AMERICANA BUILDING PRODUCTS, INC.
WELFARE BENEFIT PLAN

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ARTICLE I

GENERAL TERMS AND CONDITIONS

Section 1 Purpose

This Welfare Benefit Plan is established for the purpose of providing the employee welfare benefits described herein for the benefit of the Employer's eligible employees and dependents. This plan, together with the adoption agreement and governing documents described herein constitutes the written plan document required by ERISA § 402(a), and is an employee welfare benefit plan (within the meaning of ERISA § 3(l)). In addition, if elected in the adoption agreement, some or all of the benefit programs may be offered through a cafeteria plan arrangement under Code § 125.

Section 2 Definitions

The following capitalized terms shall have the meanings set forth below. Any reference herein to a statute, regulation or other authority, shall be a reference to such statute, regulation or other authority as amended and in effect from time to time.

2.1 "Administrator" means the Company or such other person or committee as may be appointed from time to time by the Company to supervise the operation and administration of the Plan. The Administrator shall be the "named fiduciary" under the Plan.

2.2 "Adoption Agreement" means the agreement by which the Company and Employers adopt the Plan and establish the Benefit Programs.

2.3 "Benefit Program" means an arrangement providing employee welfare benefits (within the meaning of Section 3(l) of ERISA), maintained or established by the Company or an Employer, which is a part of this Plan; provided, neither a Cafeteria Plan Arrangement nor a flexible spending account offering dependent care or adoption assistance expense reimbursements shall be deemed to be an employee welfare benefit plan. The Benefit Programs that are a part of this Plan are described in the Adoption Agreement.

2.4 "Cafeteria Plan Arrangement" means a Benefit Program that meets the requirements of Internal Revenue Code § 125, and pursuant to which an Employee can choose between cash or other taxable benefits and the Benefit Programs on a non-taxable basis.

2.5 "Claims Administrator" means the person or entity designated by the Administrator in accordance with Section 3.1 of this Article I to manage the payment of claims under a Benefit Program. If authority and responsibility to determine adverse claims determinations (within the meaning of ERISA § 503) is delegated by the Administrator to the Claims Administrator, the Claims Administrator shall act as claims fiduciary.

2.6 "Code" means the Internal Revenue Code of 1986, as amended, and the applicable regulations and rulings thereunder.

2.7 "Company" means the sponsoring employer listed on the Adoption Agreement, and any successor corporation resulting from a merger or consolidation with the Company or transfer of substantially all of the assets of the Company, if such successor or transferee shall adopt and continue the Plan.

2.8 "Dependent" means any person eligible for dependent coverage under a Benefit Program.

2.9 "Employee" means each common-law employee of an Employer who is eligible to become a Participant under a Benefit Program which is a part of this Plan. Except to the extent specifically provided otherwise in the Governing Documents of a Benefit Program, "Employee" shall not include any individual designated by an Employer as an independent contractor; a leased employee within the meaning of Code § 414(n); or a temporary or seasonal employee; even if such designation is found to be in error by a court or administrative agency of competent jurisdiction.

2.10 "Employer" means an entity, including the Company, that adopts the Plan for the benefit of its eligible Employees, and the Dependents of such Employees, as provided in Section 3.6 of this Article I. Employers participating in this Plan are listed in the Adoption Agreement.

2.11 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the applicable regulations and rulings thereunder.

2.12 "Fully Insured Benefit Program" means a Benefit Program that provides benefits solely under an insurance contract or policy, which benefits are paid directly to or on behalf of the Participant.

2.13 "Governing Documents" means, with respect to a Benefit Program and as applicable, the insurance contracts, certificates of coverage, summary plan description and any other document which governs the terms of the Benefit Program, as described in the Adoption Agreement and incorporated herein by this reference.

2.14 "Health Benefit Program" means a Benefit Program which is a group health plan and which provides benefits for health care (directly or otherwise) to Employees, former Employees, and their families, as provided under the terms of such Health Benefit Program.

2.15 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the applicable regulations and rulings thereunder.

2.16 "Insurer" means the insurance company issuing the contract or policy with respect to a Fully Insured Benefit Program.

2.17 "Participant" means any individual (including a Dependent) who is enrolled in and participates in a Benefit Program in accordance with Section 3.2 of this Article I.

2.18 "Plan" means this Welfare Benefit Plan and the Benefit Programs, as described herein.

2.19 "Plan Year" means the 12-month period described on the Adoption Agreement.

Section 3 General

3.1 **Administration of Plan and the Benefit Programs**. The Administrator shall be responsible for the general administration of the Plan, including the Benefit Programs, and shall be the "plan administrator" and "named fiduciary" within the meaning of ERISA under the Plan and the Benefit Programs (except to the extent another person or entity is specifically designated in the Governing Documents); provided, however, for Fully Insured Benefit Programs, unless specifically provided otherwise in the Governing Documents, the Insurer shall be the "named fiduciary," and claims fiduciary responsible for administering and determining benefits under such Benefit Program, and shall have full authority and discretion to interpret the terms of the Benefit Program for those purposes. With respect to the Plan, including the Benefit Programs, the Administrator shall have, without limitation, the following discretionary authority, duties and powers:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

(b) Except to the extent reserved to the Insurer with respect to a Fully Insured Benefit Program, to interpret the provisions of the Plan, make findings of fact, and correct errors in, supply omissions from, and resolve inconsistencies or ambiguities in the language of the Plan, and to decide all claims and appeals arising under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

(e) To allocate and delegate its fiduciary and administrative responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation, or designation to be in writing. Without limitation, the Administrator may designate other organizations or persons (who also may be employed by an Employer) to carry out the following:

(1) pursuant to an administrative services or claims administration agreement, the responsibility for administering and managing a Benefit Program or Programs, including the processing and payment of claims under the Program and the recordkeeping related thereto;

(2) the responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any government agency or to be prepared and disclosed to Employees, Participants or other persons entitled to disclosure under the Benefit Programs; and

(3) the responsibility to review claims or claim denials under the Benefit Programs, including discretionary authority to act as claims fiduciary to determine adverse claims determinations within the meaning of Department of Labor Regulation § 2560.503-1.

Subject to applicable law, any interpretation of the provisions of the Plan and the Benefit Programs and any decisions on any matter within the discretion of the Administrator made by the Administrator in good faith shall be binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Administrator shall make such adjustment on account thereof as it considers equitable and practicable. The Administrator shall not be liable in any manner for any determination of fact made in good faith.

3.2 **Eligibility.** Each Employee (and his or her Dependents) will become Participants, and will be eligible for the benefits provided by the Plan, solely in accordance with the terms of the Benefit Program, including any enrollment and premium payment requirements, applicable to the group or classification of Participants of which a Participant is a member. Participation in a Benefit Program will cease in accordance with the terms of such Benefit Program. Participation in the Plan will cease upon termination of the Plan or upon amendment of the Plan to exclude a group or classification of which a Participant is a member.

Retired Employees are not eligible to participate in the Plan, except as may be specifically provided under the terms of a Benefit Program.

Former Participants will become Participants again if and when they meet the eligibility requirements of the applicable Benefit Program.

3.3 **Benefits**. The benefits provided under the Plan for each group or classification of Participants are those set forth in the Governing Documents for the applicable Benefit Program.

3.4 **Contributions.**

(a) Employer Contributions. For each Plan Year, each Employer shall make such contributions under the Benefit Programs in such amounts and at such times as the Company shall determine are appropriate to fund the Benefit Programs.

(b) Employee Contributions. As a condition of eligibility under a Benefit Program, a Participant may be required to make contributions, in amounts and at times specified by the Company and the applicable Benefit Program, applicable to the coverage option selected and the group or classification of Participants of which such Participant is a member. Such contribution requirements may be adjusted from time to time. Contributions shall be made in such manner as the Administrator shall specify.

3.5 **Amendment and Termination.**

(a) Amendment. The Company reserves the right to amend any part or all of the Plan or a Benefit Program at any time or from time to time by written instrument.

(b) Termination. The Company reserves the right to terminate the Plan or a Benefit Program at any time by written instrument. The Plan or Benefit Program, as applied to any single Employer, may be terminated at any time by such Employer, subject to consent of the Company.

3.6 **Additional Employers.** Any affiliate of the Company may, with the consent of the Company, adopt the Plan and become an Employer hereunder, and designate any one or more existing plans or programs as a Benefit Program, applicable to its Employees or a group of its Employees or establish one or more Benefit Programs as applicable to such Employees.

3.7 **Discrimination.** To the extent any provision of ERISA, the Code or other applicable law or regulation prohibits discrimination in eligibility, benefits or other feature of a Benefit Program, the Administrator reserves the right to adjust, terminate or otherwise modify the terms and operation of the Benefit Program to the extent necessary to avoid, reduce or eliminate such discrimination.

3.8 **Claims Procedures.**

(a) Claims. All claims for benefits under the Plan and any assignment of benefits to a provider shall be made, processed and paid in accordance with Department of Labor Regulations § 2560.503-1 and other applicable law, and the terms and conditions of the applicable Benefit Program and the related provisions of the summary plan description for such program. The Administrator shall be the claims fiduciary unless this function is delegated to another person or entity under this Section 3.

(b) No Estoppel of Plan. No person is entitled to any benefit under the Plan except and to the extent expressly provided under the terms and conditions of the applicable Benefit Program. The fact that payments have been made from the Plan in connection with any claim for benefits does not (a) establish the validity of the claim; (b) provide any right to have such benefits continue for any period of time; or (c) prevent the Plan from recovering the benefits paid to the extent that the Administrator determines that there was no right to payment of the benefits under the Plan. Thus, if a benefit is paid and it is thereafter determined that such benefit should not have been paid (whether or not attributable to an error by the Participant or any other person), then the Administrator may take such action as it deems necessary or appropriate to remedy such situation, including without limitation, by deducting the amount of any overpayment theretofore made to or on behalf of such Participant from any succeeding payments to or on behalf of such Participant under the Plan or from any amounts due or owing to such Participant by the Company or under any other plan, program or arrangement benefiting the Employees or former Employees of the Company, or otherwise recovering such overpayment from whomever has benefited from it.

If the Administrator determines that an underpayment of benefits has been made, then the Administrator shall take such action as it deems necessary or appropriate to remedy such situation.

3.9 **Miscellaneous**

(a) Information to be Furnished by Participants. Participants under the Plan must furnish the Administrator with such evidence, data or information as the Administrator considers necessary or desirable to administer the Plan and the Benefit Programs. A fraudulent or knowing misstatement or omission of fact made by a Participant or Dependent in an enrollment form, a claim for benefits or similar manner may result in cancellation of coverage and/or denial of claims for benefits.

(b) Records. As a condition of receiving benefits payable under a Benefit Program, a Participant may be required to provide the Administrator with any evidence and records of expenses incurred by such Participant and each of such Participant's Dependents in such form as the Administrator shall from time to time specify.

(c) Uniform Rules. The Administrator shall administer the Program and the Benefit Programs on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons in similar situations.

(d) Waiver of Notice. Any notice required under the Plan or a Benefit Program may be waived by the person entitled to such notice.

(e) Gender and Number. Where the context permits, words in the masculine gender shall include the feminine and neuter genders, the singular shall include the plural, and the plural shall include the singular.

(f) Controlling Law. Except to the extent superseded by the laws of the United States, the laws of the state stipulated in the Adoption Agreement shall be controlling in all matters relating to the Plan and the Benefit Programs.

(g) Interests Not Transferable. Except as otherwise expressly permitted by a Benefit Program or as may be required by the tax withholding provisions of the Internal Revenue Code or any state's income tax act, benefits under the Plan and the Benefit Programs are not in any way subject to the debts or other obligations of the persons entitled thereto and may not be voluntarily or involuntarily sold, transferred, alienated, assigned or encumbered. Any attempt to accomplish the same is void. If the Administrator finds that such an attempt has been made, it may, in its sole discretion, elect to pay the benefits due the covered person to the covered person's spouse, parent, adult child, legal guardian of a minor child, sibling or other relative. Any such payment constitutes a complete discharge of the liability of the Plan, the Administrator and all Employers with respect to such benefits.

(h) Facility of Payment. When any person entitled to benefits under the Plan or a Benefit Program is under legal disability or in the Administrator's opinion is in any way incapacitated so as to be unable to manage his or her affairs, the Administrator, in its sole discretion, may cause such person's benefits to be paid to such person's legal representative for his benefit, or to be applied for the benefit of such person in any other manner that the Administrator may determine. Such payment shall constitute a full discharge of liability of the Plan, the Benefit Programs, the Administrator and all Employers for such benefits.

(i) No Vested Interest. No person shall have any right, title or interest in or to any contributions made under the Plan and the Benefit Programs, such contributions being made for the sole purpose of providing benefits under the Programs in accordance with their terms. Neither the Company, the Administrator, nor any Employer shall in any way guarantee the payment of any benefit that may be or become due to any person under the Plan or the Benefit Programs.

(j) Employment Rights. Employment rights of an Employee shall not be deemed to be enlarged or diminished by reason of establishment of, or participation in, the Plan or any Benefit Program, nor shall establishment of the Plan and the Benefit Programs confer upon any Employee any right to be retained in the service of an Employer.

(k) Cost of Plan and Program Administration. The costs and expenses incurred in the administration of the Plan and the Benefit Programs shall be paid, in the discretion of the Administrator, (i) from assets accumulated under the Plan and the Benefit Programs, if any; (ii) from Employee contributions; or (iii) by the Employers in such proportion as the Company or the Administrator shall determine.

(l) Evidence. Evidence required of anyone under the Plan and the Benefit Programs may be by certificate, affidavit, document or other information which the Administrator considers pertinent and reliable, and signed, made or presented by the proper party or parties.

(m) Physical Examination and Autopsy. In addition to any rights and privileges granted under a Benefit Program, the Administrator, at its own expense, shall have the right and opportunity to have a physician, designated by the Administrator, examine any individual whose injury or sickness is the basis of a claim under the Plan and the Benefit Programs, when and as often as it may reasonably require during the pendency of a claim or any period of benefits under the Plan and the Benefit Programs and to make an autopsy in case of death, provided it is not otherwise prohibited by law. Notwithstanding the foregoing, a Health Benefit Program shall not request or require an individual to undergo a genetic test.

(n) Recovery of Benefits. If, because of fraud, mistake or any other reason, a person receives a benefit payment under the Plan and the Benefit Programs that exceeds the benefit payment that should have been made, the Administrator shall have the right to recover the amount of such excess from such person. The Administrator may, however, at its option, deduct the amount of such excess from any subsequent benefits payable to, or for, the Participant or such Participant's Dependents to whom or on whose behalf the excess payment was made.

(o) Lawsuits Concerning Benefits. No lawsuit may be brought by any person or entity to recover benefits under the Plan more than one year from the date Plan benefits are finally denied.

(p) Workers' Compensation Not Affected. The Plan is not in lieu of, and does not affect any requirement for, coverage under Workers' Compensation.

(q) Severability. In case any provisions of the Plan or any Benefit Program shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions of the Plan or any Benefit Program, and the Plan and all Benefit Programs shall be construed and enforced as if such illegal and invalid provisions had never been set forth in the Plan or Benefit Program.

(r) Failure to Enforce. Failure to enforce any provision of the Plan shall not affect the Employer's or Administrator's right thereafter to enforce such provision, nor shall such a failure affect the Employer's or Administrator's right to enforce any other provision of the Plan.

(s) Indemnification. In addition to whatever rights of indemnification the members of the board of directors of the Employer or any Employee or Employees of the Employer to whom any power, authority, or responsibility is delegated pursuant to this Plan or any Benefit Program, may be entitled under the articles of incorporation, by-laws or regulations of the Employer, under any provision of law, or under any other agreement, the Employer shall satisfy any liability actually and reasonably incurred by any such person or persons, including expenses, attorneys' fees, judgments, fines, and amounts paid in settlement (other than amounts paid in settlement not approved by the Employer in connection with any threats and pending or completed action, suit, or proceeding that is related to the

exercising or failure to exercise by such person or persons of any of the powers, authority, responsibilities, or discretion as provided under the Plan or a Benefit Program, or reasonably believed by such person or persons to be provided hereunder, and any action taken by such person or persons in connection therewith, unless the same is judicially determined to be the result of such person or persons' gross negligence or willful misconduct.

ARTICLE II

SECTION 125 CAFETERIA PLAN

Section 1 General

If elected in the Adoption Agreement, the Benefit Programs shall include a Cafeteria Plan Arrangement which shall permit Employees to choose between cash (or other taxable benefits) and the Benefit Programs on a non-taxable basis, subject to the requirements of Code § 125 and the regulations thereunder.

Section 2 Eligibility

Notwithstanding anything to the contrary contained in the Governing Documents, participation in the Cafeteria Plan Arrangement shall be restricted to Employees, which may include former Employees if permitted in the Governing Documents.

Section 3 Irrevocable Elections

An Employee's election under the Cafeteria Plan Arrangement shall be effective for the plan year, as stated in the Cafeteria Plan Document, and shall be irrevocable, except to the extent permitted under the Governing Documents and Treasury Regulation § 1.125-4.

Section 4 Additional Required Terms

Additional terms required under Code § 125 shall be set forth in the Governing Documents for the Cafeteria Plan Arrangement.

ARTICLE III

HEALTH BENEFIT PROGRAMS

Section 1 Health Benefit Programs

The Plan shall include any Health Benefit Programs described by the terms of the Adoption Agreement. Such Health Benefit Programs are designated as the health care component of the Plan within the meaning of the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards") and the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"). Each reference to the "Plan" in Section 2 below shall mean the health care component of the Plan.

Section 2 HIPAA Privacy and Security Standards

2.1 **General.** If a Health Benefit Program is not exempted from the requirements of the Privacy Standards and the Security Standards, then this Section shall apply.

2.2 **Privacy and Security Standards.**

(a) The Plan shall not disclose Protected Health Information to any member of an Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment. "Protected Health Information" shall include "genetic information," as defined in the Privacy Standards. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(b) Protected Health Information disclosed to members of Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan treatment, payment functions and health care operations. The terms "treatment," "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" shall include activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information shall not be used or disclosed for "underwriting" purposes, as defined in the Privacy Standards.

(c) The Plan shall disclose Protected Health Information only to members of the Employer's workforce, who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(d) By executing the Adoption Agreement, the Company and all Employers agree to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) Implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan.

(3) Ensure that any agent or subcontractor, (i) to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information, and/or (ii) to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(4) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(5) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(6) Make available Protected Health Information to individual Plan members as required by Section 164.524 of the Privacy Standards;

(7) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information as required by Section 164.526 of the Privacy Standards;

(8) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members as required by Section 164.528 of the Privacy Standards;

(9) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(10) If feasible, return or destroy all Protected Health Information received from the Plan that the 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

(11) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above, and to use reasonable and appropriate security measures to comply with this provision.

Section 3 Family and Medical Leave Act

If an Employer is subject to the Family and Medical Leave Act of 1993, as amended (FMLA), then this Section shall apply. A Participant who is on an approved leave of absence under the FMLA shall be entitled to continue his participation in the Health Benefit Programs during such leave to the extent required by and in accordance with the FMLA and applicable regulations.

Section 4 COBRA

If the Health Benefit Program is not exempted from the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), and the regulations thereunder, the Health Benefit Program shall be operated in accordance with such requirements, as set out in the Governing Documents of such Benefit Program.

Section 5 USERRA

If the Health Benefit Program is not exempted from the requirements of the Uniformed Services Employment and Reemployment Rights Act and the regulations thereunder, the Health Benefit Program shall be operated in accordance with such requirements. This Section 5 shall be interpreted to comply with USERRA and any pertinent regulations. USERRA provisions may vary slightly among the various Health Benefit Programs. To the extent consistent with applicable law, the specific USERRA provisions in any Health Benefit Program shall govern over the terms of this Section 5.

Unless otherwise specifically provided in the applicable Governing Documents:

(1) a Participant must notify the Employer of his intention to elect USERRA continuation of coverage prior to the expiration of the COBRA election period provided under the Health Benefit Program; and

(2) any period of USERRA continuation of coverage shall run concurrently with COBRA continuation coverage.

Section 6 Qualified Medical Child Support Order Procedures

If a Health Benefit Program is subject to ERISA § 609(a), then this Section shall apply. Such Health Benefit Program shall provide benefits in accordance with the terms of a qualified medical child support order that meets the requirements of ERISA § 609(a). Each Health Benefit Program shall establish reasonable written procedures to determine whether a medical child support order is a qualified medical child support order. Such procedures shall be made available upon request of a Participant at no charge.

Section 7 Medicaid

If a Health Benefit Program is subject to ERISA § 609(b), then this Section shall apply.

7.1 Payment for benefits with respect to a Participant under a Health Benefit Program will be made in accordance with any assignment of rights made by or on behalf of such Participant or a beneficiary of the Participant as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

7.2 The fact that a Participant is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account in enrolling such Participant or in determining or making benefit payments for such Participant.

7.3 To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act in any case in which a Health Benefit Program has a legal liability to make payment for items or services constituting such assistance, payment for benefits under such program will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Participant to such payment for such items or services.

Section 8 Coverage of Dependent Children in Case of Adoption

If a Health Benefit Program is subject to ERISA § 609(c), then this Section shall apply.

8.1 With respect to any such Health Benefit Program that provides coverage for the dependent children of Employees, such Health Benefit Program shall provide benefits to dependent children placed with an Employee for adoption (as defined by ERISA Section 609(c)) under the same terms and conditions as apply to the natural children of the Employee, irrespective of whether the adoption has become final.

8.2 Such Health Benefit Program shall not restrict coverage of a child adopted or placed for adoption by an Employee, solely on the basis of a preexisting condition of such child at the time such child would otherwise become eligible for coverage under the Health Benefit Program, if the adoption or placement for adoption occurs while the Employee is eligible for coverage under the Health Benefit Program.

Section 9 HIPAA Portability and Nondiscrimination Requirements

9.1 If a Health Benefit Program is not exempted under ERISA § 732 from the HIPAA portability and nondiscrimination requirements as set out in ERISA §§ 701 through 703 and the regulations thereunder, the Health Benefit Program shall be operated in accordance with such requirements.

9.2 A Health Benefit Program shall be operated in accordance with the provisions of ERISA § 702 which restrict the use and collection of genetic information and the requirement or request for genetic testing.

Section 10 Newborn and Mothers Health Protection Act

If a Health Benefit Program is subject to ERISA § 711, then this Section shall apply.

10.1 If such Health Benefit Program provides benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child, such Health Benefit Program shall not:

(a) Except as provided in subsection (b):

(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours; or

(ii) require that a provider obtain authorization from the Health Benefit Program or the health insurance issuer for prescribing any length of stay required under clauses (i) and (ii).

(b) Paragraph (a) shall not apply in connection with any Health Benefit Program or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (a) is made by an attending provider in consultation with the mother.

10.2 Such Health Benefit Program shall not:

(a) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the Health Benefit Program, solely for the purpose of avoiding the requirements of Section 10.1 above.

(b) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under Section 10.1 above.

(c) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual Participant or beneficiary in accordance with Section 10.1 above.

(d) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual Participant or beneficiary in a manner inconsistent with Section 10.1 above; or

(e) restrict benefits for any portion of a period within a hospital length of stay required under Section 10.1 above in a manner which is less favorable than the benefits provided for any preceding portion of such stay; provided, nothing herein shall be construed to limit the terms of the Health Benefit Program with respect to deductibles, copayments or other cost-sharing provisions and limitations, except that such terms may not impose greater limits or cost sharing on any length of stay required under Section 10.1 above than for any preceding portion of such stay.

Section 11 Mental Health Parity and Addiction Equity Act

If a Health Benefit Program is subject to ERISA § 712, then the terms of this Section shall apply.

A Health Benefit Program that provides both medical and surgical benefits and mental health and/or substance abuse benefits shall not impose any limits on mental health or substance abuse benefits that violate the requirements of ERISA § 712.

Section 12 Women's Health and Cancer Rights Act

If a Health Benefit Program is subject to ERISA § 713 and provides medical and surgical benefits with respect to a mastectomy, then this Section shall apply. Such Health Benefit Program shall, with respect to a Participant who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, provide coverage for the following (subject to applicable deductibles, copayments and other Health Benefit Program limitations):

(1) reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications for all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient.

Section 13 Patient Protection and Affordable Care Act

If a Health Benefit Program is not exempted under ERISA § 732 from the requirements of Title I of the Patient Protection and Affordable Care Act of 2010, the Health Benefit Program shall be operated in accordance with such requirements.

Section 14 Subrogation and Recovery

If a Participant incurs covered expenses or receives benefits under a Benefit Program with respect to an injury or illness for which a third party (or its insurer) may be liable, the Plan retains all rights of subrogation, recovery and reimbursement as set out more specifically in the Governing Documents for each Benefit Program.

Section 15 Coordination of Benefits

15.1 **Coordination of Benefits.** When a Participant is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received. The terms of this Section 15 shall apply, except to the extent specifically provided otherwise in the Governing Documents of a Health Benefit Program.

The plan that pays first according to the rules will pay as if there were no other plan involved. If this Plan is secondary or subsequent, it will pay the amount it would have otherwise paid, minus whatever the primary plan paid, so that benefits are not duplicated. The total reimbursement will never be more than the amount that would have been paid if this Plan had been the primary plan.

15.2 **Benefit Plan.** This provision will coordinate the health benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms and applicable law, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

15.3 **Allowable Charge.** For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Participant does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Participant used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

15.4 **Automobile Limitations.** When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

15.5 **Benefit Plan Payment Order.** When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those benefits of a benefit plan which covers that person as a laid-off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(d) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(e) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

    (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

    (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(f) When a child's parents are divorced or legally separated, these rules will apply:

    (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

    (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered next. The benefit plan of the stepparent without custody will be considered last.

    (iii) This rule will be in place of clauses (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

    (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the

health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(g) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to any governmental plan to the extent required by federal law.

15.6 **Claims Determination Period.** Benefits will be coordinated on a yearly basis. This is called the claims determination period.

15.7 **Right to Receive or Release Necessary Information.** This Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Participant must give this Plan the information it asks for about other plans and their payment of Allowable Charges.

15.8 **Facility of Payment.** This Plan may repay other plans for benefits paid that the Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

15.9 **Right of Recovery.** This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Section 16 Claims Procedures

16.1 **Claims Procedures.** The specific guidelines for filing a Claim or a request for a review of a denied claim shall be set out in the summary plan description for each Health Benefit Program. Such procedures shall comply with the general provisions of this Section 16 and shall be designed to ensure the independence and impartiality of the persons involved in making decisions on such Claims. A Claimant must follow all internal claims and appeal procedures and, where applicable, all external review procedures, before he can file a lawsuit to contest the decision.

16.2 **Definitions.** For purposes of this Section 16, the following capitalized terms shall have the meanings set forth below:

"Non-Grandfathered Plan" means a Health Benefit Program that is (1) subject to Title I of the Patient Protection and Affordable Care Act of 2010, as amended, and (2) does not meet the requirements for "grandfathered status" within the meaning of that Act.

"Claimant" means the person who files a Claim or a person who has been authorized by the Claimant to act on his behalf in accordance with the procedures of the Health Benefit Program.

"Claim" means any request for a benefit under a Health Benefit Program, made by a Claimant or his representative, which complies with the reasonable procedures for making benefit Claims under such program.

"Concurrent Care Claim" means a Claim for an ongoing course of treatment to be provided over a period of time or number of treatments. Any reduction or termination by the Health Benefit Program of the course of treatment (other than by plan amendment or termination) before the end of the period of time or number of treatments originally approved is considered an Adverse Benefit Determination.

"Pre-Service Claim" means any Claim for a benefit under a Health Benefit Program which conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

"Urgent Care Claim" means a Pre-Service Claim for medical care or treatment with respect to which the time frame for a non-urgent care determination could seriously jeopardize the life or health of the Claimant; or the ability of the Claimant to regain maximum function; or in the opinion of the attending or consulting physician, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A physician with knowledge of the Claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such physician, an individual acting on behalf of the Health Benefit Program applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

"Post-Service Claim" means any Claim that is not a Pre-Service Claim.

"Adverse Benefit Determination" means a total or partial denial of a Claim. For a Non-Grandfathered Plan, a retroactive rescission of coverage due to fraud or misrepresentation shall be treated as an Adverse Benefit Determination.

"Appeal" means a Claimant's written request for review of an Adverse Benefit Determination in accordance with Section 16.4.

"Final Adverse Benefit Determination" means an Adverse Benefit Determination issued in connection with the last stage of Appeal as set forth in Section 16.4.

16.3 **Notice to Claimant of Adverse Benefit Determinations.**

(a) Initial Claims. Except with respect to Urgent Care Claims (the notification for which may be oral followed by written or electronic notification within three days of the oral notification), upon its initial determination of a Claim, the Administrator shall provide written or electronic notification of any Adverse Benefit Determination. The notice will state, in a manner calculated to be understood by the Claimant:

(1) The specific reason or reasons for the adverse determination, including, for Non-Grandfathered Plans, the denial code and its corresponding meaning, and a description of the Non-Grandfathered Plan's standard, if any, that was used in denying the Claim.

(2) Reference to the specific Health Benefit Program provisions on which the determination was based.

(3) A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Health Benefit Program's Appeal procedures including any voluntary appeal procedures offered by the Health Benefit Program and, for Non-Grandfathered Plans, any external review procedures, and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under ERISA §502.

(5) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge, or a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the Claimant upon request.

(6) If the Adverse Benefit Determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Benefit Program to the Claimant's medical circumstances, will be provided, or a statement will be included that such explanation will be provided free of charge, upon request.

(7) For Non-Grandfathered Plans, information sufficient to allow the Claimant to identify the Claim involved (including date of service, the healthcare provider and the Claim amount, if applicable, and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the Claimant as soon as feasible upon request).

(8) For Non-Grandfathered Plans, information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals procedures and external review process.

(b) Appeals. The Administrator shall also provide written or electronic notice of an Adverse Benefit Determination on Appeal. This notice shall contain the information listed in subsections (a)(i) through (viii), as well as:

(1) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim.

(2) In the case of a Final Adverse Benefit Determination for a Non-Grandfathered Plan, a discussion of the decision.

16.4 **Appeals.** When a Claimant receives an Adverse Benefit Determination, the Claimant has 180 days following receipt of the notification in which to request a review of the decision unless a shorter time is permitted by law. A Claimant may submit written comments, documents, records, and other information relating to the Claim. If the Claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Health Benefit Program documents and Health Benefit Program provisions have been applied consistently with respect to all Claimants; or

(4) constituted a statement of policy or guidance with respect to the Health Benefit Program concerning the denied treatment option or benefit.

For Non-Grandfathered Plans, the Administrator shall provide the Claimant any new or additional evidence that is relied upon, considered or generated by or at the direction of the Non-Grandfathered Plan. This new evidence shall be provided free of charge and must be provided to Claimant as soon as possible and sufficiently in advance of the time within which a Final Adverse Benefit Determination is required, to allow the Claimant time to respond.

If a Final Adverse Benefit Determination will be based on a new or additional rationale, the Claimant must be provided with this rationale as soon as possible and sufficiently in advance of the date on which the Final Adverse Benefit Determination must be provided, in order to give the Claimant a reasonable opportunity to respond prior to that date.

The Administrator's review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Health Benefit Program who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Administrator shall consult with a health care professional who was not involved in the original benefit determination, nor a subordinate of any individual involved in the original determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Health Benefit Program in connection with the initial determination will be identified.

If specifically provided under the Health Benefit Program, a Claimant may bring a second Appeal, which shall be subject to the terms of this Section 16.4.

16.5 **Voluntary Appeals, Including Voluntary Arbitration.** If a Health Benefit Program provides for a voluntary appeal process, the terms of this Section 16.5 shall apply. During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Health Benefit Program waives any right to assert that a Claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Health Benefit Program. A Claimant may elect a voluntary appeal after exhaustion of appeals of an adverse benefit determination as explained in the section above, entitled "Appeals."

The Health Benefit Program will provide to the Claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the Claimant to make an informed judgment about

whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the Claimant's rights to any other benefits under the Health Benefit Program; will list the rules of the appeal; state the Claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the Claimant as part of the voluntary level of appeal.

16.6 **Time for Responses.** Upon receipt of a Claim or an Appeal of an Adverse Benefit Determination, the Administrator (or its delegate) shall make its determination and provide any required notice within the following time periods.

(a) Urgent Care Claims. The Administrator shall decide the Claim as soon as feasible, but no later than 72 hours following receipt of the Claim. If additional information is needed in order to decide the Claim, the Administrator will notify the Claimant within 24 hours and Claimant shall have at least 48 hours to provide the required information. The Administrator will notify Claimant of its benefit determination within 48 hours after the earlier of: (i) receipt of the required information, or (ii) the expiration of the period afforded to Claimant to provide the information. In the case of an Adverse Benefit Determination, Claimant will be provided a description of the expedited claim review process for Urgent Care Claims.

Appeal of an Adverse Benefit Determination shall be decided as soon as feasible, but no later than 72 hours after the Administrator receives the request for Appeal.

(b) Pre-Service Claims. A Pre-Service Claim shall be decided within 15 days after the Administrator receives the Claim, although the review period may be extended an additional 15 days if necessary due to circumstances beyond the Administrator's control. Claimant will be notified within the original 15-day period of the reason for the extension and the date the Administrator expects to render its decision.

If Claimant does not follow a Health Benefit Program's procedures for filing a Pre-Service Claim, the Administrator must notify Claimant within 5 days of the proper procedures for Claimant to complete the claim.

If the Administrator cannot render a decision within 15 days because Claimant has not provided sufficient information to review the Claim, the notice of extension must describe the specific information needed to complete the Claim. Claimant will be given at least 45 days from receipt of this notice to provide the required information. The Administrator has 15 days after it receives the information to render its decision.

The Administrator will decide an Appeal of a denied Pre-Service Claim within 30 days after receiving the request for review; provided, if a Health Benefit Program provides for two levels of Appeal, the Administrator shall decide each level of Appeal within 15 days.

(c) Concurrent Care Claims. An Adverse Benefit Determination involving Concurrent Care will be made sufficiently in advance of any reduction in or termination of treatment to allow Claimant to appeal the Adverse Benefit Determination. If a course of treatment involves urgent care, Claimant's request to extend the course of treatment will be decided as soon as possible, but not later than 24 hours after the Administrator receives the request, provided that the request is made at least 24 hours prior to the expiration of treatment.

(d) Post-Service Claims. A Post-Service Claim shall be decided within 30 days after the Administrator receives the Claim. The Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Administrator. The Administrator will notify Claimant within the original 30-day period of the reason for the extension and the date by which the Administrator expects to render its decision.

If the Administrator cannot render a decision within 30 days because Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Health Benefit Program, the notice of extension will describe the specific information needed to complete the Claim. Claimant will be given at least 45 days from receipt of the notice to provide the required information. The Administrator has 15 days from the date of receiving such information to render its decision.

An Appeal involving a Post-Service Claim shall be decided by the Administrator within 60 days after receiving the request for review; provided, if a Health Benefit Program provides for two levels of Appeal, the Administrator shall decide each level of Appeal within 30 days.

16.7 **External Review Process.** For Non-Grandfathered Plans, upon exhaustion of the internal claims and appeal procedures, a Claimant may request that the Claim be reviewed under the Non-Grandfathered Plan's external review process. The Non-Grandfathered Plan shall comply with the applicable State external review process, if any, and if none, the federal external review process. If the federal external review process applies, the following guidelines shall apply.

The Claimant must file his request for external review within 4 months after receipt of the Final Adverse Benefit Determination.

The Administrator will determine whether the Claim is eligible for review under the external review process. This determination is based on whether:

(1) The Claimant is or was covered under the Non-Grandfathered Plan at the time the Claim was made or incurred;

(2) The denial relates to the Claimant's failure to meet the Non-Grandfathered Plan's eligibility requirements;

(3) The Claimant has exhausted the Non-Grandfathered Plan's internal claims and appeal procedures; and

(4) The Claimant has provided all the information required to process an external review.

Within one business day after completion of this preliminary review, the Administrator will provide written notification to the Claimant of whether the claim is eligible for external review.

If the request for review is complete but not eligible for external review, the Administrator will notify the Claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number.

If the request is not complete, the notice will describe the information needed to complete it. The Claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the external review process, the Administrator will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the Claimant, in writing, that the request for external review has been accepted. The notice should include a statement that the Claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Non-Grandfathered Plan. The Non-Grandfathered Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the external review process will end.

If the Non-Grandfathered Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The Claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, Claimant, or the Claimant's treating provider;

(4) The terms of the Non-Grandfathered Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Non-Grandfathered Plan and the Claimant of its final decision within 45 days after the IRO receives the request for the external review. The IRO's decision notice must contain:

(1) A general description of the reason for the external review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the Claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under federal guidelines.

Generally, a Claimant must exhaust the Non-Grandfathered Plan's claims and appeal procedures in order to be eligible for the external review process. However, an expedited external review is available if:

(1) The Claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Non-Grandfathered Plan's internal claims and appeal procedures would seriously jeopardize the Claimant's life or health or ability to regain maximum function and the Claimant has filed a request for an expedited internal review; or

(2) The Claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission,

availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Non-Grandfathered Plan must determine and notify the Claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the Claimant and the Non-Grandfathered Plan.

ARTICLE IV

FULLY INSURED BENEFIT PROGRAMS

Section 1 General

The Plan shall include the Fully Insured Benefit Programs identified on the Adoption Agreement.

Section 2 Claims Procedures

2.1 **Claims Procedures**. The specific guidelines for filing a claim or a request for a review of a denied claim shall be set out in the summary plan description for each Benefit Program. To the extent a claim involves a claim for disability benefits, such procedures shall comply with the general provisions of this Section 2. A Claimant must follow all internal claims and appeal procedures before he can file a lawsuit to contest the decision.

2.2 **Definitions**. For purposes of this Section 2, the following capitalized terms shall have the meanings set forth below:

"Claimant" means the person who files a Claim or a person who has been authorized by the Claimant to act on his behalf in accordance with the procedures of the Fully Insured Benefit Program.

"Claim" means any request for a benefit under a Fully Insured Benefit Program, made by a Claimant or by his representative, that complies with the reasonable procedure for making benefit Claims under such program, and the resolution of which requires a determination of disability by the claims fiduciary.

"Adverse Benefit Determination" means a total or partial denial of a Claim.

2.3 **Notice to Claimant of Adverse Benefit Determinations**. Upon its initial determination of a Claim, or upon its determination of an appeal of a Claim, the Insurer or its designee shall provide written or electronic notification of any Adverse Benefit Determination. The notice will state, in a manner calculated to be understood by the Claimant:

(1) The specific reason or reasons for the Adverse Benefit Determination.

(2) Reference to the specific Benefit Program provisions on which the determination was based.

(3) A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Benefit Program's review procedures, incorporating any voluntary appeal procedures offered by the Benefit Program, and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(5) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the Claimant upon request.

(6) If the Adverse Benefit Determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Benefit Program to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(7) For notification of an Adverse Benefit Determination on appeal, a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

2.4 **Appeals**. When a Claimant receives an Adverse Benefit Determination, the Claimant has 180 days following receipt of the notification in which to appeal the decision. A Claimant may submit written comments, documents, records, and other information relating to the Claim. If the Claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Benefit Program documents and Benefit Program provisions have been applied consistently with respect to all Claimants; or

(4) constituted a statement of policy or guidance with respect to the Benefit Program concerning the denied treatment option or benefit.

The Administrator’s review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Benefit Program who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination, nor a subordinate of any individual involved in the original determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of

the Benefit Program in connection with the initial determination will be identified.

2.5 **Voluntary Appeals, Including Voluntary Arbitration.** If a Fully Insured Benefit Program provides for a voluntary appeal process, the terms of this Section 2.5 shall apply. During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Benefit Program waives any right to assert that a Claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Benefit Program. A Claimant may elect a voluntary appeal after exhaustion of appeals of an Adverse Benefit Determination as explained in the section above, entitled, "Appeals."

The Benefit Program will provide to the Claimant, at no cost and upon request, sufficient information about the voluntary appeal process to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the Claimant's rights to any other benefits under the Benefit Program; will list the rules of the appeal; state the Claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the Claimant as part of the voluntary level of appeal.

2.6 **Time for Responses**. Upon receipt of a Claim or an appeal of an Adverse Benefit Determination, the Insurer (or its delegate) shall provide any required notice within the following time periods 45 days after the Administrator receives the Claim. The Insurer may extend the review period for an additional 30 days if necessary due to circumstances beyond the control of the Insurer. The Insurer will notify Claimant within the timeframe of the reason for the extension and the date by which the Insurer expects to render its decision. If, prior to the end of the first 30-day extension period, the Insurer determines that, due to matters beyond its control, a decision cannot be made within that extension period, the Insurer may extend the review period for an additional 30 days. Any notice of extension under this Section IV.2.6 shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent decision in the Claim, and the additional information needed to resolve those issues.

Claimant will be given at least 45 days from receipt of the notice to provide the required information. The Administrator has 15 days from the date of receiving such information to render its decision.

ADOPTION AGREEMENT

Any and all Benefit Programs, sponsored by the employers listed in this agreement, and subject to ERISA, shall be included as part of this agreement. Some or all of the benefit programs may be offered through a cafeteria plan arrangement under Code § 125.

The actual terms and conditions of the Benefit Programs offered under this plan are maintained in separate, written documents. In the event of a conflict between the plan documents of an individual Benefit Program and this Plan, the appropriate individual Benefit Program document shall control. Subsequently, each individual Benefit Program document, including any amendments, restatements or other changes, are considered fully incorporated into this Plan, as if fully recited herein.

I. Administrative Information

Company: Americana Building Products, Inc.

Effective Date: New Plan January 1, 2016

Affiliated Participating Employers	Effective Date of Participation	EIN:
PW Athletic Mfg Co. Patterson-Williams LLC.	March 1, 2013	86-1037646

Administrator:	The Employer and those individuals or committee appointed by the Employer
Plan Year:	Twelve-month period ending each December 31.
Controlling Law:	Except to the extent preempted by federal law, the laws of the State of Illinois shall apply.
Plan Number:	501

IN WITNESS WHEREOF Americana Building Products, Inc., has caused this Plan to be executed, effective as of the Effective Date.

_____

Authorized Signatory: Employer (Plan Sponsor)

_____

Title

_____

Date