

# PLAN DOCUMENTATION AND PROCEDURES

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## PLAN DOCUMENTATION AND PROCEDURES

### 1. HOW TO PARTICIPATE IN THE TRUST

**What steps do Banks (and their affiliates) need to take to participate in the Trust?** The Wisconsin Bankers Association Insurance Trust Fund Agreement (see Third Amendment for more details), provide more details on eligibility and affiliates. (This manual uses the term "Banks" to refer to entities participating or eligible to participate in the Trust.) To participate, Banks should:

- Adopt Board resolutions approving participation in the Trust;
- Execute a written Application for Participation in the Trust; and
- Deliver it to the Trust.

See sample resolutions and the current version of the Application for Participation.

**What is an "affiliate"?** Entities generally are considered "affiliates" if they are members of a "controlled group" within the meaning of Section 1563 of the Internal Revenue Code of 1986. This includes an 80% ownership test, but also includes other tests for common ownership. Alternatively, entities are affiliates if at least 51% of each entity is owned (through stock, capital or profits interest) by the same one or more individuals (either directly or through attribution under Code Sections 318 or 1563) and if such same individuals have the power to exercise a controlling influence over the policies of the entity and to elect its directors. Each Bank should consult its legal counsel to determine whether it belongs to a controlled group of corporations.

**What are the terms of the Trust?** The terms upon which the Trust was established are contained in a Trust Agreement. The current version of the Trust Agreement is included in this manual.

#### a. Signing Up for Specific Benefit Coverage

**What benefits can be offered by a Bank through the Trust?** The benefits are subject to change from time to time, but currently include:

- Medical;
- Dental;
- Vision;
- Life and accidental death and dismemberment;
- Dependent life;
- Long term disability; and
- Short term disability (also may be referred to as "weekly disability income").

**How does a Bank enroll for a specific benefit coverage?** A Bank enrolls for a specific benefit coverage (e.g., medical, dental, long term disability, etc.) by completing a "Request for Participation" agreement (sometimes referred to as a "Participation Agreement or Employer Application") and sending it along with other required materials to the Trust. It is critical that the Bank comply with the Minimum Participation Requirements discussed below.

Upon acceptance, the Trust and the insurers will process the enrollments and return appropriate materials to the Bank (e.g., enrollment cards, identification cards, booklets) for distribution to those enrolled.

**What are the Minimum Participation Requirements?** Under the terms of the group policies, Banks are expected to meet and maintain Minimum Participation Requirements ("MPR"). Failure to maintain MPR may be cause for termination or non-renewal of the benefit coverages under the terms of the policies. Contact EBC for information on the current MPR rules for each benefit.

## **2. PLAN DOCUMENT**

**Does each Bank need its own Plan Document?** Yes. Each Bank or controlled group of affiliated banks or other entities, by agreeing to participate in the Trust, establishes its own Plan. Form documents are provided. These forms must be carefully completed to reflect the Bank's benefits and should be reviewed by the Bank's own legal counsel.

The Employee Retirement Income Security Act of 1974, as amended ("ERISA") and other laws require a comprehensive system of documentation and procedures for a Plan funded through the Trust. This Section is a brief guide both to the law and to the documents and procedures which the Trust has made available for use by each participating Bank.

**What constitutes the Plan Document?** The completed form Plan Document and the booklets and any other materials incorporated by reference for each component benefit plan constitute the Plan Document.

**What if the Bank already has a Plan Document?** Completion of the new form Plan Document will supersede the old Plan Document. Keep prior documents in permanent Plan files.

**Do participants have a right to see the Plan Document?** Yes. A copy of the Plan Document and certain other information must be made available to participants and beneficiaries upon written request. Each Plan Sponsor, as Plan Administrator, is responsible for complying with these requirements for its Plan.

### **a. Adoption of Plan by a "Single Employer"**

**What is a "single employer"?** A single employer is a Bank that has no affiliates covered under the Trust. (See Section 1 for definition of affiliate.)

**How does a "single employer" complete the form Plan Document?**

- The Board of Directors of the Bank should adopt resolutions approving adoption of the Plan Document. (See sample resolutions.) The "Plan Sponsor" is the Bank that maintains the Plan.
- Fill in the Plan Sponsor's corporate name on the blank lines on the title page and page 1 of the Plan Document.

- Fill in the Plan Sponsor's (Bank's) name, employer identification number, and location (city) on the execution page at the end of the Plan Document.
  - Complete Appendix E to reflect benefits for current employees and note Plan Sponsor's name on last page.
  - Complete Appendix M if a Bank is a small employer opting out under the Medicare secondary payer rules. Refer to Plan Document Section 4.2.
  - Appendix R and Appendix D are not required. Complete Appendix R or Appendix D if Retiree or Director benefits are offered (include Plan Sponsor's name). Remember that Director and Retired Director benefits only can be offered by an employer that offered them under the Trust as of December 31, 1997 and only to Directors who were covered as of December 31, 1997.
  - An authorized officer should sign and date the execution page on the Plan Document and all related Appendices.
  - A copy of each Bank's executed Plan Document and all related Appendices should be sent to the Trust.
- b. Adoption of Plan by a Group of Related Employers**

**How does a Plan maintained by a group of related employers ("Controlled Group") of Banks and affiliates complete the form Plan Document?**

- The Board of Directors of each entity participating in the Plan should adopt resolutions approving adoption of the Plan Document. (See sample resolutions.)
- If the Plan is maintained for employees of a controlled group of banks or other entities owned by a bank holding company, the bank holding company ("parent corporation") generally will be the Plan Sponsor. Using the parent corporation as the Plan Sponsor, start by completing as instructed under Section 2.a above, as if for a single employer.
- Each participating employer (except the Plan Sponsor) should complete an Appendix A.
- The authorized officer of the participating employer dates and signs Appendix A. Appendix A must be sent to the Plan Sponsor.
- The Plan Sponsor must retain it in their records and provide a complete Plan Document, including Appendices E, M, R, or D as applicable, and all Appendix As, to each participating employer.
- A copy the Controlled Group's executed Plan Document, Appendices A and E, and Appendices M, R, and D, as appropriate, should be sent to the Trust.

**c. Changes to Plan Document After Adoption**

**What happens if a Plan Document, benefits, or employer is changed?** The Plan Document and any affected Appendices **must** be amended as appropriate if the Plan Document terms are affected by a change. These changes also may require revisions to the Summary Plan Description (SPD).

If a new employer is added to the group of employers or a participating employer ceases to participate, the Board of Directors of the Plan Sponsor and the new (or exiting) employer should execute corporate resolutions authorizing the new employer's participation or the exiting employer's cessation of participation (adding or termination benefits). Appendix A **must** be amended if a new employer is added to the group of employers participating in the Plan. Send a copy of the executed Appendix A to the Trust. If an employer is terminated, execute a revised Appendix A by noting the removal of the pages (include an effective date of removal), keep the removed pages in your permanent files. Keep the remaining pages. Send a copy of the removed pages to the Trust with a note about their removal.

Corporate resolutions also should be executed to authorize other changes to a Plan. The revised documents should be signed and dated and a copy sent to the Trust. The originals should be retained by the Plan Sponsor.

**What if a Plan Sponsor, Bank, or other employer name changes?** The applicable documents should be re-executed.

### **3. QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES**

**What Qualified Medical Child Support Order ("QMCSO") Procedures are required?** A QMCSO is a special type of order that requires a group health plan to provide benefits to children. Federal law requires that a group health plan have written QMCSO Procedures and comply with a QMCSO. It is each Plan's responsibility to have such written procedures. See sample QMCSO Procedures included in this manual. This manual does not address all the issues that a Plan may face regarding QMCSO administration. We suggest that the Bank consult its own counsel regarding this matter.

**How does a Plan adopt QMCSO Procedures?** The Plan Administrator (typically, the Plan Sponsor) should execute resolutions and the QMCSO Procedures on behalf of the Plan.

**What should a Bank do if it receives a QMSCO?** The Bank should promptly follow the steps outlined in its QMCSO Procedures, including providing timely notice and review of the order. The Bank also should notify EBC who will notify the affected insurer and verify coverages with the insurers. Note that the obligations for covering children may vary depending on the facts of a particular situation. We suggest that a Bank consult with its counsel if an order is received.

**Does a Bank Plan have to offer coverage if dependent coverage is not available without a QMCSO?**  
No.

### **4. SUMMARY PLAN DESCRIPTION**

**What is the Bank's responsibility for distribution a the summary plan description?** ERISA requires the Plan Administrator of every welfare benefit plan to give a Summary Plan Description ("SPD") to each participant. Under the Plan, each Plan Sponsor (usually, the Bank or Bank Holding Company) is the Plan Administrator for its Plan. As such, the Plan Sponsor is responsible for compliance with this requirement. Federal regulations specify the information to be included in the SPD. The SPD replaces the need for a separate initial COBRA notice for plans with medical, dental, or vision benefits. Thus, special distribution requirements apply.

**What constitutes the form SPD?** A complete Summary Plan Description for a Plan includes **both** the completed form **SPD document with any Appendices** and the **Plan booklet** for any benefits adopted. The Bank's legal counsel should review the form.

**How is the form SPD completed?** The Plan Sponsor should refer to its Plan Document and do the following:

- The name of the Plan Sponsor should be filled in on the title page.
- Complete Section II.A.
- A plan number must be assigned to each Plan under Section II.A. Plan numbers are assigned consecutively beginning with 501. If numbers have not been assigned, a Plan should be numbered 501 unless that number has been used for a different plan of the Bank.
- Note the part of Section II.A entitled: "STATUS OF EMPLOYER AS "SMALL EMPLOYER" UNDER THE MEDICARE SECONDARY PAYER RULES" (required to be completed by Plan Sponsors with medical benefits under the Trust.) (Refer to the Plan Document Section 4.2, Appendix M, if completed, and the Medicare Secondary Payer Section of the manual.) Generally, the Plan Sponsor will check the first blank (No Small Employer Election) if the Plan Sponsor (and related employers, if any) have more than 20 employees or if the Plan Sponsor executed Appendix M. Otherwise, if the Small Employer has qualified for and elected "small employer" status, check the second blank (Small Employer Election). Contact EBC staff with questions.
- Complete the "COBRA DESIGNATIONS" part of Section II.A if the Plan has medical, dental, or vision benefits under the Trust. Complete in accordance with your COBRA forms. Please keep the information current.
- If the SPD is used for a controlled group of employers, the Attachment to the SPD listing of all participating employers should be completed. Refer to Appendix A of the Plan Document when completing this Attachment.
- Add Appendix E and R or D if adopted as part of the Plan Document. Add Appendix C if the Bank provides medical, dental, or vision benefits under the Trust.
- Copy each completed SPD form with the appropriate Appendix (E, R, or D) for distribution with benefit booklets to each participant and other individuals as described below. Add Appendix C if medical, dental, or vision benefits are offered.

**Who should receive the SPD?** Upon completion of the Summary Plan Description form for a Plan, a copy of it, the applicable Attachments and Appendices, and the Plan booklet must be given to each eligible employee or participant, COBRA qualified beneficiary, QMCSO alternate recipient, spouse/dependent of deceased participant (if they continue to receive benefits), and representatives or guardians of incapacitated persons in that Plan. If the Plan has medical, dental, or vision benefits, the spouse of the employee or participant also must receive the SPD. See Section 4.b.

**a. Distribution Requirements for SPDs without Medical, Dental, or Vision Benefits**

This Section addresses requirements for plans **not** offering medical, dental, or vision benefits.

**How can the SPD be delivered?** Distribution can be accomplished by personal delivery or by mail. Keep good records of distribution, including date, method, and lists of names of those receiving the SPD. There are special conditions that apply if electronic delivery is desired. See Section 4.c. Contact your attorney for more information.

Included is a Sample Participant Transmittal Memo that can be used to explain what the document is and what the participant should do with it.

**When are SPDs required to be distributed?** Although it is always a good idea to distribute SPDs and revisions as soon as possible, there are specific time limitations that apply.

Generally, SPDs must be distributed:

- Within 120 days after the establishment of the Plan (90 days is required for medical, dental, or vision benefits discussed in Section 4.b); and
- Within 90 days after new participants begin coverage.

Revisions to SPDs generally must be distributed:

- No later than 60 days after adoption of any change to a group health plan that is considered a "material reduction in covered services or covered benefits;" and
- Within 210 days after the end of the plan year in which a change to the SPD is required because of a change in the Plan.

A new Summary Plan Description (form, Appendices, and booklet) generally must be distributed every five years.

#### **b. Special Distribution Requirements for SPDs with Medical, Dental, or Vision Benefits**

This Section addresses requirements for plans that offer medical, dental, or vision benefits.

**How does the SPD serve as COBRA notice?** Appendix C takes the place of the initial COBRA notice that was previously provided to participants and spouses. Do not use the old initial COBRA notice on or after January 1, 2005.

**How should the SPD be distributed if medical, dental, or vision benefits are offered?** The rules are more restrictive for medical, dental, and vision benefits since the normal SPD distribution rules (discussed in Section 4.a.) as well as the COBRA notice rules apply.

- The SPD and transmittal memo should be distributed to all eligible employees/participants and their spouses. Generally this also includes any COBRA qualified beneficiaries, qualified recipient under a Qualified Medical Child Support Order, or spouse/dependents of deceased participants who may be receiving benefits. If the SPD is revised or amended, a follow up distribution should be done.
- Future Distribution Deadline: The memo and SPD should be used throughout the year for eligible new hires and their spouses. As a general rule, the SPD with Appendix C should be delivered

**within 90 days after coverage begins.** Of course, usually Banks will want to give an individual the SPD prior to commencement of benefits. If a spouse's coverage commences after the date on which the initial notice is required to be provided to the employee, then a separate notice will be needed.

A sample Participant Transmittal Memo is included in this manual. The memo should be modified to reflect the benefits offered by the Plan Sponsor.

**How is the memo prepared for distribution?** Banks should customize the memo as follows:

- List the name of the participant.
- Also list the spouse of the participant, if applicable. Banks usually should be able to send one memo (listing both names) and one SPD to a common address. However, if the spouse lives at a separate address, a separate memo and SPD must be provided to the spouse.

**What are the options for delivery?** It is important to be able to prove that the SPD was sent to the participant and spouse. Keep records that indicate the date of distribution, a listing of names of individuals to whom it was distributed, and a copy of what was sent (remember that the materials may be modified from time to time).

- **By First Class Mail:** This is a generally recommended approach. If a Bank sends the SPD to a participant and spouse by first class mail, list both parties by name (e.g., Sarah Smith and John Smith) on the envelope. Commentators suggest that mailing with a post office certificate of mailing provides good evidence, but they note that larger plans usually operate by using first class mail with business records that document mailing.
- **By Hand Delivery:** It can be more difficult to prove that the SPD was delivered by hand delivery than by first class mail. For that reason, most commentators recommend first class mail.

**c. Electronic Distribution of SPDs**

**Can a Bank meet the distribution requirements solely by e-mail or electronic transmission of the SPD?** Probably not. Electronic transmission typically requires additional steps and follow up rather than simply sending an e-mail. Some individuals may not meet the requirements and may need to receive paper copies. Requirements for electronic transmission of SPDs have been evolving and Banks should consult with counsel to determine current requirements before proceeding. The plan administrator should become conversant with Department of Labor standards for storing electronic records.

**Electronic media cannot be used for those with no computer access.**

**Individuals with computer access** fall into the following categories:

- Those who have **work-related** computer access; or
- Those who have computer access that is **not** work-related.

**Work-Related Computer Access.** Disclosure may be made electronically to any participant:

- Who has the ability to access documents at any location where the participant reasonably could be expected to perform employment duties; and
- Whose access to the electronic information system is an integral part of those employment duties.

Making a computer kiosk generally available for use by participants would **not** meet this requirement. The Employer would need to make a determination for each employee that he or she had this type of access (and presumably reassess that determination each year).

For those with computer access, the initial requirements include the following:

- The Plan Administrator must take appropriate and necessary means to ensure that the system for furnishing documents results in actual receipt of the transmitted information (e.g., using return-receipt or notice of undelivered electronic mail features or conducting periodic reviews or surveys to confirm receipt of the transmitted information).
- The SPD must be prepared and furnished in accordance with the style, format, and content requirements for SPDs.
- Written or e-mail notice of the significance of the SPD must be provided to each recipient, at the time the electronic document is furnished. This notice must be provided each time an electronic disclosure is made. It also must notify the recipient of right to request and obtain a paper copy of the SPD.
- A paper version of the electronic SPD must be available upon request (at no charge).

**No Work-Related Computer Access.** For those individuals who need to receive the SPD, but do not have work-related computer access as defined above, electronic distribution may be possible if the following are met:

- The individual provides an address for delivery of the documents and affirmatively consents to electronic disclosure. (Consent may be given electronically.)
- Where disclosure is made through the Internet or other electronic communication system, the individual must affirmatively consent in a manner that reasonably demonstrates the individual's ability to access information in the electronic form that will be used.
- For any type of electronic disclosure, the consent must occur after the individual has been provided with a statement that explains:
  - The types of documents that will be provided electronically;
  - That consent can be withdrawn without charge;
  - The procedures for withdrawing consent and updating information (e.g., address for receiving electronic disclosure);
  - The right to request a paper version and that no charge applies; and

- The electronic delivery system and what hardware and software will be needed to use it.

If system hardware or software requirements change, a revised statement must be provided and renewed consent from the individual obtained.

Again, the rules are complex and change from time to time. Consult with counsel.

See Department of Labor Reg. Sec. 2520.104b-1(c).

**Can a Bank meet the distribution requirements by simply posting the SPD on its website?** No. Posting the SPD on the website may be simple enough, but as discussed in Section 4.b., there are extra steps that must be taken in order to meet the distribution requirements. Also, it is likely that electronic distribution will not be acceptable for all individuals, thus requiring paper distribution. (The law is evolving in this area. Check with your counsel for details on the current status of electronic distribution requirements before proceeding.)

## **5. PLAN DOCUMENT, SPD, AND QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES RECORD RETENTION**

**What documentation should be retained by the Plan Sponsor?** A copy of each Plan Document, Summary Plan Description, Plan Booklet, and Qualified Medical Child Support Order Procedures should be retained by the Plan Sponsor and Related Employer in their permanent files. It should be readily available if ever an IRS or DOL examiner asks to inspect it. (Keep the current and any prior versions in the permanent files.) Also, keep notes regarding distribution of SPDs and, if you distribute a QMCSO Procedure, keep notes on that also, including dates and methods.

**What copies must be kept for review by participants?** Copies of the Summary Plan Description, the Plan Document, the Trust, the latest Form 5500, and "other instruments under which the Plan is established or operated" must be made available for review upon request by participants and beneficiaries.

**Where do the copies need to be kept for participant/beneficiary access?** The general rule requires that copies must be available for examination by participants or beneficiaries at the principal office of the plan administrator and in such other places as may be necessary to make available all pertinent information to all participants and beneficiaries. Documents have to be "current, readily accessible, and clearly identified, and copies must be available in sufficient number to accommodate the expected volume of inquiries."

Plans typically are required to make documents available:

- At the principal office of the plan administrator; and
- At the principal office of the employer (if different from the principal office of the plan administrator) and at each employer "establishment" in which at least 50 participants covered under the Plan are customarily working. "Establishment" means a single physical location where business is conducted or where services or industrial operations are performed. Where employees are engaged in activities which are physically dispersed, the "establishment" is the place to which the employees report each day. If they do not report to a location, it is the location from which they customarily carry out their activities. Unlike the plan administrator principal office location requirement, a Bank does not have to keep the documents at these other employer establishments

at all times, but must make them available within ten calendar days following the day on which a request for disclosure at that location is made. Thus, a Bank may need to provide documents at other locations if there are at least 50 participants customarily working there.

See Department of Labor Reg. Sec. 2520.104b-1.

## **6. ANNUAL REPORT (FORM 5500) AND SUMMARY ANNUAL REPORT**

**What is the annual report and who files it?** An Annual Report (Form 5500) must be filed with the government no later than the last day of the 7th month after the close of the plan year (unless filed under an extension). The Trust files this form on behalf of all Plans of participating Banks funded through the Trust.

**What is the summary annual report and who distributes it?** The Summary Annual Report is provided annually by the Trust after the Form 5500 has been filed. The Summary Annual Report summarizes the Annual Report (Form 5500) filed by the Trust. Annually, each Plan Sponsor, as Plan Administrator, is required to distribute a Summary Annual Report to participants and beneficiaries in the Bank's Plan funded through the Trust.

**How does the Bank complete and distribute the summary annual report?** When a Plan Sponsor receives the Summary Annual Report, it should review it, complete the necessary items, copy and distribute it to each participant covered by the Plan either by personal delivery or by mailing first class. This must be done within two months of the Form 5500 filing date.

## **PROCEDURES FOR ADOPTING A PLAN Checklist**

This is intended to provide a generalized overview of the typical chronological steps involved in adoption and/or amendment of a Bank's Plan and participation in the Trust.

### **Steps for Initial Adoption**

1. Determine desired Plan/benefit design. Complete Plan Document, including related Appendices. Adopt Board resolution authorizing adoption of Plan and participation in Trust (include draft of Plan Document).
2. Complete Application for Participation in Trust (if needed). Send to EBC. (EBC will return a counter-signed Application upon approval.)
3. Complete Request for Participation in specific benefits (also known as a Participation Agreement and Employer Application For Coverage). Send to EBC. Census information, other forms, or prior billing or benefit information also may be required. EBC staff will notify the Bank and assist in the coordination of the necessary paperwork. (EBC will send the Bank Enrollment Forms.)
4. Sign approved Plan Document and Appendices. If final benefits or related requirements vary from initial draft, submit final Plan Document to Board of Directors again for approval. Send copy of final Plan Document with Appendices to the Trust. Complete Qualified Medical Child Support Order Procedures if medical, dental, or vision benefits are offered.
5. Complete the Summary Plan Description and distribute it with the benefit booklet to each participant. (EBC or insurer will send Bank benefit booklets.) See manual for allowed methods of distribution. A Sample Participant Transmittal Memo is included.
6. If possible, conduct an employee meeting to highlight provisions of the new Plan and benefits, assist participants to better understand how the benefit arrangement works for them, and answer questions participants may have. EBC staff is available to help with this task. Complete Enrollment Form for each employee. Send to EBC.
7. Check billing statement to verify all have been enrolled as elected.

### **Steps for Amending Plan**

1. Determine the desired change, obtain Board approval via resolutions, and complete and sign the Plan Document or specific Appendix as appropriate. If adding a benefit, contact EBC for assistance in completing other required information.
2. Send copy of revised documents to the Trust.
3. Review SPD and attach and distribute revised form and/or Appendix as appropriate.

**TRUST AGREEMENT AND AMENDMENTS**  
**(See Separate Documents)**

The Trust Agreement (Third Restatement)

First Amendment

Second Amendment

Third Amendment

**APPLICATION FOR PARTICIPATION**  
**(See Separate Form)**

**APPLICATION FOR PARTICIPATION IN THE  
WISCONSIN BANKERS ASSOCIATION INSURANCE TRUST FUND**

The Employer designated below hereby makes or reaffirms application for participation in the Wisconsin Bankers Association Insurance Trust Fund ("Trust"). The Employer agrees that its participation is subject to the following:

1. Participation in the Trust entitles the Employer and its employees to participate in any of the various insurance programs that may from time to time be available through the Trust. The Employer shall make appropriate applications for participation in such programs on such forms as may from time to time be supplied by the Trust or the insurer under such program.
2. The Employer agrees to be bound by all the terms and conditions of the Trust and the Trust Agreement in which it is contained, and as they may from time to time be amended.
3. The Employer acknowledges receipt of a copy of the current Trust Agreement.
4. The Employer understands that the Trust imposes certain obligations and responsibilities upon it and hereby accepts those obligations and responsibilities. Among such obligations and responsibilities is the obligation to comply with all state and Federal laws that are applicable to the Employer's plan and to the Trust. By execution of this Application for Participation, the Employer acknowledges that any benefits it provides under the Trust must be not discriminate in favor of highly compensated employees or, if applicable, in favor of key employees.
5. Notwithstanding anything in the Plan documents or any other documents to the contrary, the Employer understands that the Trust only will provide benefits to the extent the insurer has agreed in the respective policy to provide such benefits to the Employer. Any extension of benefits beyond that paid by terms of the policy as interpreted by the insurer shall be the sole responsibility of the Employer.

The Employer's obligation to reimburse the Trust continues after coverage with the Trust expires and applies to all such payments for claims incurred while it is covered under the Trust.

The undersigned Employer is Plan Sponsor and has the authority to sign for any participating Related Employers. The Plan Sponsor hereby binds any future Related Employer which may participate in the Plan Sponsor's plan.

Dated \_\_\_\_\_, 20\_\_\_\_ Employer  
By Plan Sponsor

\_\_\_\_\_

By: \_\_\_\_\_  
Print Title

Address of Plan Sponsor:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Plan Sponsor's Federal Employer Identification Number ("EIN"): \_\_\_\_\_

If Plan Sponsor is a member of a controlled group of affiliated banks and other entities or a group of unaffiliated banks that jointly maintain a benefit plan or plans, list below the other participating entities ("Related Employers"):

Name and address of Employer:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EIN: \_\_\_\_\_

Name and address of Employer:

\_\_\_\_\_  
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EIN: \_\_\_\_\_

Name and address of Employer:

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EIN: \_\_\_\_\_

Name and address of Employer:

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EIN: \_\_\_\_\_

Name and address of Employer:

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EIN: \_\_\_\_\_

Name and address of Employer:

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\_\_\_\_\_

EIN: \_\_\_\_\_

Application Approved: \_\_\_\_\_, 20\_\_\_\_.

**WISCONSIN BANKERS ASSOCIATION  
INSURANCE TRUST FUND**

By: WISCONSIN BANKERS ASSOCIATION  
EMPLOYEE BENEFITS CORPORATION, INC.,  
Administrative Services Provider

By: \_\_\_\_\_

**SUGGESTED RESOLUTION FORMAT**  
(See Separate Form)

**RESOLUTION FOR ADOPTING/AMENDING  
EMPLOYEE BENEFITS FUNDED THROUGH TRUST**

**RESOLVED**, that the Bank hereby authorizes or reaffirms its participation in the Wisconsin Bankers Association Insurance Trust Fund ("Trust");

**FURTHER RESOLVED**, that the Bank hereby adopts or amends its existing employee benefit(s) as offered through the Trust effective as of \_\_\_\_\_  
in substantially the form of the Welfare Benefit Plan attached hereto; and

**FINALLY RESOLVED**, that the appropriate officers of the Bank are authorized and directed to take whatever action may be necessary in order to effectuate the foregoing Resolutions, including, but not limited to, execution of the Application For Participation in the Trust, Plan Documents, and, if medical, dental, or vision benefits are offered, a Qualified Medical Child Support Order Procedure.

**PLAN DOCUMENT**  
**(See Separate Form)**

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

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("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]

**APPENDIX A TO PLAN DOCUMENT**  
**(See Separate Form)**

**APPENDIX A  
PARTICIPATING RELATED EMPLOYERS**

The following Related Employer agrees to be bound by the terms of the Plan Document for the Plan referenced below (each participating Related Employer should complete a separate Appendix A):

Date: \_\_\_\_\_, 20\_\_

\_\_\_\_\_  
[Typed Name of Related Employer]

\_\_\_\_\_  
[Related Employer's City]

By: \_\_\_\_\_

Title: \_\_\_\_\_

\_\_\_\_\_  
[Related Employer's Federal Employer Identification Number]

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**APPENDIX E TO PLAN DOCUMENT**  
**(See Separate Form)**

## APPENDIX E EMPLOYEE COVERAGE

By executing this Appendix E to its Welfare Benefit Plan, the Employer provides coverage under such Plan for Employees to the extent provided below. This Appendix is part of and is subject to the provisions of the Employer's Welfare Benefit Plan. This Appendix is effective as of the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_, and replaces any prior Appendix E.

E1.1 Plan Sponsor Elections for Employees. The following features are selected for this Plan. These elections and coverages shall govern benefits subject to the provisions of the Plan and Section E1.2.

(a) **Benefits and Eligibility.** All benefits to be provided under a particular Policy from time to time shall be exclusively as then provided in such Policy providing the benefit and shall be payable in accordance with such Policy's terms, conditions, and provisions, including, but not limited to, eligibility limitations. The Employer selects the following benefits to be offered to Employees under the Plan and the following eligible hourly requirement categories (complete as applicable):

- Medical** coverage shall be available for Employees who work at least \_\_\_\_\_ hours per week (hours entered must be no lower than 20 and no higher than 30).
- Dental** coverage shall be available for Employees who work at least \_\_\_\_\_ hours per week (hours entered must be no lower than 20 and no higher than 40).
- Vision** coverage shall be available for Employees who work at least \_\_\_\_\_ hours per week (hours entered must be no lower than 20 and no higher than 40).
- Life and Accidental Death and Dismemberment** coverage shall be available for Employees who work at least \_\_\_\_\_ hours per week (hours entered must be no lower than 20 and no higher than 40).
- Dependent Life** coverage (same hourly requirement as Life and Accidental Death and Dismemberment will apply).
- Long Term Disability** coverage shall be available for Employees who work at least \_\_\_\_\_ hours per week (hours entered must be no lower than 20 and no higher than 40).
- Short Term Disability** coverage shall be available for Employees who work at least \_\_\_\_\_ hours per week (hours entered must be no lower than 20 and no higher than 40).

(b) **Required Waiting Periods.** An eligible Employee shall not commence coverage until completion of the any applicable required waiting periods. "Date of hire" as used in this Section E1.1 means the date the Employee starts working. Coverage may not commence before the date which is (complete as applicable):

- Medical:**
  - \_\_\_ month(s) after date of hire;
  - \_\_\_ day(s) after date of hire;
  - 1st of month after \_\_\_ months following date of hire;
  - 1st of month after \_\_\_ days following date of hire; or
  - Date of hire (no waiting period).
  
- Dental:**
  - \_\_\_ month(s) after date of hire;
  - \_\_\_ day(s) after date of hire;
  - 1st of month after \_\_\_ months following date of hire;
  - 1st of month after \_\_\_ days following date of hire; or
  - Date of hire (no waiting period).
  
- Vision:**
  - \_\_\_ month(s) after date of hire;
  - \_\_\_ day(s) after date of hire;
  - 1st of month after \_\_\_ months following date of hire;
  - 1st of month after \_\_\_ days following date of hire; or
  - Date of hire (no waiting period).
  
- Life and Accidental Death and Dismemberment:**
  - \_\_\_ month(s) after date of hire;
  - \_\_\_ day(s) after date of hire;
  - 1st of month after \_\_\_ months following date of hire;
  - 1st of month after \_\_\_ days following date of hire; or
  - Date of hire (no waiting period).
  
- Dependent Life:** (same waiting period as Life and Accidental Death and Dismemberment will apply)
  
- Long Term Disability:**
  - \_\_\_ month(s) after date of hire;
  - \_\_\_ day(s) after date of hire;
  - 1st of month after \_\_\_ months following date of hire;
  - 1st of month after \_\_\_ days following date of hire; or
  - Date of hire (no waiting period).
  
- Short Term Disability:**
  - \_\_\_ month(s) after date of hire;
  - \_\_\_ day(s) after date of hire;
  - 1st of month after \_\_\_ months following date of hire;
  - 1st of month after \_\_\_ days following date of hire; or
  - Date of hire (no waiting period).

(c) **Credit for Time Served.** Time served as a part-time, seasonal, or temporary Employee (complete as applicable) \_\_\_ will \_\_\_ will not be credited toward satisfaction of any required waiting period under each Policy under the Plan.

(d) **Premiums.** Premiums for benefits shall be subject to change from time to time. Premiums shall be paid by the Employer except as provided below (complete as applicable):

The following contribution for **Medical** benefits shall be paid by the Employee: (Check and complete schedules below as applicable. Enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per \_\_\_\_\_.)

Employees working at least \_\_\_\_\_ hours shall pay the following percentage/dollar amount (see Section E1.1(a) for the minimum number of hours) for coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee only coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee/spouse coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee/children coverage; or  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee/family coverage.

If contribution and hours are broken down further, complete the following: Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following percentage for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee only coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee/spouse coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee/children coverage; or  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee/family coverage.

If contribution and hours are broken down further, complete the following: Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following percentage for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee only coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee/spouse coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee/children coverage; or  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee/family coverage.

The following contribution for **Dental** benefits shall be paid by the Employee: (Check and complete schedules below as applicable. Enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per \_\_\_\_\_.)

Employees working at least \_\_\_\_\_ hours shall pay the following percentage/dollar amount (see Section E1.1(a) for the minimum number of hours) for coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee only coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee/spouse coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee/children coverage; or  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee/family coverage.

- If contribution and hours are broken down further, complete the following: Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following percentage for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee only coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee/spouse coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee/children coverage; or  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee/family coverage.

- If contribution and hours are broken down further, complete the following: Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following percentage for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee only coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee/spouse coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee/children coverage; or  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee/family coverage.

- The following contribution for **Vision** benefits shall be paid by the Employee: (Check and complete schedules below as applicable. Enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per \_\_\_\_\_.)

- Employees working at least \_\_\_\_\_ hours shall pay the following percentage/dollar amount (see Section E1.1(a) for the minimum number of hours) for coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee only coverage; and  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee/family coverage.

- If contribution and hours are broken down further, complete the following Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following percentage for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee only coverage; and  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee/family coverage.

- If contribution and hours are broken down further, complete the following Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following percentage for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee only coverage; and  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Employee/family coverage.

- The following contribution for **Life and Accidental Death and Dismemberment** benefits shall be paid by the Employee: (Check and complete schedules below as applicable. Enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per \_\_\_\_\_.)

- Employees working at least \_\_\_\_\_ hours shall pay the following percentage/dollar amount (see Section E1.1(a) for the minimum number of hours) for coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee only coverage.

- If contribution and hours are broken down further, complete the following Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following amount for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee only coverage.

- If contribution and hours are broken down further, complete the following Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following amount for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee only coverage.

- The following contribution for **Dependent Life** benefits shall be paid by the Employee: (Check and complete schedules below as applicable. Enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per \_\_\_\_\_.)

- Employees working at least \_\_\_\_ hours shall pay the following percentage/dollar amount (see Section E1.1(a) for the minimum number of hours) for coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for coverage.

- If contribution and hours are broken down further, complete the following Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following amount for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for coverage.

- If contribution and hours are broken down further, complete the following Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following amount for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for coverage.

- The following contribution for **Long Term Disability** benefits shall be paid by the Employee: (Check and complete schedules below as applicable. Enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per \_\_\_\_\_.)

- Employees working at least \_\_\_\_\_ hours shall pay the following percentage/dollar amount (see Section E1.1(a) for the minimum number of hours) for coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee only coverage.

- If contribution and hours are broken down further, complete the following Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following amount for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee only coverage.

- If contribution and hours are broken down further, complete the following Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following amount for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee only coverage.

- The following contribution for **Short Term Disability** benefits shall be paid by the Employee: (Check and complete schedules below as applicable. Enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per \_\_\_\_\_.)

- Employees working at least \_\_\_\_ hours shall pay the following percentage/dollar amount (see Section E1.1(a) for the minimum number of hours) for coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee only coverage.

- If contribution and hours are broken down further, complete the following Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following amount for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee only coverage.

- If contribution and hours are broken down further, complete the following Employees working at least \_\_\_\_\_ hours, but less than \_\_\_\_\_ hours, shall pay the following amount for the coverage selected by the Employee:

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Employee only coverage.

**(e) Termination Date of Benefits.** Subject to the provisions in Article V, at termination of eligibility for a benefit, coverage shall terminate on the date indicated as follows (complete as applicable):

**Medical:**

- Date employment/eligibility terminates; or
- Last day of month in which employment/eligibility terminates.

- Dental:**
  - Date employment/eligibility terminates; or
  - Last day of month in which employment/eligibility terminates.
  
- Vision:**
  - Date employment/eligibility terminates; or
  - Last day of month in which employment/eligibility terminates.
  
- Life and Accidental Death and Dismemberment:**
  - Date employment/eligibility terminates; or
  - Last day of month in which employment/eligibility terminates.
  
- Dependent Life:** (Termination date is same as Life and Accidental Death and Dismemberment.)
  
- Long Term Disability:**
  - Date employment/eligibility terminates; or
  - Last day of month in which employment/eligibility terminates.
  
- Short Term Disability:**
  - Date employment/eligibility terminates; or
  - Last day of month in which employment/eligibility terminates.

E1.2 Policy Provisions Incorporated/Supersession. The terms of the Policies providing benefits under this Plan are 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.

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

\_\_\_\_\_

[Typed Name of Plan Sponsor]

By: \_\_\_\_\_

Title: \_\_\_\_\_

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**APPENDIX R TO PLAN DOCUMENT**  
**(See Separate Form)**

**APPENDIX R  
RETIREE COVERAGE**

By executing this Appendix R to its Welfare Benefit Plan, the Employer provides coverage under such Plan for Retirees (as defined in Section R1.1(a)) to the extent provided below. This Appendix is part of and is subject to the provisions of the Employer's Welfare Benefit Plan. This Appendix is effective as of the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, and replaces any prior Appendix R.

R1.1 Plan Sponsor Elections for Retirees. The following features are selected for this Plan. These elections and coverages shall govern benefits subject to the provisions of the Plan and Section R1.3.

**(a) Benefits and Eligibility.** All benefits to be provided under a particular Policy from time to time shall be exclusively as then provided in such Policy providing the benefit and shall be payable in accordance with such Policy's terms, conditions, and provisions, including, but not limited to, eligibility limitations. With respect to any particular benefit offered under Section R1.1(a), Retirees only include individuals who previously were covered as Employees and who continue such coverage without a break in coverage under the Plan. Retirees who do not timely elect Retiree coverage commencing at the time of retirement, are ineligible for Retiree coverage. Retirees who elect and are covered by Retiree coverage for a benefit under the Plan and then terminate Retiree coverage for such benefit, are ineligible for future Retiree coverage for such benefit under the Plan. Unless otherwise required by law or the Plan, a Retiree only may cover family members for any particular benefit under the Plan, if the family members had coverage for such benefit under the Plan by the individual immediately prior to termination of employment with the Employer and only if the family members continue such coverage without a break in coverage under the Plan. The Employer selects the following benefits to be offered to Retirees under the Plan (complete as applicable):

- Medical** coverage shall be available. Unless otherwise required by law, medical benefits for Retirees and their family members always will be secondary to Medicare.
- Dental** coverage shall be available.
- Life** coverage shall be available.

For purposes of the Plan, "Retiree" shall mean a former Employee who, prior to termination of employment with the Employer, (complete the following) has both reached the age of \_\_\_\_\_ and has \_\_\_\_\_ years of service with the Employer. (Requirements cannot be less than age 55 with 10 years of service, unless provided as follows: \_\_\_\_\_.)

**(b) Premiums.** Premiums for benefits shall be subject to change from time to time. Premiums shall be paid by the Employer except as provided below (complete as applicable):

- The following contribution for **Medical** benefits shall be paid by the Retiree: (Check and complete schedules below as applicable. Enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per \_\_\_\_\_.)
  - ( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Retiree only coverage;
  - ( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Retiree/spouse coverage;
  - ( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Retiree/children coverage; or
  - ( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Retiree/family coverage.

- The following contribution for **Dental** benefits shall be paid by the Retiree: (Check and complete schedules below as applicable. Enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per \_\_\_\_\_.)

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Retiree only coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Retiree/spouse coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Retiree/children coverage; or  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Retiree /family coverage.

- The following contribution for **Life** benefits shall be paid by the Retiree: (Check and complete schedule below as applicable. Enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per .)

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Retiree only coverage.

**(c) Termination Date of Benefits.** Except as otherwise provided in the Plan, at termination of eligibility for a benefit, coverage shall terminate on the date indicated as follows (complete as applicable):

- Medical:**
  - Date eligibility terminates; or
  - Last day of month in which eligibility terminates.
- Dental:**
  - Date eligibility terminates; or
  - Last day of month in which eligibility terminates.
- Life:**
  - Date eligibility terminates; or
  - Last day of month in which eligibility terminates.

R1.2 Continuation Coverage. Notwithstanding anything to the contrary in the Plan, to the extent allowed by law, Retiree coverage is available only in lieu of any Federal COBRA or state continuation coverage under the Plan.

R1.3 Policy Provisions Incorporated/Supersession. The terms of the Policies providing benefits under this Plan are 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.

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

\_\_\_\_\_  
[Typed Name of Plan Sponsor]

By: \_\_\_\_\_

Title: \_\_\_\_\_

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**APPENDIX D TO PLAN DOCUMENT**  
**(See Separate Form)**

## APPENDIX D DIRECTOR COVERAGE

By executing this Appendix D to its Welfare Benefit Plan, the Employer provides coverage under such Plan for Directors to the extent provided below. This Appendix is part of and is subject to the provisions of the Employer's Welfare Benefit Plan. This Appendix is effective as of the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_, and replaces any prior Appendix D.

D1.1 Plan Sponsor Elections for Non-Employee Directors. The following features are selected for this Plan. These elections and coverages shall govern benefits subject to the provisions of the Plan and Section D1.3.

**(a) Benefits and Eligibility.** All benefits to be provided under a particular Policy from time to time shall be exclusively as then provided in such Policy providing the benefit and shall be payable in accordance with such Policy's terms, conditions, and provisions, including, but not limited to, eligibility limitations. **Only non-Employee Directors who were covered as of December 31, 1997 for a benefit, and remained continuously covered, are eligible for that benefit.** The Plan covers (complete as applicable):

- Non-Employee Directors.** The Employer selects the following benefits to be offered to non-Employee Directors under the Plan (complete as applicable):
  - Medical** coverage shall be available.
  - Dental** coverage shall be available.
  - Vision** coverage shall be available.
  - Life and Accidental Death and Dismemberment** coverage shall be available.
  
- Retired non-Employee Directors.** With respect to any particular benefit offered under Section D1.1(a), Retired non-Employee Directors only include individuals who previously were covered as non-Employee Directors and who continue such coverage without a break in coverage under the Plan. Retired non-Employee Directors who did not timely elect Retired non-Employee Director coverage commencing at the time they cease to be Directors, are ineligible for Retired non-Employee Director coverage. Retired non-Employee Directors who elect and are covered by Retired non-Employee Director coverage for a benefit under the Plan and then terminate Retired non-Employee Director coverage for such benefit, are ineligible for future Retired non-Employee Director coverage for such benefit under the Plan. Unless otherwise required by law or the Plan, a Retired non-Employee Director only may cover family members for any particular benefit under the Plan, if the family members had coverage for such benefit under the Plan by the individual immediately prior to the date he or she ceased to be a Director and only if the family members continued such coverage without a break in coverage under the Plan. Life coverage is available only to Retired non-Employee Directors who retired with such coverage before July 1, 1988. The Employer selects the following benefits to be offered to retired non-Employee Directors under the Plan (complete as applicable):
  - Medical** coverage shall be available.

**Dental** coverage shall be available.

**Life** coverage shall be available.

**(b) Premiums.** Premiums for benefits shall subject to change from time to time. Premiums shall be paid by the Employer except as provided below (complete as applicable):

The following contribution for **Medical** benefits shall be paid by the Director: (Check and complete schedules below as applicable. Enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per \_\_\_\_\_.)

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Director only coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Director/spouse coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Director/children coverage; or  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Director/family coverage.

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Retired Director only coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Retired Director/spouse coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Retired Director/children coverage; or  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Retired Director/family coverage.

The following contribution for **Dental** benefits shall be paid by the Director: (Check and complete schedules below as applicable. Enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per \_\_\_\_\_.)

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Director only coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Director/spouse coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Director/children coverage; or  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Director/family coverage.

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Retired Director only coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Retired Director/spouse coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Retired Director/children coverage; or  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Retired Director/family coverage.

The following contribution for **Vision** benefits shall be paid by the Director: (Check and complete schedules below as applicable. Enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per \_\_\_\_\_.)

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Director only coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Director/spouse coverage;  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Director/children coverage; or  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_) for Director/family coverage.

The following contribution for **Life** benefits shall be paid by the Director: (Check and complete schedule below as applicable, enter either the percentage from 0% to 100% or monthly dollar amount. If dollar amount is not per month, indicate the period used: dollar amount per \_\_\_\_\_.)

( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Director only coverage; or  
( \_\_\_\_\_ %) or (\$ \_\_\_\_\_ ) for Retired Director only coverage (only if coverage was effective prior to July 1, 1988).

(c) **Termination Date of Benefits.** Except as otherwise provided in the Plan, at termination of eligibility for a benefit, coverage shall terminate on the date indicated as follows (complete as applicable):

- Medical:**
  - Date eligibility terminates; or
  - Last day of month in which eligibility terminates.
  
- Dental:**
  - Date eligibility terminates; or
  - Last day of month in which eligibility terminates.
  
- Vision:**
  - Date eligibility terminates; or
  - Last day of month in which eligibility terminates.
  
- Life:**
  - Date eligibility terminates; or
  - Last day of month in which eligibility terminates.

D1.2 Continuation Coverage. Notwithstanding anything to the contrary in the Plan, to the extent allowed by law, Retired non-Employee Director coverage is available only in lieu of any Federal COBRA or state continuation coverage under the Plan.

D1.3 Policy Provisions Incorporated/Supersession. The terms of the Policies providing benefits under this Plan are 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.

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

\_\_\_\_\_  
[Typed Name of Plan Sponsor]

By: \_\_\_\_\_

Title: \_\_\_\_\_

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**APPENDIX M TO PLAN DOCUMENT**  
**(See Separate Form)**

**APPENDIX M**  
**MEDICARE SECONDARY PAYER - SMALL EMPLOYER EXCEPTION**

By executing this Appendix M to its Welfare Benefit Plan, the Employer declines the small employer exception under such Plan to the extent provided below. This Appendix is part of and is subject to the provisions of the Employer's Welfare Benefit Plan. This Appendix is effective as of the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

**M1.1 Small Employer Exception Election Declined.** (Check box if applicable.)

- Employer declines to make the small employer exception election (relating to the 20-employee threshold for coordination of benefits for the working aged with Medicare) described in Plan Section 4.2.

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

\_\_\_\_\_  
[Typed Name of Plan Sponsor]

By: \_\_\_\_\_

Title: \_\_\_\_\_

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**QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES**  
**(See Separate Form)**

## Qualified Medical Child Support Order Procedures

This document is a description of the Procedures governing determinations under any Qualified Medical Child Support Order ("QMCSO"), including any National Medical Support Notice ("NMSN").

### 1. What plans are covered by these Procedures?

These Procedures are adopted with respect to certain group health plan benefits offered through the Welfare Benefit Plan of \_\_\_\_\_ ("Plan Sponsor") ("Plan") and funded through the Wisconsin Bankers Association Insurance Trust Fund ("Trust").

These Procedures cover orders submitted with respect to health, dental, and vision benefits, as applicable, under the Plan, and only to the extent required by law.

### 2. What is a QMCSO and who decides whether the order is "qualified"?

A QMCSO creates or recognizes the right of a child of a participant (the law refers to the child as an "alternate recipient") to receive benefits under his or her parent's employer's group health plan. The Plan Administrator for the applicable Plan benefit(s) determines whether a medical child support order meets the requirements for treatment as a QMCSO.

The Plan is not required to provide coverage under medical child support orders that are not "qualified."

### 3. What type of order can be considered a QMCSO?

A QMCSO generally is a medical child support order that meets certain requirements under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). A National Medical Support Notice ("NMSN") also might be a QMCSO.

A medical child support order is a court judgment, decree, or order (including an approval of a property settlement), or a state administrative order, that either (a) provides for child support or health benefits coverage for the child of a group health plan participant, is made pursuant to a state domestic relations law, and relates to benefits under such plan, or (b) is made pursuant to certain state medical child support laws enacted under the Social Security Act with respect to a group health plan. Typically, these orders are issued in divorce proceedings or state child support order proceedings.

To be a "qualified" medical child support order, the order:

- Must contain the name and last known mailing address of the participant and each alternate recipient. The order may substitute the name and mailing address of a state or local official for the mailing address of any alternate recipient.
- Must contain a reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined).
- Must include the time period to which the order applies.
- May not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet certain state law requirements

relating to medical child support if such requirements apply to the Plan. This means, among other things, that an order may not require the Plan to provide dependent coverage when that option is not otherwise available under the Plan.

**4. What is a National Medical Support Notice ("NMSN"), and when is an NMSN a QMCSO?**

Certain state agencies are required by Federal law to use a type of QMCSO called a National Medical Support Notice. An NMSN that meets the same standards that cause a medical child support order to be "qualified" is deemed to be a QMCSO.

**5. What happens when the Plan receives a medical child support order?**

- The Plan Administrator determines if the document is a judgment, order, or decree issued by a court or an order issued through a state administrative process.
- The Plan Administrator promptly notifies the participant and each alternate recipient (at the address specified in the order) of the receipt of such order and provides a copy of these QMCSO Procedures.
- The Plan Administrator determines the employment status of the affected employee-parent and reviews Plan provisions generally applicable to dependent coverages to determine which, if any, group health plan benefits are available to the alternate recipient.
- Within a reasonable period of time, the Plan Administrator reviews the order and determines whether the order is a QMCSO.

**6. What happens when the Plan receives a NMSN?**

The process is similar to the process when the Plan receives a medical child support order. However, the National Medical Support Notice provisions contain separate, specific time limits on the processing of the notice by employers and plan administrators. Therefore, the process is as follows:

- The Plan Administrator determines if the document is an NMSN.
- The Plan Administrator promptly notifies the participant, each alternate recipient, and the issuing court or agency (at the address specified in the NMSN) of the receipt of such NMSN and provides a copy of these QMCSO Procedures.
- The Plan Administrator determines the employment status of the affected employee-parent and reviews Plan provisions generally applicable to dependent coverages to determine which, if any, group health plan benefits are available to the alternate recipient.
- Within a reasonable time, the Plan Administrator determines if the NMSN is appropriately completed. If the NMSN is appropriately completed, the Plan Administrator must treat the NMSN as a QMCSO.
- The Plan Administrator must complete the Plan Administrator Response, indicating whether the NMSN is a QMCSO, and return it to the state agency that issued the NMSN within 40 business days after the date of the NMSN.

A copy of a model NMSN is attached to these Procedures.

**7. What happens if the document is determined to be a QMCSO?**

The Plan Administrator will provide written notification of its determination to the participant and each alternate recipient. Written comments regarding this determination may be submitted to the Plan Administrator for a period of 10 days from the date of the notification letter or such other period as the Plan Administrator may indicate. If the Plan Administrator receives no comments within this period, the determination will be final. If the Plan Administrator receives comments within this period, then the Plan Administrator will consider those comments and will issue a final determination within a reasonable time.

**8. What happens if the document is determined not to be a QMCSO?**

If the Plan Administrator determines that a medical child support order or NMSN is not a QMCSO, the Plan Administrator will provide written notification of its determination to the participant and each alternate recipient. Written comments regarding this determination may be submitted to the Plan Administrator for a period of 10 days from the date of the notification letter or such other period as the Plan Administrator may indicate. If the Plan Administrator receives no comments within this period, the determination will be final. If the Plan Administrator receives comments within this period, then the Plan Administrator will consider those comments and will issue a final determination within a reasonable time.

**9. What happens if the employer is unable to withhold from the participant's paycheck the employee contributions necessary to provide coverage to the child under a QMCSO?**

If the Plan Administrator determines that a document is a QMCSO, then the employer will determine whether Federal or state withholding limitations or prioritization rules permit the withholding from the employee's income of the amount required to obtain coverage for the child or children under the terms of the Plan.

If the employer is not able to withhold the necessary contribution from the participant's paycheck, the Plan is not required to extend coverage to the child, unless the participant voluntarily consents and the law so provides.

**10. What claim procedures apply to determinations of the qualified status of a medical child support order or NMSN?**

The Plan Administrator has sole discretion and authority to determine whether a medical child support order or NMSN is a QMCSO. Issues relating to a QMCSO must be resolved pursuant to the procedures set forth in ERISA Section 609(a)(5) and these Procedures.

Any disputes raised by any party shall be in writing and referred to the Plan Administrator.

**11. Once a medical child support order or NMSN is finally determined to be a QMCSO, what happens ?**

In accordance with the QMCSO, the Plan will permit either parent to submit the appropriate enrollment forms.

Generally, each alternate recipient who is required to be enrolled in a benefit under the Plan as a result of a QMCSO will be considered a beneficiary for that benefit under the Plan. However, for purposes of reporting and disclosure requirements, each alternate recipient who is required to be enrolled in the Plan as a result of a QMCSO will be considered a participant under the Plan and will be entitled to receive a copy of the summary plan description, summaries of Plan changes, and the summary Plan report.

When a child is covered through the noncustodial parent, the Plan will provide the custodial parent information to enable the child to obtain benefits from the Plan and to permit the custodial parent to file benefit claims without the approval of the noncustodial parent. If reimbursement is required for health expenses paid by the child or custodial parent, payment will be made to the child or custodial parent.

Upon receipt of completed required forms and applications, the Plan Administrator will instruct each third-party administrator or insurance carrier, as appropriate, to enroll each alternate recipient by adding his or her name as a dependent of the participant.

**12. If a Plan offers more than one option, and the QMCSO does not expressly state which option should be provided, what happens?**

In this situation, the Plan Administrator should select the participant's selected option for the beneficiary, unless the Plan Administrator determines that the participant's selected option would not be feasible.

These Procedures are effective as of the date of execution unless otherwise provided here: \_\_\_\_\_  
\_\_\_\_\_. These Procedures supersede any previous QMCSO procedures with respect to the benefits covered hereunder.

Dated: \_\_\_\_\_, 20\_\_\_\_

Plan Administrator

By: \_\_\_\_\_

\_\_\_\_\_  
Title

APPENDIX  
**NATIONAL MEDICAL SUPPORT NOTICE**  
**PART A**

**NOTICE TO WITHHOLD FOR HEALTH CARE COVERAGE**

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998.

Issuing Agency: _____ Issuing Agency Address: _____ _____ Date of Notice: _____ Case Number: _____ Telephone Number: _____ FAX Number: _____	Court or Administrative Authority: _____ Date of Support Order: _____ Support Order Number: _____
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_____ ) Employer/Withholder's Federal EIN Number	RE* _____ Employee's Name (Last, First, MI)
_____ ) Employer/Withholder's Name	_____ Employee's Social Security Number
_____ ) Employer/Withholder's Address	_____ Employee's Mailing Address
_____ ) Custodial Parent's Name (Last, First, MI)	_____ Substituted Official/Agency Name and Address
_____ ) Custodial Parent's Mailing Address	_____ _____ Child(ren)'s Mailing Address (if different from Custodial Parent's)
_____ ) _____ ) _____ ) Name, Mailing Address, and Telephone Number of a Representative of the Child(ren)	_____ _____ _____ Child(ren)'s Name(s)                      DOB      SSN      Child(ren)'s Name(s)                      DOB      SSN

The order requires the child(ren) to be enrolled in [ ] any health coverages available; or [ ] only the following coverage(s):  Medical;  Dental;  Vision;  Prescription drug;  Mental health;  Other (specify): \_\_\_\_\_

THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. OMB control number: 0970-0222 Expiration Date: 12/31/2003.

### EMPLOYER RESPONSE

If either 1, 2, or 3 below applies, check the appropriate box and return this Part A to the Issuing Agency within 20 business days after the date of the Notice, or sooner if reasonable. NO OTHER ACTION IS NECESSARY. If neither 1, 2, nor 3 applies, forward Part B to the appropriate plan administrator(s) within 20 business days after the date of the Notice, or sooner if reasonable. Check number 4 and return this Part A to the Issuing Agency if the Plan Administrator informs you that the child(ren) is/are enrolled in an option under the plan for which you have determined that the employee contribution exceeds the amount that may be withheld from the employee's income due to State or Federal withholding limitations and/or prioritization.

- 1. Employer does not maintain or contribute to plans providing dependent or family health care coverage.
- 2. The employee is among a class of employees (for example, part-time or non-union) that are not eligible for family health coverage under any group health plan maintained by the employer or to which the employer contributes.
- 3. Health care coverage is not available because employee is no longer employed by the employer:

Date of termination: \_\_\_\_\_

Last known address: \_\_\_\_\_

Last known telephone number: \_\_\_\_\_

New employer (if known): \_\_\_\_\_

New employer address: \_\_\_\_\_

New employer telephone number: \_\_\_\_\_

- 4. State or Federal withholding limitations and/or prioritization prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan.

Employer Representative:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

EIN (if not provided by Issuing Agency on Notice to Withhold for Health Care Coverage): \_\_\_\_\_

## INSTRUCTIONS TO EMPLOYER

This document serves as notice that the employee identified on this National Medical Support Notice is obligated by a court or administrative child support order to provide health care coverage for the child(ren) identified on this Notice. This National Medical Support Notice replaces any Medical Support Notice that the Issuing Agency has previously served on you with respect to the employee and the children listed on this Notice.

The document consists of **Part A - Notice to Withhold for Health Care Coverage** for the employer to withhold any employee contributions required by the group health plan(s) in which the child(ren) is/are enrolled; and **Part B - Medical Support Notice to the Plan Administrator**, which must be forwarded to the administrator of each group health plan identified by the employer to enroll the eligible child(ren).

### EMPLOYER RESPONSIBILITIES

1. If the individual named above is not your employee, or if family health care coverage is not available, please complete item 1, 2, or 3 of the Employer Response as appropriate, and return it to the Issuing Agency. **NO FURTHER ACTION IS NECESSARY.**
2. If family health care coverage is available for which the child(ren) identified above may be eligible, you are required to:
  - a. Transfer, not later than 20 business days after the date of this Notice, a copy of **Part B - Medical Support Notice to the Plan Administrator** to the administrator of each appropriate group health plan for which the child(ren) may be eligible, and
  - b. Upon notification from the plan administrator(s) that the child(ren) is/are enrolled, either
    - 1) withhold from the employee's income any employee contributions required under each group health plan, in accordance with the applicable law of the employee's principal place of employment and transfer employee contributions to the appropriate plan(s), or
    - 2) complete item 4 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholding.
  - c. If the plan administrator notifies you that the employee is subject to a waiting period that expires more than 90 days from the date of its receipt of **Part B** of this Notice, or whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), notify

the plan administrator when the employee is eligible to enroll in the plan and that this Notice requires the enrollment of the child(ren) named in the Notice in the plan.

#### LIMITATIONS ON WITHHOLDING

The total amount withheld for both cash and medical support cannot exceed \_\_\_% of the employee's aggregate disposable weekly earnings. The employer may not withhold more under this National Medical Support Notice than the lesser of:

1. The amounts allowed by the Federal Consumer Credit Protection Act (15 U.S.C., section 1673(b));
2. The amounts allowed by the State of the employee's principal place of employment; or
3. The amounts allowed for health insurance premiums by the child support order, as indicated here: \_\_\_\_\_.

The Federal limit applies to the aggregate disposable weekly earnings (ADWE). ADWE is the net income left after making mandatory deductions such as State, Federal, local taxes; Social Security taxes; and Medicare taxes.

#### PRIORITY OF WITHHOLDING

If withholding is required for employee contributions to one or more plans under this notice and for a support obligation under a separate notice and available funds are insufficient for withholding for both cash and medical support contributions, the employer must withhold amounts for purposes of cash support and medical support contributions in accordance with the law, if any, of the State of the employee's principal place of employment requiring prioritization between cash and medical support, as described here: \_\_\_\_\_.

#### DURATION OF WITHHOLDING

The child(ren) shall be treated as dependents under the terms of the plan. Coverage of a child as a dependent will end when similarly situated dependents are no longer eligible for coverage under the terms of the plan. However, the continuation coverage provisions of ERISA may entitle the child to continuation coverage under the plan. The employer must continue to withhold employee contributions and may not disenroll (or eliminate coverage for) the child(ren) unless:

1. The employer is provided satisfactory written evidence that:

- a. The court or administrative child support order referred to above is no longer in effect; or
  - b. The child(ren) is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan; or
2. The employer eliminates family health coverage for all of its employees.

#### **POSSIBLE SANCTIONS**

An employer may be subject to sanctions or penalties imposed under State law and/or ERISA for discharging an employee from employment, refusing to employ, or taking disciplinary action against any employee because of medical child support withholding, or for failing to withhold income, or transmit such withheld amounts to the applicable plan(s) as the Notice directs.

#### **NOTICE OF TERMINATION OF EMPLOYMENT**

In any case in which the above employee's employment terminates, the employer must promptly notify the Issuing Agency listed above of such termination. This requirement may be satisfied by sending to the Issuing Agency a copy of any notice the employer is required to provide under the continuation coverage provisions of ERISA or the Health Insurance Portability and Accountability Act.

#### **EMPLOYEE LIABILITY FOR CONTRIBUTION TO PLAN**

The employee is liable for any employee contributions that are required under the plan(s) for enrollment of the child(ren) and is subject to appropriate enforcement. The employee may contest the withholding under this Notice based on a mistake of fact (such as the identity of the obligor). Should an employee contest the withholding under this Notice, the employer must proceed to comply with the employer responsibilities in this Notice until notified by the Issuing Agency to discontinue withholding. To contest the withholding under this Notice, the employee should contact the Issuing Agency at the address and telephone number listed on the Notice. With respect to plans subject to ERISA, it is the view of the Department of Labor that Federal Courts have jurisdiction if the employee challenges a determination that the Notice constitutes a Qualified Medical Child Support Order.

#### **CONTACT FOR QUESTIONS**

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed above.

**NATIONAL MEDICAL SUPPORT NOTICE** OMB NO. 1210-0113

**PART B**

**MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR**

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974, and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998. Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The rights of the parties and the duties of the plan administrator under this Notice are in addition to the existing rights and duties established under such law.

Issuing Agency: _____ Issuing Agency Address: _____ Date of Notice: _____ Case Number: _____ Telephone Number: _____ FAX Number: _____	Court or Administrative Authority: _____ Date of Support Order: _____ Support Order Number: _____
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_____) Employer/Withholder's Federal EIN Number	RE* _____ Employee's Name (Last, First, MI)
_____) Employer/Withholder's Name	_____) Employee's Social Security Number
_____) Employer/Withholder's Address	_____) Employee's Address
_____) Custodial Parent's Name (Last, First, MI)	_____) Substituted Official/Agency Name and Address
_____) Custodial Parent's Mailing Address	
_____) Child(ren)'s Mailing Address (if Different from Custodial Parent's)	
_____) _____) _____) Name(s), Mailing Address, and Telephone Number of a Representative of the Child(ren)	
Child(ren)'s Name(s)                      DOB                      SSN	Child(ren)'s Name(s)                      DOB                      SSN
_____	_____
_____	_____
_____	_____

The order requires the child(ren) to be enrolled in  any health coverages available; or  only the following coverage(s):  medical;  dental;  vision;  prescription drug;  mental health;  other (specify): \_\_\_\_\_

**PLAN ADMINISTRATOR RESPONSE**

(To be completed and returned to the Issuing Agency within 40 business days after the date of the Notice, or sooner if reasonable)

This Notice was received by the plan administrator on \_\_\_\_\_.

1. This Notice was determined to be a "qualified medical child support order," on \_\_\_\_\_. Complete **Response 2 or 3, and 4**, if applicable.

2. The participant (employee) and alternate recipient(s) (child(ren)) are to be enrolled in the following family coverage.

- a. The child(ren) is/are currently enrolled in the plan as a dependent of the participant.
- b. There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the participant under the plan.
- c. The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.
- d. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

Coverage is effective as of \_\_\_/\_\_\_/\_\_\_ (includes waiting period of less than 90 days from date of receipt of this Notice). The child(ren) has/have been enrolled in the following option: \_\_\_\_\_ Any necessary withholding should commence if the employer determines that it is permitted under State and Federal withholding and/or prioritization limitations.

3. There is more than one option available under the plan and the participant is not enrolled. The Issuing Agency must select from the available options. Each child is to be included as a dependent under one of the available options that provide family coverage. If the Issuing Agency does not reply within 20 business days of the date this Response is returned, the child(ren), and the participant if necessary, will be enrolled in the plan's default option, if any: \_\_\_\_\_.

4. The participant is subject to a waiting period that expires \_\_\_/\_\_\_/\_\_\_ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: \_\_\_\_\_). At the completion of the waiting period, the plan administrator will process the enrollment.

5. This Notice does not constitute a "qualified medical child support order" because:  
 The name of the  child(ren) or  participant is unavailable.  
 The mailing address of the  child(ren) (or a substituted official) or  participant is unavailable.  
 The following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under the plan \_\_\_\_\_ (insert name(s) of child(ren)).

Plan Administrator or Representative:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

## INSTRUCTIONS TO PLAN ADMINISTRATOR

This Notice has been forwarded from the employer identified above to you as the plan administrator of a group health plan maintained by the employer (or a group health plan to which the employer contributes) and in which the noncustodial parent/participant identified above is enrolled or is eligible for enrollment.

This Notice serves to inform you that the noncustodial parent/participant is obligated by an order issued by the court or agency identified above to provide health care coverage for the child(ren) under the group health plan(s) as described on **Part B**.

(A) If the participant and child(ren) and their mailing addresses (or that of a Substituted Official or Agency) are identified above, and if coverage for the child(ren) is or will become available, this Notice constitutes a "qualified medical child support order" (QMCSO) under ERISA or CSPIA, as applicable. (If any mailing address is not present, but it is reasonably accessible, this Notice will not fail to be a QMCSO on that basis.) You must, within 40 business days of the date of this Notice, or sooner if reasonable:

(1) Complete Part B - Plan Administrator Response - and send it to the Issuing Agency:

(a) if you checked Response 2:

(i) notify the noncustodial parent/participant named above, each named child, and the custodial parent that coverage of the child(ren) is or will become available (notification of the custodial parent will be deemed notification of the child(ren) if they reside at the same address);

(ii) furnish the custodial parent a description of the coverage available and the effective date of the coverage, including, if not already provided, a summary plan description and any forms, documents, or information necessary to effectuate such coverage, as well as information necessary to submit claims for benefits;

(b) if you checked Response 3:

(i) if you have not already done so, provide to the Issuing Agency copies of applicable summary plan descriptions or other documents that describe available coverage including the additional participant contribution necessary to obtain coverage for the child(ren) under each option and whether there is a limited service area for any option;

(ii) if the plan has a default option, you are to enroll the child(ren) in the default option if you have not received an election from the Issuing Agency within 20 business days of the date you returned the Response. If the plan does not have a default option, you are to enroll the child(ren) in the option selected by the Issuing Agency.

(c) if the participant is subject to a waiting period that expires more than 90 days from the date of receipt of this Notice, or has not completed a waiting period whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), complete Response 4 on the Plan Administrator Response and return to the employer and the Issuing Agency, and notify the participant and the custodial parent; and upon satisfaction of the period or requirement, complete enrollment under Response 2 or 3, and

(d) upon completion of the enrollment, transfer the applicable information on Part B - Plan Administrator Response to the employer for a determination that the necessary employee contributions are available. Inform the employer that the enrollment is pursuant to a National Medical Support Notice.

(B) If within 40 business days of the date of this Notice, or sooner if reasonable, you determine that this Notice does not constitute a QMCSO, you must complete Response 5 of Part B - Plan Administrator Response and send it to the Issuing Agency, and inform the noncustodial parent/participant, custodial parent, and child(ren) of the specific reasons for your determination.

(C) Any required notification of the custodial parent, child(ren) and/or participant that is required may be satisfied by sending the party a copy of the Plan Administrator Response, if appropriate.

#### **UNLAWFUL REFUSAL TO ENROLL**

Enrollment of a child may not be denied on the ground that: (1) the child was born out of wedlock; (2) the child is not claimed as a dependent on the participant's Federal income tax return; (3) the child does not reside with the participant or in the plan's service area; or (4) because the child is receiving benefits or is eligible to receive benefits under the State Medicaid plan. If the plan requires that the participant be enrolled in order for the child(ren) to be enrolled, and the participant is not currently enrolled, you must enroll both the participant and the child(ren). All enrollments are to be made without regard to open season restrictions.

#### **PAYMENT OF CLAIMS**

A child covered by a QMCSO, or the child's custodial parent, legal guardian, or the provider of services to the child, or a State agency to the extent assigned the child's rights, may file claims and the plan shall make payment for covered benefits or reimbursement directly to such party.

#### **PERIOD OF COVERAGE**

The alternate recipient(s) shall be treated as dependents under the terms of the plan. Coverage of an alternate recipient as a dependent will end when similarly situated dependents are no longer eligible for coverage under the terms of the plan. However, the continuation coverage provisions of ERISA or other applicable law may entitle the alternate recipient to continue coverage under

the plan. Once a child is enrolled in the plan as directed above, the alternate recipient may not be disenrolled unless:

- (1) The plan administrator is provided satisfactory written evidence that either:
  - (a) the court or administrative child support order referred to above is no longer in effect, or
  - (b) the alternate recipient is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan;

(2) The employer eliminates family health coverage for all of its employees; or

(3) Any available continuation coverage is not elected, or the period of such coverage expires.

**CONTACT FOR QUESTIONS**

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed above.

**Paperwork Reduction Act Notice**

The Issuing Agency asks for the information on this form to carry out the law as specified in the Employee Retirement Income Security Act or the Child Support Performance and Incentive Act, as applicable. You are required to give the Issuing Agency the information. You are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Issuing Agency needs the information to determine whether health care coverage is provided in accordance with the underlying child support order. The Average time needed to complete and file the form is estimated below. These times will vary depending on the individual circumstances.

	<u>Learning about the law or the form</u>	. . . .	<u>Preparing the form</u>
First Notice	1 hr. ___		1 hr., 45 min.
Subsequent Notices	-----		35 min.

**SUMMARY PLAN DESCRIPTION**  
**(See Separate Form)**

**WELFARE BENEFIT PLAN OF**

**("PLAN")**

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**("PLAN SPONSOR")**

**SUMMARY PLAN DESCRIPTION**

Effective January 1, 2005  
(or as specified)

**This document, together with the Attachments listed herein, constitute the written Summary Plan Description for the above-defined "Plan" required by ERISA Section 102.**

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## I. INTRODUCTION

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The Employer maintains the Plan for the exclusive benefit of its eligible employees and their spouses and dependents. The Plan provides you and your eligible dependents with access to medical, dental, vision, life and accidental death and dismemberment, dependent life, long term disability, and/or short term disability benefits as elected by the Employer. This Plan provides the benefits listed in Appendices E, R, or D. Other Appendices may be applicable if provided by the Employer as part of the Summary Plan Description. The Appendices as well as a copy of each booklet, summary, or other governing document of the respective benefits constitute Attachments to this Summary (all of the foregoing material as included is generically referred to in this Summary by the term "booklet"). This document and its Attachments are the Summary Plan Description for the benefits described in Appendices E, R, or D as required by ERISA Section 102.

This Summary describes the terms of the Plan as of the Plan Year starting on or after January 1, 2005.

Although this Summary will give you a general understanding of how the Plan works, it is only an overview. The detailed legal documents under which the Plan is established, including the policies, and not this Summary, control your rights and will be controlling if the documents for the Plan and this overview conflict in any respect. Copies of the legal documents will be made available for your review at the offices of the Employer.

It is intended that the Plan comply with current Federal laws. However, you should be aware that the Plan will change if the laws change or if otherwise amended by the Employer.

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## II. GENERAL PROVISIONS

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### A. GENERAL INFORMATION

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PLAN SPONSOR:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EMPLOYER I.D. NUMBER: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

Related Employers, if any, also sponsoring the plans are attached. The Plan Sponsor and Related Employers are limited to those eligible for participation under the Trust. The term "Employer" includes the Plan Sponsor named above and will include any listed Related Employer.

PLAN ADMINISTRATOR, NAMED FIDUCIARY, AND AGENT FOR SERVICE OF LEGAL PROCESS:

NAME: Plan Sponsor

BUSINESS ADDRESS: Same as address above

TELEPHONE NUMBER: Same as telephone number above

If the Plan Sponsor is not a Plan Administrator and/or Agent for Service of Legal Process, the above information will be replaced by correct information in an attached statement. Service of Legal Process may be made upon the Trustee or Plan Administrator.

PLAN NUMBER: 50\_\_\_\_\_

TYPE OF PLAN: To the extent the Plan benefits provide medical care as defined by Federal law, these benefits may be group health plan type benefits. To the extent the Plan benefits provide medical, dental, vision, life insurance, accidental death and dismemberment, or disability coverage, they may be welfare plan type benefits subject to the provisions of ERISA.

TYPE OF ADMINISTRATION: Employer administration. The following insurers or HMOs also perform administrative functions, e.g. they make claims determinations and payments and issue Certificates of Creditable Coverage, where applicable:

- Blue Cross Blue Shield of Wisconsin ("BCBSWi") (for medical and dental benefits) or Compcare Health Services Insurance Corporation (commonly known as CompcareBlue) (for medical benefits);

- AIG Life Insurance Company through its vision benefits manager National Vision Administrations (for vision benefits); and
- Effective January 1, 2006, Jefferson Pilot Financial Insurance Company (prior to January 1, 2006, Hartford Life and Accident Insurance Company) (for life, accidental death and dismemberment, short term disability, long term disability, and dependent life benefits).

The booklets for the various benefits contain the addresses and phone numbers of the insurers/HMOs and their administrators.

**TRUSTEE:**

**NAME:** Marshall and Ilsley Trust Company  
**ADDRESS:** 401 N. Segoe Road, 2N  
Madison, Wisconsin 53705  
(608) 232-2000

**SOURCE OF CONTRIBUTIONS TO THE PLAN:** The Plan Administrator provides a schedule of the applicable premiums during the enrollment and at such time participant contributions may change and upon request for each of the benefits, as applicable. Participant and/or Employer contributions may be made as provided in Appendices, except as otherwise noted. If participants are required to make contributions and you need further information about this, please contact the Employer. If participants are required to make contributions, they may be entitled to a refund or premium reduction if applicable to the Employer under the Plan. Contact the Employer for more information.

**FUNDING MEDIUM:** The medical and dental benefits are insured under a "modified premium arrangement" with Blue Cross Blue Shield of Wisconsin ("BCBSWi") or Compcare Health Services Insurance Corporation (medical only), on a "cost plus basis." This means that if the reserves held in the Wisconsin Bankers Association Insurance Trust Fund ("Trust") would not be sufficient to pay claims of participants and beneficiaries, BCBSWi or Compcare Health Services Insurance Corporation would be obliged to pay those claims. Other benefits are fully insured. The insurers are listed under "Type of Administration." All benefits will be paid by the respective insurer; provided however, if the benefit is a medical or dental benefit, the insurer will pay any benefits not covered by the Trust as discussed in the booklets. The Employer is not responsible for paying claims with respect to any benefits.

**PLAN YEAR:** Unless otherwise provided, the Plan's financial and other records are maintained on the basis of a "Plan Year" which is the year beginning each January 1 and ending each December 31. If the Plan was adopted after January 1, 2005, the effective date was

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**FINANCING OR ADMINISTRATION BY A HEALTH INSURANCE ISSUER:** Certain benefits are guaranteed under a contract or policy of insurance issued by a health insurance company or HMO. Refer to the underlying benefit policies for more detail regarding the involvement of a health insurer or HMO in those policies.

**STATUS OF EMPLOYER AS "SMALL EMPLOYER" UNDER MEDICARE SECONDARY PAYER RULES** (*If medical benefits are offered, Plan Sponsor must choose and mark one of the two following options*):

\_\_\_\_\_ No Small Employer Election. As of the date of the completion of this Summary, the Employer did not qualify for (or qualified for, but did not elect) "small employer" status (see Questions and Answers III.5 through III.7 for important information on how this affects benefits).

\_\_\_\_\_ Small Employer Election. As of the date of the completion of this Summary, the Employer both qualified for and elected "small employer" status (see Questions and Answers III.5 through III.7 for important information on how this affects benefits).

**COBRA DESIGNATIONS** (*If medical, dental, or vision benefits are offered, Plan Sponsor should review and, if desired, complete the following*):

**PREMIUM PAYMENTS:** The Plan Sponsor does not allow payment of COBRA premiums other than by check, unless specified as follows (*Complete with other methods of payment, if allowable*): \_\_\_\_\_

**FACSIMILE (FAX) NUMBER** (*Complete only if the Plan Sponsor allows faxed COBRA notices*): \_\_\_\_\_

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### III. ELIGIBILITY, PARTICIPATION, AND BENEFITS

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#### 1. Who is eligible and when does coverage start?

Appendices E, R, and D, if applicable, provide information on the eligibility for benefits. In addition, only those persons who meet the eligibility requirements of the underlying policy, enroll, and remain insured under the policy are participants in the Plan. Benefits provided under the Plan are subject to the terms, conditions and provisions of the applicable underlying policy and will be exclusively as provided from time to time under the policy. **Please review the booklets carefully.**

Information about enrollment procedures, including when coverage begins and ends for the various benefits, is found in the materials for each benefit. Each participant will sign documents and provide the Employer and Plan Administrator with information and evidence as may reasonably be requested to administer the Plan.

The Plan Administrator will let you know the amount of premiums that apply to the benefits under the Plan (if any) and any changes in the premiums under those benefits.

**2. What are the rules for HIPAA special enrollments?**

"HIPAA," the Health Insurance Portability and Accountability Act, is a law that only applies to certain types of benefits. If you do not elect to enroll yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in policies that provide certain group health benefits (medical), provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. These benefits are subject to the provisions of the policy for the benefit. State law may provide different requirements. See the booklets. For more information on when HIPAA applies, please see the Questions and Answers on HIPAA in Section IV.E.

**3. Are there preexisting condition exclusions under the Plan?**

Certain group welfare benefits (including medical) may have preexisting condition exclusions. Please refer to those booklet policies for information as to whether those benefits are subject to any preexisting condition exclusions.

**4. What benefits are offered under the Plan?**

Each benefit has a booklet, describing eligibility, benefits, how benefits may be lost, and other important information. See the booklets for details.

**5. If I have medical benefits, do I or my family members need to enroll in Medicare when eligible?**

It depends. Sometimes Medicare is the primary payer and sometimes it is the secondary payer.

- It is especially critical for those eligible for Medicare to enroll in Medicare Parts A and B **when Medicare is primary** to avoid gaps in coverage.
- However, enrolling **when Medicare is secondary** also may be beneficial.

See Questions and Answers III.6 and III.7 which give more information on when Medicare is the primary or secondary payer of medical benefits.

**6. If an individual is Medicare eligible, when is Medicare the primary payer?**

Medicare generally will be the **primary payer** of medical benefits (and the Plan will be **secondary**) for individuals in the following categories:

- Certain individuals with end stage renal disease after 30 months of coverage;
- Certain disabled individuals who are covered, but not because of the individual's (or a family member's) current employment status;
- Certain former employees or former directors (or certain dependents of such individuals) (for information on retiree or director coverage, see Appendix R or D); or
- Certain individuals (age 65 or older) who are Medicare eligible and are working as employees or are active directors (or certain dependents of such employees or directors) (see Appendix E or D, if applicable) under a plan sponsored by an employer that has qualified for and made the Small Employer Election. See Section II to determine whether the Employer has made the Small Employer Election. This information may change from time to time so check with the Employer for current information.

Note that not every situation has been addressed and that the rules determining who falls into the above categories can be complex. For information on COBRA continuation coverage, see Appendix C. See the Employer for more information.

These are only general guidelines on coordination of Medicare with the Plan. (See also Question and Answer III.5 and III.7.) See the booklets or the Employer for more information.

**7. If an individual is Medicare eligible, when is Medicare the secondary payer?**

Medicare generally will be the **secondary payer** of medical benefits (and the Plan will be **primary**) for individuals in the following categories:

- Certain individuals with end stage renal disease prior to 30 months of coverage;
- Certain disabled individuals who are covered because of the individual's (or a family member's) current employment status; or
- Certain individuals (age 65 or older) who are Medicare eligible and are working as employees or are active directors (or certain dependents of such employees or directors) (see Appendix E or D, if applicable) under a plan sponsored by an employer that has not qualified for (or if qualified, has not made the Small Employer Election). See Section II to determine whether the Employer has made the Small Employer Election. This information may change from time to time so check with the Employer for current information.

Note that not every situation has been addressed and that the rules determining who falls into the above categories can be complex. See the Employer for more information.

These are only general guidelines on coordination of Medicare with the Plan. (See also Question and Answer III.5 and III.6.) See the booklets or the Employer for more information.

**8. Does eligibility for Medicare Part D affect benefits?**

Eligibility for Medicare Part D may affect certain benefits under the Plan. Contact the Plan Sponsor for more information.

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## IV. OTHER INFORMATION ABOUT THE PLAN

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### A. ENDING PARTICIPATION

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**1. When will my participation in the Plan or in a benefit end?**

Participation will end if:

- You no longer meet the eligibility requirements for that benefit;
- To the extent allowed by law, if you do not make contributions for that benefit required under the Plan;
- Your hours drop below any required hourly threshold;
- To the extent allowed by law (and if not otherwise limited or addressed the booklet for a benefit), you submit false claims; or
- For any other reason as set forth in the booklets for a benefit.

See Section IV.B and booklets for information about leaves of absence. See Appendices E, R, and D and booklets about termination events for more information.

Participation also will end if the Plan is terminated. Participation in a particular benefit also will end if that benefit is terminated.

You may be entitled to continue to participate in one or more of the group health benefits pursuant to any rights you have under COBRA, as explained in Appendix C. The right to convert to a personal policy, if applicable, is addressed in the booklets.

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## **B. FAMILY, MEDICAL, OR UNIFORMED SERVICES LEAVE AND COURT ORDERS**

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### **1. What happens to my benefits if I go on family and medical leave?**

If you go on a family or medical leave that is subject to the Federal Family and Medical Leave Act of 1993 ("FMLA") or, in some cases, similar state laws, you have certain rights to continue coverage of health benefits.

If an employee goes on a leave of absence that is not an FMLA leave (or uniformed services leave (see Question and Answer IV.B.2)), the employee will be treated as having terminated participation unless otherwise permitted under the policies. If an employee goes on an FMLA leave (or uniformed services leave (see also Question and Answer IV.B.2)):

- Benefits other than "group health benefits" are provided 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
- For group health benefits, the employee can choose to have the Employer continue to maintain the employee's health benefits coverage 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.

An employee on FMLA leave will be considered to have terminated employment with the Employer on the earliest to occur of:

- 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);
- The date the employee notifies the Employer of his or her intent not to return to employment; or
- 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.

The Plan's FMLA procedures will comply with any additional requirements mandated by applicable law. Contact the Employer to determine whether FMLA applies.

**2. What happens to my benefits if I go on military leave?**

If you leave work for military duty in the uniformed services that is covered under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), then you have certain rights under the Plan.

In general, you may make the same type of elections as described in Section IV.B.1 for FMLA leave. If you are on a uniformed services leave, you and your spouse and dependents have a right to elect coverage of the lesser of: 24 months of continuation coverage of group health benefits under the Plan to the extent required by law, beginning on the date the uniformed services leave begins; or the period ending on the date you fail to apply for or return to active employment with the Employer. (24 months applies to elections for such continuation coverage made on and after December 10, 2004; see the Employer for information regarding prior elections.)

Generally, a person who elects to continue coverage under USERRA leave may be required to pay up to 102 percent of the full premium under the Plan. However, if you are on leave for less than 31 days, such person will pay only the employee share, if any, for such coverage.

While on uniformed services leave, you generally are entitled to non-health benefits on the same terms and on the same basis as those benefits are offered to other employees on a leave of absence.

The Plan will comply with any requirements under USERRA or other Federal laws relating to military service to the extent required by those laws. If you go on military duty, please see the Plan Administrator for more information.

**3. How can a Qualified Medical Child Support Order affect my benefits?**

You may be required to modify your elections under the health benefits subject to these orders, including to continue participation, in order to provide coverage for your child pursuant to an order issued by a court, or a notice issued by certain state agencies, that qualifies as a Qualified Medical Child Support Order ("QMSCO"). You will be notified if the Plan Administrator receives such an order affecting your group health benefit participation. The Plan has detailed procedures for determining whether an order qualifies as a QMSCO. Participants may obtain, without charge, a copy of such procedures from the Plan Administrator.

**C. CONTINUATION OF COVERAGE AFTER THE  
OCCURRENCE OF CERTAIN EVENTS THAT CAUSE  
LOSS OF GROUP HEALTH COVERAGE UNDER THE PLAN**

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See Appendix C for important COBRA continuation coverage information if you have health, dental, or vision coverage.

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**D. PLAN AMENDMENT OR TERMINATION**

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**1. How and when can the Plan be terminated or amended?**

The Plan Sponsor reserves the right to discontinue the Plan or any benefits at any time, subject to certain restrictions. The Plan Sponsor also has the ability to amend certain provisions of the Plan at any time. Such actions will be approved by written resolution of the Employer's governing body, or by such other person or persons authorized by the governing body to take such actions. Amendments will be signed on behalf of the Employer and will be effective as of the dates specified in the amendment. Amendments may include retroactive effective dates to the extent allowed by law. However no amendment will deprive any participant or beneficiary of any right to which he or she is entitled under the affected benefits with respect to contributions previously made or provide for use of funds or assets other than for the benefit of employees and beneficiaries except as may be allowed by law or regulation. Neither the Employer nor any of its employees will have any further financial obligations hereunder from and after termination of any of the benefits except with respect to obligations that have accrued up to the date of termination which have not been satisfied. You will be notified of any such change.

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 nor does the Plan Sponsor need to reexecute its Plan document with respect to such an amendment. The Trust will provide each Plan Sponsor a copy of the amended Plan document (either by providing substitute or additional pages, or by providing a restated document.)

**2. Are there other circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of benefits that I might otherwise reasonably expect to receive from the Plan?**

Yes. Besides those circumstances mentioned above, some examples would be:

- If you were found to be ineligible to participate in a benefit under the Plan, you would be ineligible for that benefit (see Section III, the Appendices, and booklets for more information on participation);
- Mistakes by the Employer or Plan Administrator with respect to your eligibility, contribution, reimbursement or other aspects of the Plan, will be corrected as allowed by law; this may result, for example, in your return of an overpayment from the Plan and/or adjustment of your benefits (see Section IV.F and booklets for more information);
- If your claim for benefits is denied, your reimbursement may be affected (see Section V and booklets for claims procedures); or
- If benefits are to be paid to you, but you cannot be located after reasonable efforts, the benefits may be forfeited.

There may be other circumstances which could affect the benefits you might expect to receive. If you have any questions on the above circumstances or on a specific situation not mentioned here, please consult the booklets or see the Plan Administrator.

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## E. HIPAA

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### 1. HIPAA Notice of Preexisting Condition Exclusion

The medical benefits offered under this summary may contain direct restrictions based on preexisting conditions. The existence and terms of any preexisting condition exclusion, if any, and your right to demonstrate creditable coverage and any applicable waiting periods will be covered under the terms of the policy covering that benefit. You may request a Certificate of Creditable Coverage from a prior plan or insurer/HMO if necessary under such prior underlying health plan. The Plan (or insurer/HMO of underlying benefits) will assist in obtaining a certificate from any prior plan or insurer/HMO, if necessary.

### 2. Does HIPAA apply?

HIPAA ("Health Insurance Portability and Accountability Act of 1996") includes rights to special enrollment, preexisting condition exclusion limitations, participation due to special enrollment rights in a different health plan, and certificates of creditable coverage. References to these rights in this Summary generally apply only to medical group health benefits.

**3. What is the HIPAA procedure for requesting a Certificate of Creditable Coverage?**

If HIPAA applies and your coverage ceases, you automatically will be issued a Certificate of Creditable Coverage by the applicable health insurance insurer or HMO, as appropriate. Also, if HIPAA applies, you or someone on your behalf may request a certificate within 24 months after coverage ends. A request must be accompanied by a written authorization if not made by you personally. See Question and Answer IV.E.2 for information about which benefits may be covered. Please direct requests to the insurer or HMO.

**4. HIPAA Notice of Alternative Method**

In the event HIPAA applies, please consult the booklets for the applicable benefit documents to determine whether the "regular" method (instead of the "alternative") is used. If a booklet is silent as to the method used, the regular method is used. (The "regular" method reports creditable coverage based on all types of coverage. The "alternative" method requires reporting creditable coverage separately for mental health, dental, vision, prescription drug and substance abuse treatment coverages.)

**5. What HIPAA privacy rights apply?**

Under another provision of HIPAA, plans offering group health benefits are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice from the Employer (or insurers or the Trust) that outlines its health privacy policies. The Plan may make a HIPAA "hybrid entity" election which allows it to separate group health plan benefits and non-group health plan benefits for HIPAA privacy purposes. See the Plan Sponsor or Employer for information on whether a hybrid entity election has been made. This Question and Answer is effective as of the later of April 14, 2004, or the date of adoption of the group health benefits under the Plan.

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**F. MISCELLANEOUS PROVISIONS**

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**1. Am I guaranteed employment due to my participation in the Plan?**

No. Participation in the Plan is not a guarantee of employment. However, the Employer may not fire you or discriminate against you to prevent you from becoming eligible for the Plan or from obtaining a benefit or exercising your rights under ERISA.

**2. Can I assign my benefits?**

You cannot assign your benefits under the Plan to anyone else except as permitted in the life insurance booklet. However, your benefits and coverage under the Plan may be assigned to another person providing coverage to your child pursuant to a court order that qualifies as a **Qualified Medical Child Support Order**. See Section IV.B.

**3. What if the Plan cannot locate a payee?**

If the Plan Administrator 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 will be forfeited following a reasonable time (as determined by the Plan Administrator) after the date any such payment first became due.

**4. What if a mistake is made?**

The Plan Administrator will be entitled to take certain actions in the event of a mistake as to the eligibility or participation of an employee or other individual, or the amount of benefits paid or to be paid to a participant or other person. To the extent the Plan Administrator deems it administratively possible and permissible under law, it will 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, to the extent allowed by law.

**5. Who is the Named Fiduciary and what does that mean?**

To the extent ERISA applies, the Plan Administrator and the insurer are the "named fiduciaries" of the Plan in accordance with ERISA Section 402(a), and as such are responsible for different aspects of the operation of the Plan for the covered employees. The insurance companies for the respective benefits are responsible for (a) determining eligibility for and the amount of any benefits payable under their respective benefits, and (b) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefits. Except as delegated to the insurers, the Plan Administrator has full and complete authority, responsibility, discretion and control over the management, administration, and operation of the Plan, including, but not limited to, formulation, adoption, issuance and application of procedures and rules, and change, alteration or amendment of such procedures and rules in accordance with the law, interpretation and application of the provisions of the Plan, and determinations concerning eligibility for benefits.

Subject to your rights explained in Section VI, the Plan Administrator's determinations will be final, conclusive and binding on all parties as to all aspects of the Plan, including any portion of the Plan not governed by ERISA. If you have any questions regarding your eligibility for, or the

amount of, any benefit payable under the insured benefit policies, please contact the appropriate insurer/HMO.

The Wisconsin Bankers Association and Wisconsin Bankers Association Employee Benefits Corporation, Inc. are not fiduciaries with respect to the Plan.

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## **V. CLAIMS AND REVIEW PROCEDURE**

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### **A. GENERAL INFORMATION**

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The booklet for a specific benefit should be examined for the requirements as to notice and the presentation of proof of claim to the insurer and for claims and review procedures. Contact the insurer for information on how to file.

For purposes of the determination of the amount of, and entitlement to, benefits provided under the booklets, the respective insurer or HMO is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance or HMO contract.

To obtain benefits from the insurer of a particular benefit, you must follow the claims procedures under the applicable booklet, which may require you to complete, sign and submit a written claim on the insurer's form. In that case, the form is available from the insurer or HMO.

The insurer or HMO will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurer or HMO has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim.

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### **B. CLAIMS PROCEDURES/LEGAL ACTIONS**

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#### **1. What if the procedures are not followed in processing my claim?**

In case of your failure to follow claim procedures consistent with Federal requirements with respect to a benefit governed by ERISA, you would not be entitled to pursue any available remedies under an action under ERISA Section 502(a). For example, no action at law or in equity may be brought to recover benefits under the Plan until the appeal rights described in Section V.A

have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part.

In case of the failure of the Plan to follow claim procedures consistent with Federal requirements in processing your claim, you may be entitled to pursue any available remedies under an action under ERISA Section 502(a).

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## **VI. STATEMENT OF ERISA RIGHTS**

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This Statement of ERISA supercedes any Statement of ERISA Rights in booklets. To the extent that ERISA applies to the Plan, participants in the Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

**1. Receive Information About Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, if applicable, all documents governing the Plan, including insurance contracts, if applicable, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, if applicable, and copies of the latest annual report (Form 5500 Series), if any, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. When applicable, the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**2. Continue Group Health Plan Coverage**

- If applicable, continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description (see, e.g., Appendix C) and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions, if applicable, under your group health plan, if you have creditable coverage from another

plan. To the extent a plan benefit is subject to HIPAA requirements, you should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer (e.g., insurer or HMO) when you lose coverage under such plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion, to the extent provided for under the Plan benefit, for 12 months (18 months for late enrollees) (or such lesser periods of time as provided in the policy for the benefit) after your enrollment date in your coverage.

### **3. Prudent Actions By Plan Fiduciaries**

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

### **4. Enforce Your Rights**

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Except as precluded by law, the Claims and Review Procedure in Section V of this Summary describes steps that must be exhausted prior to your filing suit in a court.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report, if any, from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**5. Assistance With Your Questions**

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

**ATTACHMENT TO THE  
SUMMARY PLAN DESCRIPTION OF THE WELFARE BENEFIT PLAN OF  
\_\_\_\_\_ ("PLAN SPONSOR")**

**List of Related Employers (Other Than Plan Sponsor) Maintaining the Plan**

Name:

Address

Federal Employer I.D. Number:

Telephone Number:

Name:

Address:

Federal Employer I.D. Number.

Telephone Number:

Name:

Address:

Federal Employer I.D. Number:

Telephone Number:

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**APPENDIX C TO SUMMARY PLAN DESCRIPTION**  
**(See Separate Form)**

**APPENDIX C TO SUMMARY PLAN DESCRIPTION  
CONTINUATION OF COVERAGE AFTER THE  
OCCURRENCE OF CERTAIN EVENTS THAT CAUSE  
LOSS OF GROUP HEALTH COVERAGE UNDER THE PLAN**

**This Appendix C is a part of the Summary Plan Description. Cross-references in this Appendix C to the main body of the Summary Plan Description are identified with a Roman numeral.**

**1. Introduction to COBRA Continuation Coverage**

**The following information about your right to continue your medical, dental, or vision benefits coverage (as applicable) in the Plan is important. Please read it very carefully.**

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage otherwise would end. **This Appendix C generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you otherwise would lose your group health coverage under the Plan. It also can become available to your spouse and dependent children, if they are covered under the Plan, when they otherwise would lose their group health coverage under the Plan.

The Plan Administrator will determine the extent to which COBRA may apply, within the terms of the Plan. Please contact the Plan Administrator for more details.

**2. What benefits under the Plan and what Employers are subject to COBRA continuation coverage?**

COBRA applies to your medical, dental, and/or vision benefits. It does not cover life insurance, dependent life insurance, accidental death and dismemberment, short term disability, or long term disability benefits, except to the extent that such benefits may provide benefits for medical care subject to COBRA, if any. The Plan's continuation coverage procedures will comply with any additional requirements that may be mandated by applicable law.

COBRA does not apply to Employers with less than 20 employees as determined under the regulations; however, the equivalent of Federal coverage shall be provided regardless of the Federal 20 employee threshold. Employers with less than 20 employees that offer the equivalent of COBRA continuation coverage, shall not be subject to COBRA penalties or requirements. Except as stated with respect to the 20 employee threshold and otherwise specified in this document, the Plan provides no greater COBRA rights than what COBRA requires - nothing in this Summary Plan Description is intended to expand your rights beyond COBRA's requirements. Participants, spouses, or dependents may contact the Employer to see if COBRA applies to them.

**3. What is "COBRA continuation coverage"?**

COBRA continuation coverage is a continuation of the benefit coverage under the Plan when coverage otherwise would end because of a life event known as a "**qualifying event.**" Specific qualifying events are listed in Question and Answer 6.

After a qualifying event occurs and any required notice of that event is properly provided to the Employer, COBRA continuation coverage must be offered to each person losing coverage for that benefit who is a "qualified beneficiary."

**4. Who is a "qualified beneficiary" eligible for continuation coverage under COBRA?**

Continuation coverage under COBRA only is available for "**qualified beneficiaries.**" A covered employee, spouse, and dependent children could become qualified beneficiaries and would be entitled to elect COBRA if benefit coverage under the Plan is lost because of the qualifying event (defined in Question and Answer 6). The term "covered employee" can include non-employee Directors, if Director coverage is offered by the Employer, and retirees, if Retiree coverage is offered by the Employer. (See Appendices D and R as applicable for more information on Director and Retiree coverage.)

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA continuation coverage for himself or herself. The child's COBRA continuation coverage begins when the child is enrolled in the benefit under the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA continuation coverage lasts for other family members of the employee. To be enrolled in benefits in the Plan, the child must satisfy the otherwise applicable benefit eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order ("QMCSO") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

**5. How does COBRA continuation coverage compare to my current coverage and who pays for it?**

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under that benefit under the Plan who are not receiving COBRA continuation coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan with respect to the elected benefit as other participants or beneficiaries covered under that benefit under the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. If coverage is modified for similarly-situated participants, then COBRA continuation coverage will be modified in the same way.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

## **6. What are a qualifying events?**

If you are an **employee**, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the **spouse** of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Under COBRA, Medicare "entitlement" means that a person who is eligible for Medicare actually has become enrolled in Medicare.

If you are the **dependent child** of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your parent-employee dies;
- Your parent-employee's hours of employment are reduced;
- Your parent-employee's employment ends for any reason other than his or her gross misconduct;
- Your parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- Your parents become divorced or legally separated; or

- You stop being eligible for coverage under the benefit in the Plan as a "dependent child."

Sometimes, filing a proceeding in **bankruptcy** under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children also will become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan or coverage is substantially reduced within one year before or after the Employer's bankruptcy.

## **7. When does FMLA leave or military leave result in a COBRA election?**

If an employee takes FMLA leave and does not return to work at the end of the FMLA leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA continuation coverage at the end of the FMLA leave, for a benefit under the Plan:

- If they were covered for that benefit under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and
- If they will lose coverage for that benefit under the Plan within 18 months of and due to the employee's failure to return to work. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered for that benefit under the Plan during the leave provided they were covered for the benefit on the day before the day the leave began.)

COBRA continuation coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. See Questions and Answers 23 and IV.B.1.

See Section IV.B.2 or the Plan Administrator for information about military leave.

## **8. How does trade adjustment assistance affect COBRA elections?**

Special COBRA election rights apply to individuals eligible for certain payments (including eligible alternative recipients) under the Trade Act of 1974 who lost group health plan coverage due to a job loss. These individuals are entitled to a second opportunity to elect COBRA continuation coverage (if they did not already elect COBRA continuation coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which the individual becomes eligible for the trade adjustment assistance, but only if the election is made within the 6 months immediately after the individual's group health plan coverage ended. If you qualify or may qualify, contact the Employer using the Plan contact information provided in Question and Answer 29. **Contact the Employer promptly after qualifying or you will lose the right to elect COBRA during a special second election period.**

**9. When is COBRA continuation coverage available and who must give notice of qualifying events?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries **only after proper notice has been provided** to the Plan Administrator.

- **Employer Notice to the Plan Administrator:** When the qualifying event is the **end of employment (other than for gross misconduct), reduction of hours of employment, or death of the employee; the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both); or the commencement of a proceeding in bankruptcy with respect to the Employer**, the Employer must notify the Plan Administrator of the qualifying event. The qualified beneficiaries will be notified of the right to elect COBRA continuation coverage. You need not notify the Employer of any of these qualifying events.
  
- **You Must Give Notice of Some Qualifying Events:** When the qualifying event is **divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child**, a COBRA election will be available to you only if you (the employee or the qualified beneficiary) notify the Employer in writing within 60 days after the later of:
  - The date of the qualifying event; and
  - The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

**Note:** You may have additional notification obligations, e.g., if certain qualifying events occur after you have elected COBRA continuation coverage. See the discussion at Questions and Answers 24 and 25.

**10. What steps must I follow in giving notice of a qualifying event?**

In providing notice of a qualifying event, you must use the Plan's form "**Notice of Qualifying Event**," and you must follow the procedures specified in the Question and Answer 29. If these procedures are not followed or if the notice is not provided in writing to the Employer during the 60-day notice period, **you will lose your right to elect COBRA**. You may obtain a copy of the form from the Employer.

**11. How is COBRA continuation coverage provided and do qualified beneficiaries have an independent right to elect coverage?**

Once the Plan Administrator receives notice that a qualifying event has occurred, any applicable COBRA continuation coverage will be offered to each of the qualified beneficiaries. The length of the coverage varies depending upon the individual's situation. Important information on the length of the coverage is provided in the Questions and Answers that follow in this Appendix C.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's spouse may elect COBRA even if the employee does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children.

Any qualified beneficiary for whom **COBRA is not elected within the 60-day election period** specified in the Plan's COBRA election notice **will lose his or her right to elect COBRA continuation coverage.**

**12. If I am enrolled in one or more group health benefits, what coverages are available?**

If you or your eligible family members qualify for such continuation coverage, the medical, dental, and vision benefits will be treated as separate coverages for purposes of COBRA. Accordingly, as an example, assume an employer offers medical, dental, and vision benefits, and at the time of the qualifying event, an active employee had elected both medical and dental coverage, but not vision coverage. Under COBRA, the employee may be able to elect to continue coverage for either medical or dental coverage or both, but cannot elect vision coverage.

**13. What if I have other group health coverage or am entitled to Medicare?**

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits (Part A, Part B, or both) on or before the date on which COBRA is elected. Under COBRA, Medicare "entitlement" means that a person who is eligible for Medicare actually has become enrolled in Medicare. Note that it is important to enroll in Medicare Parts A and B to avoid gaps in coverage. Continuation coverage is provided secondary to Medicare unless otherwise required by law. However, as discussed in more detail in Question and Answer 25, a qualified beneficiary's COBRA continuation coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits (with respect to medical benefits) or becomes covered under other group health plan coverage for a benefit (medical, dental, or vision) covered under COBRA (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**14. What notification obligations arise if a qualified beneficiary becomes entitled to Medicare?**

When you complete the **Election Form**, you must notify the Employer if any qualified beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the **Election Form**, immediately notify the Employer of the date of your Medicare entitlement in writing at the address and in the manner specified in Question and Answer 17 for submission of the **Election Form**.

**15. What steps are required to elect COBRA continuation coverage?**

To elect COBRA, you or the qualified beneficiary must complete the **Election Form** that is part of the Plan's COBRA election notice and submit it to the Employer. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You or other qualified beneficiaries also may obtain a copy of the **Election Form** from the Employer.

**16. How much time is allowed to make the COBRA continuation coverage election?**

Under Federal law, a qualifying beneficiary must have **60 days** after the date of the COBRA election notice provided at the time of the qualifying event to decide whether to elect COBRA under the Plan.

**17. How is the COBRA continuation coverage Election Form completed and submitted?**

The qualified beneficiary must mail, fax (if the Employer has provided a fax number in Section II.A), or hand deliver the completed **Election Form** to:

- Human Resources Department, Employer (see Section II.A for Employer address and, if provided, fax number).

The Election Form must be completed in writing. The following are **not** acceptable as COBRA elections and will **not** preserve COBRA rights:

- Oral communications regarding COBRA continuation coverage, including in-person or telephone statements about an individual's COBRA continuation coverage; and
- Electronic communications, including e-mail. (See Section II.A to see if faxed communications are allowed.)

If mailed, your election must be postmarked; if faxed (if the Employer has provided a fax number in Section II.A), your election must be electronically transmitted; and if hand-delivered, your election must be received by the individual at the address specified above, no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event or, if later, no later than 60 days after the date that the benefit coverage terminates. **If you do not submit a completed election form by this due date, you will lose your right to elect COBRA.**

**18. What if I file an Election Form rejecting COBRA, but later change my mind?**

If you reject COBRA before the due date, you may change your mind as long as you furnish a revised completed **Election Form** before the due date. However, COBRA continuation coverage will not be provided retroactively. In such a case, COBRA continuation coverage will be provided only from the date the waiver is revoked. Thus, for example, the qualified beneficiary may have

a gap in coverage between the date that Plan coverage is lost due to a qualifying event and the date the waiver is revoked and COBRA continuation coverage becomes effective.

Also, note that the maximum length of COBRA continuation coverage generally may be shorter in the event COBRA continuation coverage is elected after revocation of a waiver since the coverage periods typically are measured from the later of the date of the qualifying event or the date of the loss of coverage, and not the date of the waiver. (Note: for qualifying events occurring prior to October 1, 2005, the coverage period typically was measured from the date of the qualifying event.) See the Employer for more information.

**19. Do I have to send payments with my COBRA continuation coverage Election Form?**

No. You do not have to send any payment with your **Election Form** when you elect COBRA. Important additional information about payment for COBRA continuation coverage is included in other Questions and Answers in this Appendix C.

**20. If I decide not to elect COBRA, could this affect my future rights?**

Yes. In considering whether to elect COBRA, you should take into account that a failure to elect COBRA may affect your future rights under Federal law. Some special considerations include the following:

- You can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA may help you not have such a gap.
- You can lose the Federal guaranteed conversion rights to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you.

You should take into account that you may have special enrollment rights under Federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed in Question and Answer 6. You also may have the same special enrollment right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

As a general matter, these Federal rights may apply only to medical benefits offered under this Appendix. See Section IV.E of the Summary Plan Description for more information.

**21. What is the cost of COBRA continuation coverage?**

Each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage as

determined by the Plan Administrator, in accordance with applicable law. The Employer may charge an administrative fee in addition to the amount of the required contribution. However, the amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA continuation coverage due to a disability, 150 percent) of the cost of the group health benefit (including both Employer and employee contributions) for coverage of a similarly situated participant or beneficiary who is not receiving such COBRA continuation coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA continuation coverage and will most likely increase over time. You will be notified of COBRA premium changes.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("eligible individuals"). Under the new tax provisions, eligible individuals can take a tax credit equal to 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act also is available at [www.doleta.gov/tradeact/2002act\\_index.asp](http://www.doleta.gov/tradeact/2002act_index.asp).

## **22. How is payment made for COBRA continuation coverage?**

**(a) General.** All COBRA premiums must be paid by check, unless otherwise allowed by the Employer in Section II.A. Your first payment and all monthly payments for COBRA continuation coverage must be mailed or hand-delivered (unless otherwise allowed under Section II.A) to:

- Human Resources Department, Employer (see Section II.A for Employer address).

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified in the bullet above. You will not be considered to have made any payment by mailing or hand delivering a check or by other method if allowed under Section II.A if your check is returned due to insufficient funds or your payment otherwise is not made.

**(b) First Payment.** If you elect COBRA, you do not have to send any payment with the **Election Form**. However, you must make your first payment for COBRA continuation coverage not later than 45 days after the date of your election. (The date of your election, if mailed, is the date your **Election Form** is postmarked; if the **Election Form** is faxed (if the Employer has provided a fax number in Section II.A), the date it is electronically transmitted; or if hand-delivered, the date your **Election Form** is received by the individual at the address specified for delivery of the **Election Form**.) See Question and Answer 17.

Your first payment must cover the cost of COBRA continuation coverage from the time your coverage under the Plan otherwise would have terminated up through the end of the month before the month in which you make your first payment.

**Example:** Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.

You are responsible for making sure that the amount of your first payment is correct. You may contact the Employer using the contact information provided in Question and Answer 28 to confirm the correct amount of your first payment. Claims for reimbursement under indemnity or reimbursement arrangement benefits will not be processed or paid prior to the time you have elected COBRA and made the first payment for it. If benefits are provided under a health option that provides health services within the meaning of the COBRA regulations, use of the facility will be deemed a constructive COBRA election unless otherwise provided.

If you do not make your first payment for COBRA continuation coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

**(c) Monthly Payments.** After you make your first payment for COBRA continuation coverage, you will be required to make monthly payments for each subsequent month of COBRA continuation coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event.

Under the Plan, each of these monthly payments for COBRA continuation coverage is due on the first day of the month for that month's COBRA continuation coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA continuation coverage under the Plan will continue for that month without any break. The Employer will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill to you for your COBRA continuation coverage - it is your responsibility to pay your COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA continuation coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA continuation coverage under the Plan.

### 23. How long does COBRA continuation coverage last?

COBRA continuation coverage is a temporary continuation of coverage. The COBRA continuation coverage periods described in this Question and Answer are maximum coverage periods. COBRA continuation coverage can end before the end of the maximum coverage period for several reasons, which are described in Question and Answer 25.

- **36 months:** When benefit coverage under the Plan is lost due to a qualifying event that is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage **for qualified beneficiaries other than the employee** generally can last for **up to a total of 36 months** from the later of the date of the qualifying event or the date of loss of coverage due to such qualifying event. (Note: for qualifying events occurring prior to October 1, 2005, the coverage period generally was measured from the date of the qualifying event.)
- **18 months extended 36 months:** When benefit coverage under the Plan is lost due to a qualifying event that is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits **before the later of the date of the qualifying event or the date of loss of coverage due to such qualifying event**, COBRA continuation coverage **for qualified beneficiaries other than the employee** who lose coverage as a result of the qualifying event generally can last until **the later of: up to 36 months after the date of the employee's Medicare entitlement;** or up to 18 months after the later of the date of the qualifying event or the date of loss of coverage due to such qualifying event.

**Example:** An Employer offers medical benefits. If a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates (assume that coverage is lost on the same date employment terminates), COBRA continuation coverage under the Plan's medical benefits for his spouse and children who lost coverage as a result of his termination of employment can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event/loss of coverage (36 months minus 8 months).

This COBRA continuation coverage period generally is available **only if the covered employee becomes entitled to Medicare within 18 months before the termination or reduction of hours/loss of coverage.**

- **18 months:** When benefit coverage under the Plan is lost due to the end of employment (other than for gross misconduct) or reduction of the employee's hours of employment, COBRA continuation coverage generally can last for only **up to a total of 18 months** from the later of the date of the qualifying event or the date of loss of coverage due to such qualifying event. See Question and Answer 24 for information on extensions of the 18-

month period. (Note: for qualifying events occurring prior to October 1, 2005, the coverage period generally was measured from the date of the qualifying event.)

#### **24. When can there be an extension of the maximum coverage period?**

**(a) General.** If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is **disabled** or a **second qualifying event occurs**. You must notify the Employer of a disability or a second qualifying event in order to extend the period of COBRA continuation coverage.

Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA continuation coverage. (These extension opportunities do not apply to a period of COBRA continuation coverage resulting from other qualifying events, such as, but not limited to, a covered employee's death, divorce, or legal separation or a dependent child's loss of eligibility.)

**(b) Disability Extension.** If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA continuation coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the period of COBRA continuation coverage that would be available without the disability extension (generally 18 months, as described in Question and Answer 23). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the Employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage for the benefit under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You also must provide this notice before the end of the initial (18-month) period of COBRA continuation coverage in order to be entitled to a disability extension.

In providing this notice, you must use the Plan's form "**Notice of Disability**" and you must follow the procedures specified in Question and Answer 29. If these procedures are not followed or if

the notice is not provided in writing to the Employer during the 60-day notice period and before the end of the initial (18-month) period of COBRA continuation coverage, **then there will be no disability extension of COBRA continuation coverage.** You may obtain a copy of the form from the Employer.

**(c) Second Qualifying Event Extension.** An extension of coverage will be available to spouses and dependent children who are receiving COBRA continuation coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the later of the covered employee's termination of employment or reduction of hours or loss of coverage due to such qualifying event. The maximum amount of COBRA continuation coverage available when a second qualifying event occurs is 36 months.

Such second qualifying events may include the death of a covered employee, divorce, or legal separation from the covered employee, the employee becomes entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan, but do not include a bankruptcy qualifying event. The eligible events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

This extension due to a second qualifying event is available only if you notify the Employer in writing of the second qualifying event within 60 days after the later of:

- The date of the second qualifying event; and
- The date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

In providing this notice, you must use the Plan's form "**Notice of Second Qualifying Event**" and you must follow the procedures specified in Question and Answer 29. If these procedures are not followed or if the notice is not provided in writing to the Employer during the 60-day notice period, **then there will be no extension of COBRA continuation coverage due to a second qualifying event.** You may obtain a copy of the form from the Employer.

**25. When can COBRA continuation coverage terminate before the end of the maximum coverage period?**

COBRA continuation coverage will automatically terminate for a benefit before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan for the benefit (medical, dental, or vision) covered under COBRA (but only after any preexisting condition exclusions of that other plan for a preexisting condition of

the qualified beneficiary have been exhausted or satisfied). If the other plan has applicable exclusions, then your COBRA continuation coverage will terminate after the exclusion no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan;

- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA for medical benefits. This will apply only to the person who becomes entitled to Medicare;
- The Employer ceases to provide any group health coverage for its employees; or
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see Question and Answer 24.

COBRA continuation coverage also may be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

You must notify the Employer in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). You must use the Plan's form "**Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability**," and you must follow the procedures specified in Question and Answer 29. You may obtain a copy of the form from the Employer.

COBRA continuation coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement (with respect to medical benefits) or as of the beginning date of the other group health coverage for a benefit (medical, dental, or vision) covered under COBRA (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Employer (or its designee) will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the Employer of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Employer of that fact within 30 days after the Social Security Administration's determination. You must use the Plan's form "**Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability**," and you must follow the procedures specified in Question and Answer 29. You may obtain a copy of the form from the Employer.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA continuation coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month

that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. The Employer (or its designee) will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the Employer that the disabled qualified beneficiary is no longer disabled. For more information about the disability extension period, see Question and Answer 24.

**26. What if I have other questions?**

Questions concerning your Plan or your COBRA rights should be addressed to the contact identified in Question and Answer 28. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

**27. Am I required to keep the Plan informed of address changes?**

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

**28. What is the Plan contact information?**

You may obtain information about the Plan and COBRA continuation coverage on request from:

- Human Resources Department, Employer (see Section II.A for address, telephone number and, if provided, fax number of Employer).

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent summary plan description (if you are not sure whether this is the Plan's most recent summary plan description, you may request the most recent one from the Employer).

**29. What are the Notice Procedures for the Plan?**

The following are the **Notice Procedures** that apply to the Plan.

**COBRA CONTINUATION COVERAGE NOTICE PROCEDURES**

**(a) Notice Procedures for Notice of Qualifying Event**

- (1) Deadline.** The deadline for providing this notice is 60 days after the later of:

- The qualifying event (that is, a divorce or legal separation or a child's loss of dependent status); and
- The date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the qualifying event.

**(2) Delivery.** You must mail, fax (if the Employer has provided a fax number in Section II.A), or hand deliver this notice to:

- Human Resources Department, Employer (see Section II.A for Employer address and, if provided, fax number).

Your notice must be in writing (using the Plan's form described in Question and Answer 29(a)(3)) and must be mailed, faxed (if the Employer has provided a fax number in Section II.A), or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Faxed notices are not acceptable unless the Employer has provided a fax number in Section II.A. Other electronic (including e-mailed) notices are not acceptable.

If mailed, your notice must be postmarked no later than the deadline described in Question and Answer 29(a)(1). If faxes are allowed (see above), your faxed notice must be electronically transmitted no later than the deadline described in Question and Answer 29(a)(1). If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described in Question and Answer 29(a)(1).

**(3) Required Form and Information.** You must use the Plan's form "Notice of Qualifying Event" to notify the Employer of a qualifying event (that is, a divorce or legal separation or a child's loss of dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the form from the Employer.)

Your notice must contain the following information:

- The name of the Plan (Welfare Benefit Plan of (specify your Employer));
- The name and address of the employee or former employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the qualifying event (divorce, legal separation, or child's loss of dependent status);
- The qualifying event (divorce, legal separation, or child's loss of dependent status);
- The date that the divorce, legal separation, or child's loss of dependent status happened; and
- The signature, name, and contact information of the individual sending the notice.

If you are notifying the Employer of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and you are notifying the Employer that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, you must provide notice within 60 days of the divorce or legal separation in accordance with these **Notice Procedures for Notice of Qualifying Event** and must in addition provide evidence satisfactory to the Employer that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

If you provide a written notice that does not contain all of the information and documentation required by these **Notice Procedures for Notice of Qualifying Event**, such a notice will nevertheless be considered timely if all of the following conditions are met:

- The notice is mailed, faxed (if the Employer has provided a fax number in Section II.A), or hand-delivered to the individual and address specified in Question and Answer 29(a)(2);
- The notice is provided by the deadline described in Question and Answer 29(a)(1);
- From the written notice provided, the Employer is able to determine that the notice relates to the Plan;
- From the written notice provided, the Employer is able to identify the covered employee and qualified beneficiary(ies), the qualifying event (the divorce, legal separation, or child's loss of dependent status), and the date on which the qualifying event occurred; and
- The notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these **Notice Procedures for Notice of Qualifying Event**) within 15 business days after a written or oral request from the Employer for more information (or, if later, by the deadline for the **Notice of Qualifying Event** described in Question and Answer 29(a)(1)).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

The covered employee (that is, the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

If your notice was regarding a child's loss of dependent status, you must, if the Employer requests it, provide documentation of the date of the qualifying event that is satisfactory to the Employer

(for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the Employer to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the Employer that the child ceased to be a dependent on the date specified in your **Notice of Qualifying Event**, his or her COBRA continuation coverage may be terminated (retroactively if applicable) as of the date that COBRA continuation coverage would have started. The Employer (or its designee) will require repayment to the Plan of all benefits paid after the termination date.

**(b) Notice Procedures for Notice of Disability**

**(1) Deadline.** The deadline for providing this notice is 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours.

Your **Notice of Disability** also must be provided before the end of the initial (18-month) period of COBRA continuation coverage.

**(2) Delivery.** You must mail, fax (if Employer has provided a fax number in Section II.A), or hand deliver this notice to:

- Human Resources Department, Employer (see Section II.A for the Employer address and, if provided, fax number).

Your notice must be in writing (using the Plan's form described in Question and Answer 29(b)(3)) and must be mailed, faxed (if Employer has provided a fax number in Section II.A), or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Faxed notices are not acceptable unless Employer has provided a fax number in Section II.A. Other electronic (including e-mailed) notices are not acceptable.

If mailed, your notice must be postmarked no later than the deadline described in Question and Answer 29(b)(1). If faxes are allowed (see above), your notice must be electronically transmitted no later than the deadline described in Question and Answer 29(b)(1). If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described in Question and Answer 29(b)(1).

**(3) Required Form and Information.** You must use the Plan's form "Notice of Disability" to notify the Employer of a qualified beneficiary's disability, and all of the applicable items on the form must be completed. (You may obtain a copy of the form from the Employer.)

Your notice must contain the following information:

- The name of the Plan (Welfare Benefit Plan of (specify your Employer));
- The name and address of the employee or former employee who is or was covered under the Plan;
- The initial qualifying event that started your COBRA continuation coverage (the covered employee's termination of employment or reduction of hours);
- The date that the covered employee's termination of employment or reduction of hours happened;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA continuation coverage at the time of the notice;
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary became disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name, and contact information of the individual sending the notice.

Your **Notice of Disability** must include a copy of the Social Security Administration's determination of disability.

If you provide a written notice to the Employer that does not contain all of the information and documentation required by these **Notice Procedures for Notice of Disability**, such a notice will nevertheless be considered timely if all of the following conditions are met:

- The notice is mailed, faxed (if the Employer has provided a fax number in Section II.A), or hand-delivered to the individual and address specified in Question and Answer 29(b)(2);
- The notice is provided by the deadline described in Question and Answer 29(b)(1);
- From the written notice provided, the Employer is able to determine that the notice relates to the Plan and a qualified beneficiary's disability;

- From the written notice provided, the Employer is able to identify the covered employee and qualified beneficiary(ies) and the date on which the covered employee's termination of employment or reduction of hours occurred; and
- The notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these **Notice Procedures for Notice of Disability**) within 15 business days after a written or oral request from the Employer for more information (or, if later, by the deadline for the **Notice of Disability** described in Question and Answer 29(b)(1)).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

The covered employee (that is, the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the covered employee's termination or reduction of hours and is still receiving COBRA continuation coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA continuation coverage period due to the disability reported in the notice.

**(c) Notice Procedures for Notice of Second Qualifying Event**

**(1) Deadline.** The deadline for providing this notice is 60 days after the later of:

- The date of the second qualifying event (that is, a divorce or legal separation, the covered employee's death, or a child's loss of dependent status); and
- The date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the second qualifying event (if this event had occurred while the qualified beneficiary was still covered under the Plan).

**(2) Delivery.** You must mail, fax (if the Employer has provided a fax number in Section II.A) or hand deliver this notice to:

- Human Resources Department, Employer (see Section II.A for the Employer address and, if provided, fax number).

Your notice must be in writing (using the Plan's form described in Question and Answer 29(c)(3)) and must be mailed, faxed (if Employer has provided a fax number in Section II.A), or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Faxed notices are not acceptable unless Employer has provided a fax number in Section II.A. Other electronic (including e-mailed) notices are not acceptable.

If mailed, your notice must be postmarked no later than the deadline described in Question and Answer 29(c)(1). If faxes are allowed (see above), your notice must be electronically transmitted no later than the deadline described in Question and Answer 29(c)(1). If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described in Question and Answer 29(c)(1).

**(3) Required Form and Information.** You must use the Plan's form "Notice of Second Qualifying Event" to notify the Employer of a second qualifying event (that is, a divorce or legal separation, the covered employee's death, or a child's loss of dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the form from the Employer).

Your notice must contain the following information:

- The name of the Plan (Welfare Benefit Plan of (specify your Employer));
- The name and address of the employee or former employee who is or was covered under the Plan;
- The initial qualifying event that started your COBRA continuation coverage (the covered employee's termination of employment or reduction of hours);
- The date that the covered employee's termination of employment or reduction of hours happened;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA continuation coverage at the time of the notice;
- The second qualifying event (a divorce or legal separation, the covered employee's death, or a child's loss of dependent status);
- The date that the divorce or legal separation, the covered employee's death, or a child's loss of dependent status happened; and
- The signature, name, and contact information of the individual sending the notice.

If you are notifying the Employer of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

If you provide a written notice to the Employer that does not contain all of the information and documentation required by these Notice Procedures for Notice Second Qualifying Event, such a notice will nevertheless be considered timely if all of the following conditions are met:

- The notice is mailed, faxed (if the Employer has provided a fax number in Section II.A), or hand-delivered to the individual and address specified in Question and Answer 29(b)(2);
- The notice is provided by the deadline described in Question and Answer 29(c)(1);
- From the written notice provided, the Employer is able to determine that the notice relates to the Plan;
- From the written notice provided, the Employer is able to identify the covered employee and qualified beneficiary(ies), the first qualifying event (the covered employee's termination of employment or reduction of hours), the date on which the first qualifying event occurred, the second qualifying event, and the date on which the second qualifying event occurred; and
- The notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these **Notice Procedures for Notice of Second Qualifying Event**) within 15 business days after a written or oral request from the Employer for more information (or, if later, by the deadline for this **Notice of Second Qualifying Event** described in Question and Answer 29(c)(1)).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

The covered employee (that is, the employee or former employee who is or was covered under the benefit under the Plan), a qualified beneficiary who lost coverage due to the covered employee's termination or reduction of hours and is still receiving COBRA continuation coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA continuation coverage period due to the second qualifying event reported in the notice.

**If your notice was regarding a child's loss of dependent status**, you must, if the Employer requests it, provide documentation of the date of the qualifying event that is satisfactory to the Employer (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the Employer to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA continuation coverage.

If you do not provide satisfactory evidence within 15 business days after a written or oral request from the Employer that the child ceased to be a dependent on the date specified in your **Notice of Second Qualifying Event**, his or her COBRA continuation coverage may be terminated (retroactively if applicable) as of the date that COBRA continuation coverage would have ended

without an extension due to loss of dependent status. The Employer will require repayment to the Plan of all benefits paid after the termination date.

**If your notice was regarding the death of the covered employee**, you must, if the Employer requests it, provide documentation of the date of death that is satisfactory to the Employer (for example, a death certificate or published obituary). This will allow the Employer to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA continuation coverage.

If you do not provide satisfactory evidence within 15 business days after a written or oral request from the Employer that the date of death was the date specified in your **Notice of Second Qualifying Event**, the COBRA continuation coverage of all qualified beneficiaries receiving an extension of COBRA continuation coverage as a result of the covered employee's death may be terminated (retroactively if applicable) as of the date that COBRA continuation coverage would have ended without an extension due to the covered employee's death. The Employer (or its designee) will require repayment to the Plan of all benefits paid after the termination date.

**(d) Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability**

**(1) Deadline.** If you are providing a **Notice of Other Coverage** (a notice that a qualified beneficiary has become covered, after electing COBRA, under another group health plan for a benefit (medical, dental, or vision) covered under COBRA, the deadline for this notice is 30 days after the other coverage becomes effective or, if later, 30 days after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary.

If you are providing a **Notice of Medicare Entitlement** (a notice that a qualified beneficiary has become entitled, after electing COBRA for medical benefits, to Medicare Part A, Part B, or both), the deadline for this notice is 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

If you are providing a **Notice of Cessation of Disability** (a notice that a disabled qualified beneficiary whose disability resulted in an extended COBRA continuation coverage period is determined by the Social Security Administration to be no longer disabled), the deadline for this notice is 30 days after the date of the Social Security Administration's determination.

**(2) Delivery.** You must provide these notices to:

- Human Resources Department, Employer (see Section II.A for the Employer address and, if provided, fax number).

Your notice must be provided no later than the deadline described in Question and Answer 29(d)(1).

**(3) Required Form and Information.** You should use the Plan's form "Notice of Other

**Coverage, Medicare Entitlement, or Cessation of Disability"** to notify the Employer of any of these events, and all of the applicable items on the form should be completed. You may obtain a copy of the form from the Employer.

Your notice should contain the following information:

- The name of the Plan (Welfare Benefit Plan of (specify your Employer));
- The name and address of the employee or former employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiary(ies);
- The qualifying event that started your COBRA continuation coverage;
- The date that the qualifying event happened; and
- The signature, name, and contact information of the individual sending the notice.

If you are providing a **Notice of Other Coverage**, your notice should include:

- The name and address of the qualified beneficiary who obtained other coverage;
- The date that the other coverage became effective (and, if there were any preexisting condition exclusions applicable to the qualified beneficiary, the date that these were exhausted or satisfied); and
- Evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage).

If you are providing a **Notice of Medicare Entitlement**, your notice should include:

- The name and address of the qualified beneficiary who became entitled to Medicare;
- The date that Medicare entitlement occurred; and
- If available, a copy of the Medicare card showing the date of Medicare entitlement.

If you are providing a **Notice of Cessation of Disability**, your notice must include:

- The name and address of the disabled qualified beneficiary,
- The date of the Social Security Administration's determination that he or she is no longer disabled; and

- A copy of the Social Security Administration's determination.

The covered employee (that is, the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

If a qualified beneficiary first becomes covered by another group health plan for a benefit (medical, dental, or vision) covered under COBRA after electing COBRA, that qualified beneficiary's COBRA continuation coverage will terminate (retroactively if applicable) as described in Question and Answer 25 regardless of whether or when a **Notice of Other Coverage** is provided.

If a qualified beneficiary first becomes entitled to Medicare Part A, Part B, or both after electing COBRA, that qualified beneficiary's COBRA continuation coverage for medical benefits will terminate (retroactively if applicable) as described in Question and Answer 25 regardless of whether or when a **Notice of Medicare Entitlement** is provided.

If a disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled, COBRA continuation coverage for all qualified beneficiaries whose COBRA continuation coverage is extended due to the disability will terminate (retroactively if applicable) as described in Question and Answer 25 regardless of whether or when a **Notice of Cessation of Disability** is provided.

### **30. What are my rights under state law for continuation coverage?**

Your rights vary depending on factors including your state of residence. The Employer will notify you if state law becomes applicable to your situation.

### **31. Should I choose continuation coverage?**

You should review the materials carefully and consult your personal advisor for advice on whether electing continuation coverage is beneficial to you.

### **32. Do I have the right to convert to a personal policy?**

Consult the booklets to determine whether you have the conversion rights.

Effective date: Plan Years starting on and after January 1, 2005.

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**SAMPLE PARTICIPANT TRANSMITTAL MEMO**  
**(See Separate Form)**

**SAMPLE PARTICIPANT TRANSMITTAL MEMO**

To: \_\_\_\_\_

From: \_\_\_\_\_

Date: \_\_\_\_\_

Certain of the Bank's employee benefits are funded through the Wisconsin Bankers Association Insurance Trust Fund ("Trust"). Insurers issue group policies for benefits to the Trust and administer claims payments under the Bank Welfare Benefit Plan.

To assist you to an awareness and better understanding of the Plan benefits, the insurer prepares a Group Policy booklet and Certificate of Insurance (benefit "booklet"). The benefit booklets present the various Plan elements, for example, eligibility, benefits, what happens when no longer covered, and so forth.

Enclosed with the benefit booklet(s) are separate pages entitled Summary Plan Description ("SPD"). The SPD is required by Federal law and further explains your rights under the Plan. The benefit booklets are intended to be part of the SPD.

The SPD contains important information about your Plan. Please read and familiarize yourself with the Plan provisions. To know the Plan is to better appreciate the benefits it provides. If you have questions not answered by the SPD, including booklets, please discuss them with the employee benefits officer.

*[For plans with medical, dental, or vision benefits: The enclosed Appendix C includes important information about continuation coverage applicable to medical, dental, and/or vision benefits. The initial notice of COBRA continuation coverage is provided in this Appendix C, which includes other important COBRA continuation coverage information, such as Notice Procedures which apply to participants and any covered spouse or dependents who may be eligible for such continuation coverage.]*

Sincerely,

\_\_\_\_\_  
Plan Sponsor

(The transmittal memo could be modified to refer to the specific Bank benefits funded through the WBA Insurance Trust Fund. The last paragraph should only be used for plans offering medical, dental, or vision benefits.)