Participant Coverage no later than the first day of the fourth month that begins on or after the date of the transfer.

On an ongoing basis, Employees' schedules will be monitored over the course of a 12-month Standard Measurement Period that will begin on September 1. For newly hired Employees, this period will count concurrently as some or all of the Initial Measurement Period. Immediately following the end of the Standard Measurement Period, there will be a one-month Standard Administrative Period during which the Employer will evaluate the results of the monitoring and conduct enrollment-related administrative tasks. This Standard Administrative Period will run concurrent with all or part of the Plan's Annual Open Enrollment Period. If the results show that the Employee averaged 30 or more hours per week over the course of the Standard Measurement Period, he or she will be eligible for Participant Coverage during a 12-month Standard Stability Period that will begin on October 1 immediately after the expiration of the Standard Administrative Period. The Standard Stability Period will be the same as the 12-month period for Annual Open Enrollment Elections. The cycle of consecutive Standard Measurement, Administrative, and Stability Periods will continuously repeat.

If during an Initial or Standard Measurement Period an Employee experiences a break of 26 or more weeks during which he or she is not credited for any hours of service, any time applied to the Measurement Period before the break will be lost and the Employee will be subject to an entire new Measurement Period that will begin on the first of the month following the Employee's return to work. Likewise, if during the Initial or Standard Measurement Period the Employee experiences a break of at least four but fewer than 26 weeks during which he or she is not credited for any hours of service, any time applied to the Measurement Period before the break will be lost if the break lasted longer than the period of credited service that immediately preceded it. A break of fewer than four weeks, or a break of at least four but fewer than 26 weeks that was shorter than the period of credited employment that preceded it, will have no effect other than to temporarily suspend the Initial or Standard Measurement Period, which will resume upon the Employee's return to work. An Employee who was enrolled for Participant Coverage before the break in service will be eligible to re-enroll as soon as administratively feasible (generally no later than the first day of the month after the Employee's return to work).

NOTE: An individual who is eligible to participate in the Plan as both a Participant and a Dependent may enroll as a Participant or as a Dependent, but not as both.

8. In the **ELIGIBILITY AND PARTICIPATION** section of the Plan document, the **ANNUAL OPEN ENROLLMENT PERIOD** subsection will be deleted in its entirety and replaced with the following:

ANNUAL OPEN ENROLLMENT PERIOD

The Plan will offer an Annual Open Enrollment Period in September each year for eligible Employees and their dependents to enroll or re-enroll for coverage under this Plan. For those Employees and their dependent(s), their elections will go into effect on October 1 following the Annual Open Enrollment Period.

Employees who satisfy the Participant Eligibility Requirements for Employees in Full-Time or Part-Time Employment and who continue to be eligible for Participant Coverage may enroll or re-enroll for coverage under the Plan during the Annual Open Enrollment Period.

Beginning October 1, 2015, any other Employee will be eligible to enroll or re-enroll for coverage under the Plan during the Annual Open Enrollment Period if he or she averaged 30 or more hours per week during the preceding 12-month Standard Measurement Period. Alternatively, an Employee who is eligible for coverage during his or her Initial Stability Period will be able to enroll or re-enroll for coverage under the Plan during the Annual Open Enrollment Period but coverage and the election will both terminate upon the expiration of the Initial Stability Period.

9. In the **TERMINATION OF COVERAGE** section of the Plan document, paragraph B. in the ***PARTICIPANT TERMINATION*** subsection will be deleted in its entirety and replaced with the following:

Date on which the Participant goes on a leave of absence, is laid-off, or is, on a regular basis, Actively at Work in employment by the Employer for less than the number of hours per week required to be initially eligible for coverage. However, a reduction in hours owing to a family or medical leave as defined by the FMLA shall not cause health coverage to end to the extent required by the FMLA, nor shall a reduction in hours during an Initial or Standard Stability Period cause health coverage to end to the extent required by Health Care Reform.

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

IN WITNESS WHEREOF, the undersigned has caused this amendment to be duly adopted and effective as of July 1, 2015, unless specifically stated otherwise above.

8-10-15	Carla Howard	L. Hyslop
Date (Mandatory)	Witness	BERRIEN RESA