

**PLAN DOCUMENT FOR THE
WELFARE BENEFIT PLAN OF**

("Plan Sponsor")

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ARTICLE I. INTRODUCTION

1.1 Establishment or Restatement. _____ ("Plan Sponsor") hereby establishes or restates, as applicable, the Welfare Benefit Plan, effective as of the _____ day of _____, 20____, except as specifically stated otherwise in this Plan.

1.2 Single Employer Plan. This Plan is a single employer plan and not a multiple employer plan for purposes of the Code and ERISA.

1.3 Policy Provisions Incorporated/Supersession. The terms of the Policies providing benefits under this Plan are hereby incorporated into the Plan document. Such Policies may change from time to time. The terms of the Policies are modified by this Plan and made subject to the terms of the Plan. However, notwithstanding anything in this Plan to the contrary, to the extent that the terms of this Plan would cause payment of a benefit not allowed under the terms of the underlying Policy for such benefit, the terms of the particular benefit Policy will govern.

ARTICLE II. DEFINITIONS

Unless the context clearly indicates otherwise, the following definitions apply for purposes of the Plan:

2.1 "COBRA" shall mean the health care continuation coverage provisions under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time. Reference to any section or subsection of such law includes reference to any comparable or succeeding provisions of any legislation which amend, supplement, or replace such section or subsection.

2.2 "Code" shall mean the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amend, supplement, or replace such section or subsection.

2.3 "Dependent" shall mean a dependent as defined in the Policy for a specific benefit. A Policy may define a dependent to include a spouse and/or other individuals.

2.4 "Director" shall mean any member of the Board of Directors of the Employer who is not eligible by reason of employment status.

2.5 "Employee" shall mean any individual employed by the Employer and classified as a common law employee by the Employer, except that the term "Employee" shall not include:

(a) A leased employee or any person who would be a leased employee but for the fact that he or she is the common-law employee of an Employer; or

(b) Individuals who the Employer treats as independent contractors during the period that the individuals are so treated. Workers treated as independent contractors include, but are not limited to, those whose services or purchases are reported on a Form 1099, or would be so reported but for failure to meet the minimum reporting threshold of such Form 1099, and not on a Form W-2.

2.6 "Employer" shall mean the Plan Sponsor named above, and any Related Employer that adopts this Plan with the approval of the Plan Sponsor.

2.7 "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to any section or subsection of ERISA includes reference to any comparable or succeeding provisions of any legislation which amend, supplement, or replace such section or subsection.

2.8 "FMLA" shall mean the Family and Medical Leave Act of 1993 (29 U.S.C. Section 2601 *et seq.*) and the Wisconsin Family and Medical Leave Act and other similar state laws, if applicable, as each of these laws may be amended from time to time. Reference to any section or subsection of these laws includes reference to any comparable or succeeding provisions of any legislation which amend, supplement, or replace such section or subsection.

2.9 "FMLA Leave" shall mean a leave of absence that the Employer, if subject to FMLA, is required to offer an Employee under the provisions of FMLA.

2.10 "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as may be amended from time to time, and any similar state law to the extent applicable. Reference to any section or subsection of such law includes reference to any comparable or succeeding provisions of any legislation which amend, supplement, or replace such section or subsection.

2.11 "Participant" shall mean any individual who participates in the Plan in accordance with Article III.

2.12 "Plan" shall mean this Welfare Benefit Plan, as set forth in this document, as amended or restated from time to time.

2.13 "Plan Administrator" shall mean the Plan Sponsor or such other person or committee the Plan Sponsor may appoint from time to time to supervise administration of the Plan.

2.14 "Plan Sponsor" shall mean the Employer named in Section 1.1.

2.15 "Plan Year" generally shall mean the 12-month period beginning on each January 1 and ending on each December 31. The first Plan Year begins on the initial effective date for the Plan and ends on the following December 31.

2.16 "Policy" shall mean such insurance policies or contracts (whether fully insured, minimum premium, or administrative services only) or other appropriate arrangements as may from time to time be available through the Trust. The policy, contract, or arrangement applicable to a particular benefit and any related applications and enrollment forms are referred to in this Plan Document as the "Policy" for that benefit. The Policies for the benefits provided hereunder are incorporated by reference into this Plan document.

2.17 "Related Employer" shall mean an employer affiliated with the Employer and treated as a single employer with the Employer within the meaning of Code Section 414(b), (c), or (m). Related Employers, if any, that have adopted this Plan are listed in Appendix A to this Plan. However, for purposes of Sections 2.13, 2.14, 8.1, and 8.2 and execution of the Plan, "Employer" does not include Related Employers. See Section 2.6.

2.18 "Retiree" shall mean an individual who meets the definition of a Retiree specified in Appendix R, if applicable.

2.19 "Spouse" shall mean a Participant's spouse, as defined under the applicable Policy for a specific benefit.

2.20 "Trust" shall mean the Wisconsin Bankers Association Insurance Trust Fund, as amended from time to time. Reference to any section or subsection of the Trust includes reference to any comparable or succeeding provisions of the Trust which amend, supplement, or replace such section or subsection.

2.21 "Uniformed Services" shall mean the Armed Forces, the Army National Guard, the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, any other category of persons designated by the President of the United States in time of war or national emergency, or other category which may be specified from time to time by USERRA, to the extent such individuals are subject to the provisions of USERRA.

2.22 "Uniformed Services Leave" shall mean a leave of absence to serve in the Uniformed Services which is subject to USERRA.

2.23 "USERRA" shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time. Reference to any section or subsection of USERRA includes reference to any comparable or succeeding provisions of any legislation which amend, supplement, or replace such section or subsection.

ARTICLE III. PARTICIPATION

3.1 Commencement of Participation. Notwithstanding anything to the contrary, only those persons who meet the requirements of this Plan and who have satisfied the eligibility requirements for coverage under the Policy for a particular benefit offered under this Plan and become and remain covered under it shall be Participants for that benefit under the Plan.

3.2 Coverage and Benefits. Notwithstanding anything to the contrary, coverage and benefits for a particular benefit coverage shall be determined by and shall be subject to the terms, conditions and provisions of both this Plan and the Policy for the particular benefit.

3.3 Cessation of Participation. Termination of coverage for a particular benefit offered under this Plan shall occur on the date that the individual ceases to be eligible as provided by terms of the applicable Policy and by this Plan to the extent not inconsistent with the terms of the applicable Policy, provided that eligibility may continue beyond such date for purposes of COBRA continuation coverage as may be permitted under Article V. Notwithstanding the preceding, termination of coverage for a particular benefit shall cease, to the extent allowed by law, as of the effective date that the benefit is terminated under this Plan or the Plan is terminated.

3.4 Leaves of Absence. If an Employee goes on a leave of absence that is not an FMLA Leave or Uniformed Services Leave, the Employee will be treated as having terminated participation, as described under Section 3.3. Unless otherwise provided in the Policy for such benefit, if an Employee goes on an FMLA Leave or Uniformed Services Leave, then to the extent required by FMLA or USERRA, as applicable, (a) the Employee's entitlement to benefits other than "group health benefits" within the meaning of FMLA or USERRA, as may be applicable, shall be determined by the Employer's established policy for providing such benefits when the employee is on other forms of leave (paid or

unpaid, as appropriate); and (b) at the option of the Employee, the Employer will continue to maintain an Employee's coverage under any portion of the Plan that is a "group health plan" within the meaning of FMLA or USERRA, as applicable, on the same terms and conditions as coverage would have been provided if the Employee had been continuously employed during the entire leave period, subject to the Employee making any required contribution. Except as limited by law or regulations, an Employee on FMLA Leave shall be considered to have terminated employment with the Employer on the earliest to occur of: (1) the date the Employee's employment relationship with the Employer would have terminated if the Employee had not taken FMLA Leave (e.g., if the Participant's position is eliminated as part of a nondiscriminatory reduction in force and the Employee would not have been transferred to another position); (2) the date the Employee notifies the Employer of his or her intent not to return to employment; or (3) the date the Employee fails to return to employment at the end of the FMLA Leave or continues on leave after exhausting his or her FMLA Leave entitlement in the 12-month period.

If an Employee chooses not to retain group health plan coverage during an FMLA Leave, upon the Employee's return from FMLA Leave on or before the expiration of the FMLA Leave, the Employee shall have the right to be reinstated on the same terms as prior to taking the leave, including family or dependent coverages. If coverage lapses because an Employee on FMLA Leave has not made required premium payments, the Employer must still restore the Employee and all eligible dependents to coverage and benefits under the portion of the Plan that is considered a group health plan equivalent to those the Employee and his or her dependents would have had if the FMLA Leave had not been taken and the required contributions had not been missed. In the event that an Employee's coverage is reinstated as provided in this paragraph, the Employee and his or her dependents shall not be required to give new or additional evidence of insurability such as passing a new physical examination and the Employee shall not be required to meet any new qualification requirements imposed by the group health plan, such as any new preexisting condition waiting period or to wait for an open enrollment period.

Provisions similar to those above relating to FMLA Leave also shall apply to Uniformed Services Leave to the extent consistent with USERRA; provided however, that no rights shall be granted to Employees in excess of those required by USERRA.

3.5 Special Enrollment. Notwithstanding anything in the Plan to the contrary, individuals also may commence participation in any portion of the Plan that is a "group health plan" as such term is used in Code Section 9801(f), to the extent required by the special enrollment rules set forth in Code Section 9801(f). If applicable, the health insurance issuer for the benefit shall determine whether to require a written statement that coverage under another group health plan or other health insurance coverage is the reason for declining initial enrollment. Employees shall be notified of any such requirement pursuant to regulations under Code Section 9801(f), if applicable.

ARTICLE IV. ELECTED PLAN FEATURES

4.1 Election of Coverage for Employees, Retirees, or Directors. Coverages provided by the Employer are as elected in Appendices to this Plan. The Plan cannot provide Dependent Life coverage unless the Plan also provides Life and Accidental Death and Dismemberment coverage.

(a) Coverage for Employees may be provided by the Employer by completing and attaching Appendix E to the Plan document.

(b) Coverage for Retirees may be provided by the Employer by completing and attaching Appendix R to this Plan document. Coverage for Retirees only may be elected by the Employer

if Employees are covered for the same benefit under Appendix E. If coverage for Employees for a benefit under Appendix E is terminated, coverage for Retirees for the same benefit automatically shall terminate effective as of the same date.

(c) Coverage for Directors may be provided by the Employer by completing and attaching Appendix D to this Plan document; provided however, Director coverage is allowed only for benefits for those Directors continuously covered for such benefit since December 31, 1997. Coverage for Directors and/or retired Directors only may be elected by the Employer if Employees are covered for the same benefit under Appendix E. If coverage for Employees for a benefit under Appendix E is terminated, coverage for Directors and/or retired Directors for the same benefit automatically shall terminate effective as of the same date.

4.2 Election of Small Employer Exclusion from Medicare Secondary Payer Rules. If at any time the Employer satisfies the definition of "small employer" for purposes of the small employer exclusion (relating to the 20 employee rule for coordination of benefits with Medicare) under 42 U.S.C. Section 1395y(b)(1)(A)(ii) and, if applicable, 42 U.S.C. Section 1395y(b)(1)(A)(iii), the Employer hereby elects treatment under such small employer exclusion. The Employer must complete and file a Small Employer Exclusion Notice with the Trust in order for this election to be valid. This Section shall apply unless Appendix M is executed by the Plan Sponsor to decline treatment as a small employer under 42 U.S.C. Section 1395y(b)(1)(A)(i).

4.3 Payment for Benefits with Respect to Participants Eligible for Medicaid.

(a) Any payment for benefits made under a portion of the Plan that meets the definition of a "group health plan" as such term is used in ERISA Section 609(b), with respect to a Participant who is eligible for Medicaid under Title XIX of the Social Security Act and, if applicable, medical assistance under Chapter 49 of the Wisconsin Statutes or similar laws of other states, if any, shall be subject to an assignment of rights by or on behalf of such Participant or such Participant's beneficiary to the respective state. If the Plan has a legal liability for payment for items or services provided to a Medicaid-eligible Participant or his or her beneficiary which are paid for under a state's medical assistance program, to the extent required by law, payment for benefits under the Plan will be made in accordance with any applicable state law which provides that the state has acquired the rights with respect to a Participant to such payment for such items or services.

(b) The group health benefits provided under the Plan shall not take into account the fact that a Participant or beneficiary of a Participant is eligible for or receives Medicaid in enrolling the Participant for such Plan benefit or in determining or making any payments for such Plan benefits.

4.4 Qualified Medical Child Support Order. Notwithstanding any other provisions in the Plan, any portion of the Plan that is a "group health plan" as that term is used in ERISA Section 609(a), will recognize the right of an Alternate Recipient to benefits under that Plan pursuant to a qualified medical child support order, as defined by ERISA Section 609(a), that satisfies the requirements of ERISA Sections 609(a)(3) and (4), whether or not the Alternate Recipient otherwise would qualify as a Dependent for purposes of the Plan. "Alternate Recipient" shall mean a child of a Participant who is an alternate recipient as defined in ERISA Section 609(a)(2)(C).

4.5 Benefits for Adopted Children. Notwithstanding any other provisions in the Plan, any portion of the Plan that is a "group health plan" as that term is used in ERISA Section 609(c), that provides coverage for dependent children of Participants or beneficiaries, shall provide benefits to dependent

children placed with Participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of Participants or beneficiaries under that portion of the Plan, irrespective of whether the adoption has become final.

4.6 Compliance with Laws. The Plan will comply with and provide benefits in accordance with all applicable laws to the extent required by such laws, including, but not limited to, ERISA and the Code. With respect to any portion of the Plan that is a "group health plan," such portion of the Plan will comply with and provide benefits in accordance with the requirements of all applicable laws to the extent required by such laws, including, but not limited to, ERISA Section 609(d) dealing with pediatric vaccines, COBRA, HIPAA, Newborns' and Mothers' Health Protection Act of 1996, Mental Health Parity Act of 1996, and Women's Health and Cancer Rights Act of 1998, as such laws may be amended from time to time.

ARTICLE V. CONTINUATION COVERAGE

5.1 Continuation Coverage after Termination of Normal Participation. Sections 5.1 through 5.9 of this Article shall apply to the extent benefits under a portion of the Plan meet the definition of a "group health plan" subject to ERISA Section 601. If more than one benefit under the Plan is considered a "group health plan," each benefit provided under a separate Policy shall be considered a "separate plan" within the meaning of Treas. Reg. Sec. 54.4980B-2, Q/A-6. In addition, a group health plan which is otherwise excepted from compliance with Sections 5.1 through 5.9 for any calendar year if all Employers maintaining a group health plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year within the meaning of ERISA Section 601(b) shall provide continuation coverage under Sections 5.1 through 5.9, but shall not be subject to statutory or regulatory COBRA fines, penalties, or jurisdiction. Notwithstanding anything to the contrary in other Articles of the Plan, the Employer shall, to the extent required by law, allow a "qualified beneficiary" who otherwise would lose coverage under the group health plan due to a "qualifying event" the option to elect, within an election period, continuation coverage under such group health plan according to the procedures set forth in this Article.

A "qualified beneficiary" means, with respect to a covered Employee under a group health plan (but not an Employee whose Employee status is solely as a nonresident alien with no U.S. source income):

- (a) With respect to qualifying events (i) - (vi) described below, any other individual who, on the day before the qualifying event for that Employee, is a beneficiary under a group health plan as the spouse or dependent child of such Employee;
- (b) With respect to qualifying events (i) - (vi) described below, a child born to or placed for adoption with the covered Employee during a period of continuation coverage;
- (c) With respect to qualifying events (i) and (ii) below, the Employee; and
- (d) With respect to qualifying event (vii) below, certain retired covered Employees, the spouse of such retired covered Employees, the dependent children of such retired covered Employees and certain surviving spouses of such retired covered Employees.

A "qualifying event" means either (i) the termination of the covered Employee's employment (whether voluntarily or involuntarily) other than by reason of his or her gross misconduct, (ii) the reduction of the covered employee's hours, (iii) the covered employee's death, (iv) the covered employee becoming

entitled to Medicare benefits, (v) the divorce or legal separation of the covered Employee and his or her spouse, (vi) the covered Employee's child ceasing to be a dependent, or (vii) a Title 11 bankruptcy proceeding with respect to the Employer. If an Employee is on FMLA Leave, no "qualifying event" shall occur before the earlier of (1) the date the Employee who is on FMLA Leave gives notice to the Employer of his or her intent not to return to active employment or (2) the end of the FMLA Leave if the Employee fails to return to active employment on that date.

The taking of FMLA Leave shall not constitute a "qualifying event." However, a "qualifying event" shall occur if (a) an Employee (or the Employee's spouse or dependent child) is covered by a group health plan on the day before the first day of FMLA Leave or becomes covered during the FMLA Leave, (b) the covered Employee does not return to employment at the end of the FMLA Leave, (c) the covered Employee (or the Employee's spouse or dependent child) would lose coverage under the group health plan absent continuation coverage, and (d) the Employer has not eliminated, on or before the Employee's last day of FMLA Leave, coverage under a group health plan for the class of Employees to which the Employee would have belonged but for taking FMLA Leave. In the event a covered Employee is on FMLA Leave, no "qualifying event" based on satisfaction of (a), (b), (c), and (d) above shall occur before the last day of FMLA Leave.

In addition, for purposes of continuation coverage during a Uniformed Services Leave, the "qualifying event" shall be the first day the Employee is absent from employment of at least 20 hours per week due to the Uniformed Services Leave. An Employee on Uniformed Services Leave and his or her dependents shall be treated as qualified beneficiaries for purposes of Sections 5.4 and 5.5, subject to any specific provisions to the contrary contained herein.

5.2 Notice.

(a) **Initial Notice.** The Plan shall provide, written notice of COBRA rights to each covered employee and spouse of the employee (if any) within 90 days after commencement of coverage under the group health plan, or 90 days after the Plan first becomes subject to COBRA requirements, if later. Such notice may be provided in the summary plan description.

(b) **Notice on Death, Termination, Reduction of Hours, Eligibility for Medicare, or Bankruptcy.** Within 30 days of the later of the date of a Participant's qualifying event or loss of coverage under the group health plan due to death, termination of service (other than by reason of the Participant's gross misconduct), reduction of hours, eligibility for Medicare, or a Title 11 bankruptcy proceeding with respect to the Employer, the Employer shall inform the Plan Administrator that persons previously receiving coverage under the group health plan may be eligible to elect continuation coverage. Within 14 days after receiving such notice, the Plan Administrator then shall provide written notice to any qualified beneficiaries of their rights to elect continuation coverage pursuant to procedures established by the Plan Administrator.

(c) **Notice of Change in Marital Status, Dependent Status, or Disability.** If a Participant becomes divorced or legally separated or if a child of a Participant ceases to be eligible for coverage under the group health plan because he or she is no longer a dependent, either the Participant, the Participant's spouse or the Participant's child shall provide written notice to the Plan Administrator of these events within 60 days of their occurrence in order to be eligible to elect continuation coverage. Each qualified beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of continuation coverage must notify the Plan Administrator of such determination within 60 days after the date of the determination or as provided by Regulation, and

within the time provided in Section 5.6. Each such qualified beneficiary shall provide written notice to the Plan Administrator within 30 days of a determination that the qualified beneficiary is no longer disabled. Notice by a qualified beneficiary of the occurrence of an event giving rise to an election shall not be deemed an election to receive continuation coverage under the group health plan. Within 14 days after receiving notice of a change in marital or dependent status, the Plan Administrator, if notified within the time period specified in this Subsection (c), shall provide written notice to the qualified beneficiaries of their eligibility to elect continuation coverage.

5.3 Election Period and Procedure.

(a) **General Rule.** The election to continue coverage must be made during the period beginning no later than the date coverage terminates due to a qualifying event and ending 60 days after the later of (1) the date when coverage would otherwise cease under the group health plan or (2) the date when the Plan Administrator notifies the qualified beneficiary of the election right. A qualified beneficiary's failure to comply with the procedures and requirements established by the Plan Administrator for making the election shall constitute a failure to make an election to continue coverage. An election shall be considered to be made on the date it is sent to the Plan Administrator. The written waiver by a qualified beneficiary (or by the qualified beneficiary's legal guardian) of the election to continue coverage shall not terminate the qualified beneficiary's right to later make an election for future continuation coverage if the qualified beneficiary later revokes the waiver during the election period.

(b) **Special Trade Act of 2002 Rule.** Notwithstanding Section 5.3(a), a Nonelecting TAA-Eligible Individual may elect continuation coverage during the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual, but only if such election is made not later than six months after the date of the TAA-Related Loss of Coverage. Any such election for continuation coverage by a TAA-Eligible Participant shall commence at the beginning of such 60-day election period and shall not include any period prior to such 60-day election period.

For purposes of this Section 5.3(b):

(1) "TAA-Eligible Individual" shall mean an eligible TAA recipient as defined in Code Section 35(c)(2) or an eligible alternative TAA recipient as defined in Code Section 35(c)(3).

(2) "Nonelecting TAA-Eligible Individual" shall mean a TAA-Eligible Individual who has a TAA-Related Loss of Coverage and did not elect continuation coverage under Part 6 of Subtitle B of Title I of ERISA or Code Section 4980B(f)(5) during the TAA-Related Election Period.

(3) "TAA-Related Election Period" shall mean, with respect to a TAA-Related Loss of Coverage, the 60-day election period under Part 6 of Subtitle B of Title I of ERISA or Code Section 4980B(f)(5) which is a direct consequence of such loss.

(4) "TAA-Related Loss of Coverage" shall mean with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

This Section 5.3(b) shall only apply to such individuals to the extent required by the Trade Act of 2002.

5.4 Continuation Coverage Offered. A qualified beneficiary who elects continuation coverage pursuant to the terms of this Article shall be eligible to receive the same coverage as a similarly situated non-continuation coverage beneficiary. If the group health plan benefits provided to similarly situated non-continuation coverage beneficiaries under the group health plan are increased, decreased or otherwise amended or changed either before or after the qualified beneficiary's election of continuation coverage, the coverage made available to the qualified beneficiary shall be modified in the same manner. If, under the group health plan, there is an open enrollment period during which Participants are permitted to select various options with respect to benefits, qualified beneficiaries shall have the same rights available to them.

5.5 Payment for Continuation Coverage. The qualified beneficiary's cost for continuation coverage shall be determined from time to time by the Plan Administrator. The Plan Administrator also shall establish procedures for the billing and payment of the cost of the continuation coverage. The lack of timely payment for a qualified beneficiary's continuation coverage shall result in termination of such continuation coverage as of the date covered by the last payment and the qualified beneficiary shall be precluded from extending, renewing, or reelecting such continuation coverage.

5.6 Duration of Continuation Coverage. A qualified beneficiary electing to purchase continuation coverage under the group health plan shall be eligible for such continuation coverage until the earliest of the following:

(a) **Maximum Required Coverage Period.** Notwithstanding the following, if coverage for a benefit under the Plan is lost at a date later than the date of the qualifying event, then the maximum required coverage period determined under Section 5.6(a) is measured from the date coverage is lost rather than from the date of the qualifying event. The preceding extension of required periods shall be applicable to and interpreted consistent with periods allowed to be extended under Treas. Regulation Section 54.4980B-7, Q&A-4(b).

(1) With respect to a qualifying events described in Section 5.1(i) or (ii), 18 months after the date of the qualifying event, provided however, that if a qualifying event (other than a qualifying event described in Section 5.1(vii)) occurs during the 18 months after the date of the qualifying event described in Section 5.1(i) or (ii), that date which is 36 months after the date of the qualifying event described in Section 5.1(i) or (ii).

(2) With respect to a qualifying event described in Section 5.1(vii), the date of the death of the covered Employee or qualified beneficiary who, on the day before the qualifying event, was a beneficiary under the group health plan as the surviving spouse of a covered Employee, or in the case of the surviving spouse or dependent of the covered Employee, 36 months after the date of the death of the covered Employee.

(3) With respect to a qualifying event described in Section 5.1(iii), (iv), (v), or (vi), the date which is 36 months after the date of the qualifying event.

(4) With respect to a qualifying event described in Section 5.1(i) and (ii) that occurs less than 18 months after the date the covered Employee becomes entitled to benefits under Title XVIII of the Social Security Act, the period of coverage for qualified beneficiaries other than the covered Employee shall not terminate before the close of the 36 month period beginning on the date the covered Employee became so entitled.

In the case of a qualifying event described in Section 5.1(i) and (ii), a qualifying beneficiary who is determined, under Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continuation coverage, reference in Section 5.6(a)(1) to 18 months is deemed a reference to 29 months (with respect to all qualified beneficiaries), but only if the qualified beneficiary has provided notice of such determination as set forth in Section 5.2(b) before the end of the 18 months.

(b) The date on which the Employer ceases to provide any group health plan to any employee.

(c) The date on which the qualified beneficiary's continuation coverage payments become overdue as determined by the Plan Administrator pursuant to applicable law. The payment of any premium shall be considered timely if made within 30 days after the date due or within such longer period as applies to or under the Plan; provided however, that in no event may the Plan require payment of any premium before the day that is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage.

(d) The date on which the qualified beneficiary first becomes, after the date of the election, covered under any other group health plan (as an employee or otherwise) for the benefit (medical, dental, or vision) for which continuation coverage is provided hereunder, which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary (other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of Code Chapter 100 or similar provisions in ERISA or the Public Health Service Act, if applicable) or, in the case of a qualified beneficiary with respect to medical benefits for which continuation coverage is provided hereunder (other than a qualified beneficiary described in Section 5.1(d)) entitled to benefits under Title XVIII of the Social Security Act.

(e) In the case of a qualified beneficiary who is disabled at any time during the first 60 days of continuation coverage under this Section, the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.

The maximum period of coverage for a child born to or placed for adoption with a covered Employee during a period of continuation coverage is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of birth or placement for adoption).

5.7 Special Rules for Coverage for Uniformed Services Leave. An Employee receiving continuation coverage due to a Uniformed Services Leave that lasts more than 31 days shall be eligible for a period of continuation coverage equal to the shorter of (a) 18 months beginning on the date the Employee is absent due to a Uniformed Services Leave or (b) the day after the date on which the Employee fails to apply for or return to active employment with the Employer. (The reference to "18 months" in the prior sentence is replaced with "24 months" with respect to elections made for such continuation coverage on or after December 10, 2004.)

Except as provided by law, a person who elects to continue health-plan coverage due to a Uniformed Services Leave may be required to pay not more than 102 percent of the full premium under the Plan (determined in the same manner as the applicable premium under Code Section 4980B(f)(4)) associated with such coverage for the Employer's other employees, except that in the case of a person who

performs service in the Uniformed Services for less than 31 days, such person may not be required to pay more than the employee share, if any, for such coverage.

5.8 Miscellaneous Continuation Coverage Provisions. In the event of any inconsistency or omission, this Article and the provisions of the Plan document shall be construed, interpreted, and administered in a manner which meets the minimum requirements of the law.

5.9 Effective Date of Sections 5.1 through 5.9. Notwithstanding anything to the contrary in the Plan, this Sections 5.1 through 5.9 of this Article shall be effective as of the Plan Year starting on or after January 1, 2000.

5.10 State Law Continuation Coverage. Notwithstanding anything to the contrary in any other Section of the Plan, any portion of the Plan subject to Wisconsin or other state health care continuation and conversion laws shall comply with such requirements to the extent the Employer and the Plan benefits are subject to such law. If more than one benefit under the Plan is subject to such law, each benefit provided under a separate Policy shall comply as a "separate plan" to the extent allowable under such law.

ARTICLE VI. ADMINISTRATION OF PLAN

6.1 Plan Administrator.

(a) General. The Plan has a Plan Administrator. Plan administration shall be under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among those persons.

(b) Powers. The Plan Administrator will have full and exclusive authority and responsibility to control the operation and administration of the Plan in all of its details, subject to the terms of the Plan and underlying Policies and the applicable requirements of law. For this purpose, the Plan Administrator's powers will include, but will not be limited to, the following authority, in addition to all other powers provided by the Plan:

- (1) To perform all functions assigned to the Plan Administrator by the Plan;
- (2) To perform all functions assigned to the positions of "administrator" and "plan administrator" under ERISA and the Code, respectively;
- (3) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;
- (4) To construe and interpret the Plan, and decide all matters thereunder, its good faith interpretation and decision thereof to be final and conclusive on all persons claiming benefits under the Plan provided that the insurer with respect to benefits covered by a Policy shall be the fiduciary with respect to such Policy benefits;
- (5) Except to the extent delegated to the insurer under a Policy, to decide all questions concerning the eligibility of any person to participate in the Plan including, without limitation, the determination of those individuals who are deemed employees of an Employer;

(6) Except to the extent delegated to the insurer under a Policy, to compute the amount of benefits which will be payable to any Participant or other person in accordance with the provisions of the Plan, and to determine the person or persons to whom such benefits will be paid;

(7) Except to the extent delegated to the insurer under a Policy, to authorize the payment of benefits under the Plan;

(8) To prepare and file all reports required to be filed by the Plan with any governmental agency;

(9) To comply with all disclosure requirements;

(10) To maintain records of Participants and other records of the Plan;

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

(12) To allocate and delegate its 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. The insurer under the Policies shall be deemed delegated responsibility as provided under the Policies.

The decisions of the Plan Administrator (or its designee) shall be final and binding on all parties. Benefits under the Plan will be paid only if the Plan Administrator or its designee decides in its discretion in applying the terms of the Plan that the applicant is entitled to them.

(c) **Named Fiduciary.** The Plan Administrator shall be a "named fiduciary" for purposes of ERISA Section 402(a)(1) with authority to control and manage the operation and administration of this Plan, and shall be responsible for complying with all of the reporting and disclosure requirements of Part 1 of Subtitle B of Title I of ERISA. The Plan Sponsor shall be the agent for the service of legal process on the Plan.

6.2 Examination of Records. The Plan Administrator shall make available to each Participant his or her records under the Plan for examination at reasonable times during normal business hours.

6.3 Reliance on Tables, Etc. In administering the Plan, the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all insurance premium amounts, tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of the underlying benefit Policies, or by any insurer, accountant, counsel or other expert employed or engaged by the Plan Administrator.

6.4 Bonding. The Plan Administrator shall be bonded to the extent required by ERISA.

6.5 Inability to Locate Payee. If the Plan Administrator or its designee is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot determine the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited and no longer payable following a reasonable time (as determined by the Plan Administrator or its designee) after the date any such payment first became due.

6.6 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent it deems administratively possible and otherwise permissible under law, allocate, withhold, or otherwise make adjustment or recovery of such amounts. Such action by the Plan Administrator may include, but is not limited to, withholding of any amounts due to the Plan or the Employer from compensation paid by the Employer.

6.7 Claims and Review Procedures and Time Limitation.

(a) Claims and appeals of claims for benefits shall be made under the claims and review procedures provided by Policies covering benefits under the Plan.

(b) **Exhaustion of Administrative Remedies Required.** Except as precluded by law, no action at law or in equity shall be brought by a Participant or beneficiary to recover under this Plan until the claim and review rights herein provided have been exercised and the Plan benefits requested have been denied in whole or in part.

(c) This Section 6.7 is intended to comply with applicable rules and regulations set forth in Federal law for the administration of claims. In the event of any inconsistency or omission, the claim and review procedures for the Plan shall be administered in a manner which meet the minimum requirements of the law.

6.8 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

6.9 Indemnification of Plan Administrator. The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Plan Administrator or as a member of a committee designated as Plan Administrator (including any Employee or former Employee who formerly served as Plan Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE VII. ACCESS, PORTABILITY, AND RENEWABILITY REQUIREMENTS

7.1 Applicability. This Article shall apply to any benefits under the Plan to the extent it is considered to be a group health plan under HIPAA with respect to the provisions of HIPAA addressed in this Article. This Article shall be subject to the Trade Act of 2002.

7.2 Notice of Preexisting Condition Exclusion Period. There are no preexisting condition exclusions imposed on any Participant or beneficiary under any of the benefits except to the extent so provided pursuant to the terms of the underlying Policy. Any such preexisting condition shall not exceed the maximum length allowed by HIPAA and the regulations issued thereunder and shall be reduced by creditable coverage as defined in HIPAA and the regulations issued thereunder. The rights of any individual to demonstrate creditable coverage (and any applicable waiting periods) including the right to request a certificate from a prior plan or issuer are covered under such prior plans. To the extent required

by law or regulations, the Plan (or issuer) shall provide assistance to Participants in obtaining a certificate of creditable coverage from any prior plan or issuer.

7.3 Certificate of Creditable Coverage.

(a) Certificates of creditable coverage shall be issued by the Plan Administrator to the extent required by law, unless the Policy issuer has issued such certificates.

(b) Creditable coverage for the Policy shall be determined under the standard method or alternative method under Code Section 9801 as determined by the terms of such group health plan benefit.

(c) The Plan Administrator shall supply certificates under the alternative method to the extent required by law, unless the Policy issuer has issued such certificates. The Plan Administrator or its designee may charge the requesting entity for the reasonable cost of disclosing information under the alternative method of counting creditable coverage.

7.4 Procedure for Requesting Certificates. An individual may request a certificate of creditable coverage if the individual or his or her representative or potential health insurer requests a certificate within 24 months after coverage ceases. A request made on behalf of the individual will not be honored without the written authorization of the individual.

ARTICLE VIII. AMENDMENT AND TERMINATION OF PLAN

8.1 Amendment.

(a) The Plan Sponsor reserves the power at any time or times to amend certain elective provisions of the Plan, including retroactive amendments to the extent allowed by law, to any extent and in any manner it deems advisable, by written resolution of the Plan Sponsor's governing body or by any person or persons authorized by the governing body to take such action, and any such amendment will automatically apply to the Related Employers participating in this Plan. Section 4.1 and other provisions of the Plan contain limitations on coverage that can be elected. Notwithstanding the foregoing, Plan amendments for Plans participating in the Trust are limited to those elections allowed in Article IV and adoption of Appendices A, D, E, H, M, or R, if applicable.

(b) The Trust may amend this Plan on behalf of the Plan Sponsor who is maintaining the Plan at the time of the amendment. An amendment by the Trust does not require consent of the Plan Sponsor or Related Employers participating in this Plan nor does the Plan Sponsor need to reexecute its Plan document with respect to such an amendment. The Trust shall provide each Plan Sponsor a copy of the amended Plan document (either by providing substitute or additional pages, or by providing a restated document.)

8.2 Termination. The Plan Sponsor expects the Plan to be permanent, but necessarily must, and hereby does, reserve the right to terminate the Plan at any time by written resolution of the Plan Sponsor's governing body or by any person or persons authorized by the governing body to take such action, and any such termination will automatically apply to the Related Employers participating in this Plan. Neither the Plan Sponsor, Related Employers, Plan, nor Participants shall have any further financial obligations hereunder from and after such termination of the Plan except such that have accrued up to the

date of termination and have not been satisfied. Any Related Employer shall be entitled to terminate sponsorship of the Plan with respect to that Related Employer.

ARTICLE IX. MISCELLANEOUS PROVISIONS

9.1 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or the Plan Administrator, except as provided herein. Furthermore, nothing contained in this Plan shall be construed as a contract of employment between any Employer and any Employee, or as a right of any Employee to continue in the employment of any Employer, or as a limitation of the right of any Employer to discharge any of its Employees, with or without cause.

9.2 Exclusive Benefit. The Plan shall be maintained for the exclusive benefit of the Participants and their Spouses and Dependents.

9.3 Contributions. Premiums and any other costs and expenses of providing the Policies through the Trust shall be paid to the Trust. The Employer shall determine if any part of such contributions for a particular benefit are to be made by the Participants in that Plan. If so, the Employer shall be responsible for collecting such contributions from the Participants. The Employer shall forward all contributions to the Trust when and as required by the Trust, and contributions collected from the Participants shall be forwarded to the Trust on the earliest date they reasonably can be segregated from the Employer's general assets, not to exceed 90 days after being withheld from pay or contribution by the Participant.

9.4 Benefits From Trust. The benefits provided under the Plan shall be paid solely from Policies held under the Wisconsin Bankers Association Insurance Trust Fund. Nothing herein shall be construed to require the Employer or Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any contribution to the Trust may be made.

9.5 Refunds and Dividends. Any payments made to or credits given to the Trust by any insurer in accordance with the experience rating provisions, if any, of any Policy, or in the nature of dividends or other refunds, shall be the separate property of the Trust. To the extent any of the foregoing are distributed to or used by or allocated to the Employer in accordance with the Trust, they shall then become the separate property of the Employer except as required by law to be shared with Participants. If the Employer determines that the Participants are entitled to any part of such of the foregoing as are returned to or allocated to the Employer by the Trust, the same shall be paid or allocated to the Participants as soon as they reasonably can be segregated from the Employer's general assets, not to exceed 90 days after distribution or allocation.

9.6 Premium Reduction. Any premium reduction passed through to the Employer by the Trust shall be shared with Participants if and to the extent required by law to be shared with Participants. If the Employer determines that the Participants are entitled to any part of such of the foregoing as passed through to the Employer by the Trust, the same shall be passed through to the Participants as soon as they reasonably can be segregated from the Employer's general assets, not to exceed 90 days after such premium reduction pass-through.

9.7 Nonassignability of Rights. Subject to Section 4.4 and the terms of any Policies, the right of any Participant to receive any benefits under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to be taken by his or her creditors by any process whatsoever, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

9.8 Information to be Furnished. Each Participant shall provide the Employer and the Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administering the Plan.

9.9 Communication to Employees. As soon as reasonably practicable after the Plan is established, the Employer shall notify all Employees of the availability and terms of such Plan.

9.10 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantees that any amounts paid under the Plan will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for Federal and state income tax purposes, and to notify the Plan Administrator if the Participant has reason to believe that any such payment is not so excludable.

9.11 Liability. Except to the extent required under Part 4 of Title I of ERISA, the Employer shall not be liable for any acts or omissions with respect to or under the Plan, unless such acts or omissions constitute willful misconduct or bad faith.

9.12 Governing Law. The Plan shall be governed by and construed, administered and enforced according to the laws of the State of Wisconsin, except to the extent preempted by the laws of the United States of America.

9.13 Severability of Provisions. If any provision of this Plan document shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect the validity and enforceability of any other provisions.

9.14 Construction. Unless the context plainly requires otherwise, the plural of words defined in the singular shall mean one or more of the same, the singular of words defined in the plural shall mean one of the same, and all words used in any gender shall extend to and include all genders. The Plan is intended to meet the requirements of ERISA and other applicable law, and regulations issued thereunder, and shall be so construed and interpreted. Any provisions of the Plan inconsistent with or contrary to such laws or such regulations shall be void and unenforceable and shall not affect the rest of the Plan.

9.15 References. Unless the context plainly requires otherwise, all references to Sections and Articles are to Sections and Articles in this Plan document. References to any section or sections in regulations cited herein shall include references to any comparable or succeeding regulations which amend, supplement, or replace such section or sections.

9.16 Headings. The headings of and within Sections and Articles are for convenience of reference only and shall not be a part of the Plan or used in construing such Plan.

9.17 Additional Provisions. Additional terms, conditions and provisions of the Plan may be contained in Appendices A, D, E, H, M, or R, which, if completed and attached hereto, shall be a part of this Plan document.

IN WITNESS WHEREOF, the Plan Sponsor has hereunto caused this Plan to be signed by its authorized undersigned officer as of the _____ day of _____, 20__.

[Typed Name of Plan Sponsor]

[Plan Sponsor's City]

By: _____

Title: _____

_____-_____
[Plan Sponsor's Federal Employer Identification Number]