

SUMMARY PLAN DESCRIPTION
FOR THE
MICHIGAN TRUCKING, LLC
EMPLOYEE BENEFITS PLAN

This Summary Plan Description includes various booklets furnished by the Plan's third party administrator and insurance company that explain your benefits in more detail. Please read these booklets and the Summary Plan Description carefully. If you have any questions regarding the Plan, contact the Benefits Department of your participating employer.

TABLE OF CONTENTS

	Pages
MICHIGAN TRUCKING, LLC EMPLOYEE BENEFITS PLAN	1
PARTICIPATION	2
Who Is Eligible to Participate in the Plan?	2
Who Is Not Eligible to Participate in the Plan?	2
When Are You Eligible to Participate in the Specific Programs?	3
When Does Plan Participation Terminate?	3
What Happens if You Are on a Leave of Absence or Layoff?	4
BENEFIT ELECTIONS	5
How Do You Elect to Participate?	5
How Do You Change Your Election During The Annual Enrollment Period?	6
How Do You Change Your Election During The Plan Year?	6
FLEXIBLE BENEFIT FEATURES	11
Employee Pre-Tax Contributions	11
How Does Participation in The Plan Affect Your Taxes?	12
Employee After-Tax Contributions	12
BENEFIT PROGRAMS	13
Health Care Program	13
Life Insurance Program	13
Medical Expense Reimbursement Program	18
Dependent Care Reimbursement Program	19
CLAIM AND APPEAL PROCEDURES	21
In General	21
Self-Insured Benefit Claims	22
Special Rules for Reimbursement Claims	23
Appeals From Denials of Self-Funded Benefit Claims	24
Special Rules For Disability Determinations	25
Special Rules For Health Care Determinations	25
Special Rules for Medical Expense Reimbursement Determinations	26
What if Your Appeal is Denied?	26
COBRA CONTINUATION OF COVERAGE	27
Health Care Program Continuation Coverage	27
Reduction of Coverage Period	28
Your Notice Obligations	28

Election Period.....	29
Type of Coverage.....	29
Medical Expense Reimbursement Coverage	30
Cost of Continuation Coverage.....	30
YOUR RIGHTS AS A PARTICIPANT	31
Your ERISA Rights and Protections.....	31
Other Rights Under The Plan.....	34
Rights Upon Military Service Leaves of Absence.....	36
OTHER IMPORTANT INFORMATION	36
The Cost of the Benefits	36
How Are Benefits Funded And Paid?.....	37
Are There Limitations on Benefits?.....	37
Limitations	38
Amendment and Termination	38
DEFINITIONS	39
GENERAL INFORMATION	41

PLEASE NOTE

ALL DECISIONS REGARDING HEALTH CARE ARE UP TO YOU AND YOUR DOCTORS.

THIS SUMMARY PLAN DESCRIPTION AND BOOKLETS POSTED ON OUR WEBSITE OR PREVIOUSLY DISTRIBUTED AND NOT REPLACED DESCRIBE THE CIRCUMSTANCES UNDER WHICH THE PLAN WILL *PAY* FOR CERTAIN TREATMENT. IF YOU AND YOUR DOCTORS DETERMINE THAT SPECIFIC TREATMENT IS APPROPRIATE, AND THE *COST* OF THAT CARE IS NOT COVERED BY THIS PLAN, YOU MAY OBTAIN TREATMENT AT YOUR OWN EXPENSE. THIS APPLIES TO MEDICAL TREATMENT FOR YOU AND YOUR DEPENDENTS.

SUMMARY PLAN DESCRIPTION

MICHIGAN TRUCKING, LLC EMPLOYEE BENEFITS PLAN

We maintain the Michigan Trucking, LLC Employee Benefits Plan to provide health care and other welfare benefits for our eligible employees. We will refer to the Michigan Trucking, LLC Employee Benefits Plan as the "**Plan**" throughout this Summary. The terms "**we**," "**us**," "**our**" and "**Company**" refer to Michigan Trucking, LLC and any other related employer that has adopted the Plan. Other participating employers are listed in the Section titled **GENERAL INFORMATION**.

Eligible employees will receive the benefits described in the section titled **BENEFIT PROGRAMS**. The method of paying for the benefits you select and the tax consequences of your selections are described in the section titled **FLEXIBLE BENEFIT FEATURES**.

This is a summary of the Plan as amended on April 1, 2010. We are responsible for administering the Plan in accordance with the plan document. The Plan is operated on a "**plan year**" basis.

The terms and conditions of the Plan are contained in written plan documents and in insurance contracts, insurance certificates, and program booklets. In general, the materials for the programs that are self-insured have been prepared by the third-party administrator (TPA). The insurance contracts and certificates have been prepared by the insurance carriers that administer the insured benefit programs. Together, these documents describe your benefits in detail, and they are incorporated in and made a part of this Summary Plan Description (incorporated materials). This Summary Plan Description will not enlarge or modify any benefits described in the incorporated materials.

If you have any questions regarding your eligibility for or the amount of any insured benefit payable, contact the appropriate insurance company. If you have any general questions regarding the Plan, your eligibility for coverage, or the amount of any self-insured benefit payable, contact the benefits department of your participating employer. The programs that are insured and insurance carriers providing those benefits and the self-insured benefits and the TPA administering them are listed at **GENERAL INFORMATION**.

In the event of any conflict between this Summary Plan Description and the incorporated materials providing these benefits, the incorporated materials will control.

PARTICIPATION

WHO IS ELIGIBLE TO PARTICIPATE IN THE PLAN?

All "**full-time**" employees, except those listed below, are eligible to participate in the Plan on the first day of the month after completing 90 days of continuous employment with us. Except for drivers, a full-time employee is an employee who is regularly scheduled to work 35 or more hours per week. A full-time driver is a driver who is scheduled to drive five (5) full days per week. You will begin participating following the date you meet these eligibility requirements and complete your enrollment by calling the enrollment center.

WHO IS NOT ELIGIBLE TO PARTICIPATE IN THE PLAN?

The following persons are not eligible to participate in the Plan:

- Employees who, at the time they are hired, are expected to work less than nine (9) months per year;
- Employees who are not citizens of the United States, who reside and are employed outside the United States, and whose compensation from the Company does not constitute income from sources within the United States;
- Employees who perform services for us pursuant to an agreement between us and another person or entity, such as an employment agency or an employee leasing organization;
or

- Employees who perform services for us pursuant to a written agreement with us that does not provide for participation in the Plan.

WHEN ARE YOU ELIGIBLE TO PARTICIPATE IN THE SPECIFIC PROGRAMS?

Generally, you will become a participant in the specific programs following the date you meet the eligibility requirements for the programs and file appropriate election forms with your participating employer.

WHEN DOES PLAN PARTICIPATION TERMINATE?

- *Participation Terminates*

Except as described below or as described in the booklets for the specific programs, your participation under this Plan will cease on the day:

- You no longer meet the eligibility requirements for participation due to retirement, cessation of active employment, reclassification, reduction in hours, leave of absence (other than FMLA) or any other reason;
- Your election for benefits is no longer in effect;
- You fail to make your required contributions under this Plan; or
- You submit fraudulent claims or otherwise abuse the benefits under the Plan.

Your dependents will lose coverage at the same time you lose coverage. Your dependents will also lose coverage on the day they no longer meet the dependent eligibility requirements under the Plan.

PLEASE NOTE: If your employment is terminated, coverage under the health care program terminates on the **last** day of the month in which one works and premium deductions for the full month will be taken from your last paycheck. Otherwise, your coverage will cease on the day as listed above.

- ***Participation Upon Reemployment***

If your employment terminates, your participation in the Plan terminates as described above. On re-employment you must again satisfy the service requirements for each benefit program, unless you are re-employed within 30 days. If your re-employment occurs within 30 days, your prior elections will be reinstated. If re-employment occurs after 30 days, you must satisfy the eligibility requirements and make new elections.

WHAT HAPPENS IF YOU ARE ON A LEAVE OF ABSENCE OR LAYOFF?

- ***FMLA Leave***

If you are on a leave of absence under the Family and Medical Leave Act ("**FMLA leave**") you may continue your health care coverage and medical expense reimbursement coverage under the Plan during FMLA leave. Your coverage and costs will be the same during the leave as the coverage and cost for similarly situated active employees who are not on FMLA leave.

If you chose to continue your coverages during your unpaid leave, you may:

- Pay your share of the premium payments on the same schedule as if you were not on leave on an after-tax basis; or
- Prepay your share of the cost of benefit plan coverage.

If you fail to pay any portion of your costs within 30 days of the due date, your coverage will terminate retroactive to the premium due date. We will notify you of nonpayment 15 days prior to the expiration of the 30-day grace period. If we choose to continue coverage, we are entitled to collect unpaid amounts from you after you return from FMLA leave.

If you let your medical expense reimbursement account lapse during the leave, you may reinstate coverage for the remaining part of the plan year when you return. However, the expenses you incur during the lapse will not be reimbursable and your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect

\$1,200 for the year and you are out on leave for two (2) months, your amount will be reduced to \$1,000.

Your full participation in the Plan will be reinstated upon your return to work prior to or upon termination of FMLA leave. If you do not return to work from FMLA leave for any reason other than the continuance, recurrence, or onset of a serious health condition, we may recover any Company contribution paid to the Plan to maintain your coverage during your leave. You will be eligible to elect continuation of health care benefits under COBRA at the termination of FMLA leave if you do not return to eligible participant status.

- ***Other Leaves of Absence or Layoff***

If you are on a non-FMLA authorized leave of absence or a temporary layoff, you will not be eligible to participate in the Plan during the layoff or leave unless the terms of the layoff or leave provide for continued participation.

If the leave or layoff provides for continued participation, you must pay your share of the premiums to continue your coverage under the Plan. If you do not pay any employee portion of the premium within 30 days of the due date, your coverage under the Plan will be terminated. The termination will be retroactive to the premium due date.

- ***All Leaves***

All periods of approved leave, including FMLA leave, will run concurrently. Your participation in the Plan will cease at the end of the period of continuation, if any, or the cessation of the condition for which the leave was granted, whichever occurs first.

BENEFIT ELECTIONS

HOW DO YOU ELECT TO PARTICIPATE?

If you are a new hire, you must call in to an enrollment center in the month prior to your effective date of coverage. You may also elect coverage during the company's annual open enrollment period. All other changes are listed in the section "HOW DO YOU CHANGE YOUR ELECTION DURING THE PLAN YEAR".

The elective benefits are as follows:

- *Health, Dental and Vision coverage*
- *Basic and Supplemental Life Insurance*
- *Short-term Disability Income Protection*
- *Medical Expense and Dependent Care Reimbursement*
- *Voluntary Products (Income Protection, Universal Life, Accident and Critical Illness)*

We highly encourage you to review your benefits during the open enrollment period. If you do not call in to review or make changes, your previous year's benefits will automatically renew with exception of the Medical Expense and Dependent Care Reimbursement. These must be renewed annually.

HOW DO YOU CHANGE YOUR ELECTION DURING THE ANNUAL ENROLLMENT PERIOD?

You may change your election each year during the "**annual open enrollment**" period. The annual open enrollment period is a period of at least 8 days beginning not earlier than February 1 and ending not later than March 31. Elections go into effect on April 1 following each annual open enrollment period.

HOW DO YOU CHANGE YOUR ELECTION DURING THE PLAN YEAR?

Generally, you cannot change your election to participate in the Plan or change your contributions or the benefits you have elected during the plan year. There are several important exceptions to this general rule. You have 30 days from the event to notify Michigan Trucking, LLC. You may change your previous election for health care coverage, medical expense reimbursement and dependent care expense reimbursement

benefits (but not supplemental life insurance or short-term disability income protection benefits) during the plan year if you experience any of the following events:

- ***Change in Status Events.*** The following are considered changes in status if the event results in the gain or loss of eligibility under the Plan or a similar employee benefit plan and the election change corresponds with that gain or loss of coverage.
 - A change in your legal *marital status*, such as marriage, legal separation, annulment, divorce, or death of your spouse;
 - A change in the *number of your dependents*, such as birth of a child, adoption or placement for adoption of a dependent, or death of a dependent;
 - A change in your *employment status* or that of your spouse or dependent that affects benefit eligibility under the Plan, or a spouse's or dependent's plan, including a termination or commencement of or return to employment, a commencement of or return from an unpaid leave of absence, or a change in work schedule or worksite;
 - A change in eligibility for *dependent status* causing a dependent to satisfy or to cease satisfying coverage requirements due to age, student status, marriage or similar circumstances; and
 - A change in your *residence* or the residence of a spouse or dependent if the change affects eligibility for coverage.
- ***Change in Status – Other Requirements.*** If you wish to change your election based on a change in status, you must establish that the change is on account of and corresponds with the change in status. Generally, a desired election change is found to be consistent with a change of status event if the event affects coverage eligibility. You must also satisfy the following specific requirements:
 - ***Health care program and medical expense reimbursement benefits:*** You may change your election only if the change in status results in becoming eligible or ineligible for the benefit or a particular benefit option under the Plan (or your spouse

or dependent's plan) and your election change corresponds with the gain or loss of coverage.

You may drop or decrease your coverage on account of a change in status but you may not add or increase coverage unless the change in status is also a special enrollment event and permitted under the terms of the health care programs.

- *Dependent care reimbursement.* You may change your election only if the change is consistent with a change in status that affects eligibility for coverage under the Plan or eligibility of dependent care expenses for the available tax exclusion. A change in dependent care provider is a change in coverage for purposes of this Plan.
- ***Special Enrollment Events.*** You have a special enrollment event for the health care programs if:
 - You acquire a dependent through marriage, birth, adoption or placement of a child with you for purposes of adoption; or
 - You declined health care program coverage under the Plan for yourself or eligible dependents because you or your dependents were covered under another group health plan or you or your dependents had other health insurance ("other coverage") as these terms are defined in HIPAA and you or your dependents lose that other coverage.

If you have a special enrollment event you may elect coverage under the health care programs for yourself and your eligible dependents if the following requirements are met:

- When you were previously offered coverage you declined coverage *in writing* because you or your dependents had other coverage;
- You request enrollment within 30 days of the loss of other coverage and provide proof of loss of the other coverage; and
- Either the other coverage was COBRA continuation coverage and it ran out or the other coverage was not COBRA

continuation coverage and it ended because you lost eligibility or the employer stopped making contributions.

- ***Certain Judgments and Orders.*** If a judgment, decree or order from a divorce, separation, annulment or custody change requires your child to be covered under this Plan, you must change your election to add healthcare coverage for this child. If the order requires another individual (such as your former spouse) to cover the child, you may change your election to revoke coverage for the child if the other coverage is actually provided.
- ***Entitlement to Medicare or Medicaid.*** If you, your spouse, or a dependent become entitled to Medicare or Medicaid, you may cancel that person's health coverage.
- ***Change in Cost.***
 - If we notify you that the cost of your coverage under the Plan is *significantly* changing during the plan year, you may choose either to make an increase in your contributions or to revoke your election and receive coverage under another Plan option that provides similar coverage or drop coverage if no similar coverage is available.
 - For *insignificant* changes in the cost of benefits, however, we will automatically adjust your contribution elections to reflect the minor change in cost.

You may change your dependent care expense election but not your medical expense reimbursement election as a result of a change in cost.

- ***Change in Coverage.***
 - If your coverage under the Plan is significantly reduced, you may revoke your election and elect coverage under another Plan option by making a corresponding election change under another option that provides similar coverage;
 - Additionally, if the Plan adds or eliminates a coverage option, you may elect the newly added option or elect another Plan option (when a Plan option has been eliminated), and may do so on a pre-tax basis by making a corresponding election change under another Plan option that provides similar coverage, if any;

- If the coverage reduction is so significant that it is a loss of coverage, you may drop coverage if no similar benefit package is available; or

You may change your dependent care expense election but not your medical expense reimbursement election as a result of changes in coverage.

- ***Change in Coverage under Another Employer's Plan.*** You may make an election change that is consistent with a change made under the employer plan of your spouse, former spouse, or dependent if:
 - The other employer's plan permits its participants to make a change; or
 - The period of coverage under this Plan is different from the period of coverage under the other employer's plan;

You may change your dependent care expense election but not your medical expense reimbursement election as a result of changes under another employer's plan.

To make a change, you must file a written request for change with the Benefits department of your participating employer within 30 days of the event permitting the change. If you wait longer than 30 days, you will not have the opportunity to change your elections until the next open enrollment period. No mid-year change is permitted under the medical expense reimbursement program that decreases the contributions for the plan year to an amount that is less than the medical expenses incurred by the participant and beneficiaries prior to the date of the revised election. All changes are prospective from your date of notification, except changes involving the birth, adoption, or placement for adoption of a child, which will be retroactive if made within the 30-day requirement. Even though one of the above events occurred, your ability to change may be limited by the program terms. We may also change your elections during the plan year to satisfy legal requirements.

The change in status exceptions are complex. If you would like to change an election during a plan year, please contact the Benefits Department of your participating employer for more information.

FLEXIBLE BENEFIT FEATURES

EMPLOYEE PRE-TAX CONTRIBUTIONS

- ***Pre-tax Premium Payments***

We provide benefits only to eligible employees who elect to participate and agree to contribute their share of the cost. We will announce your cost of these benefits prior to the beginning of each plan year and when cost changes occur during the year. You will pay your portion of the health care coverage premiums with *pre-tax* contributions. Your share of the premiums is paid through payroll deductions in approximately equal installments during the plan year.

- ***Reimbursement Accounts***

This Plan also allows you to contribute part of your compensation on a *pre-tax* basis to two (2) reimbursement accounts available to you:

- *Medical Expense Reimbursement Account* that you can use to pay for eligible medical care expenses.
- *Dependent Care Reimbursement Account* that you can use to pay for eligible dependent care expenses.

The amounts that you elect to contribute to these accounts will be paid by payroll deductions during the year in approximately equal installments on a pre-tax basis. You may not carry over unused funds in your medical expense or dependent care expense reimbursement accounts into the next plan year or transfer money from one account to another. Since federal law requires you to use all the amounts in your reimbursement accounts during the plan year, you must be very careful in determining the amount to be allocated to each of your accounts. **If you do not submit claims up to the amounts that you elected for the year, then any remaining amounts in your accounts will be forfeited.**

The amounts you allocate to your reimbursement accounts may not be changed during the plan year unless you have a change described in **HOW**

DO YOU CHANGE YOUR ELECTION DURING THE PLAN YEAR? More information about reimbursement accounts is described in **BENEFIT PROGRAMS**.

HOW DOES PARTICIPATION IN THE PLAN AFFECT YOUR TAXES?

- ***Income Taxes***

The pre-tax premium payment and reimbursement account features of the Plan can help you reduce your taxes and increase your spendable income. The amounts you contribute to the Plan are placed in your premium payment and reimbursement accounts before taxes are taken out. These amounts are not counted in your taxable income and are not reported on your W-2 form. This keeps your benefit costs low and can even result in a net increase in spendable income. This can be illustrated by the following example:

	<u>With Your Plan</u>	<u>Without Your Plan</u>
Gross Taxable Wages	\$30,000	\$30,000
Pre-tax Contribution	<u>1,800</u>	<u>N/A</u>
Taxable Wages	\$28,200	\$30,000
Estimated Taxes*	\$3,554	\$3,942
After-tax Contribution	<u>N/A</u>	<u>1,800</u>
Take-home Pay	\$24,646	\$24,258

*Assumptions: Married couple; two children; joint return; 10% federal income tax rate; 3.9% state income tax rate; 7.65% FICA tax rate; no non-wage income; and before tax credits and other adjustments.

By paying for benefits before taxes are calculated, estimated taxes are reduced by approximately \$388, which is over \$32 per month more in take-home pay in our example. Your savings may be greater if your marginal income tax rate is higher.

- ***Social Security Taxes***

If you pay your share of the premium or pay for any benefits using pre-tax dollars, the amount of your Social Security taxes will be reduced. This means your Social Security benefits may also be reduced at retirement.

EMPLOYEE AFTER-TAX CONTRIBUTIONS

We provide supplemental life insurance, short-term disability income protection and voluntary benefits only on an after-tax basis. The Company will announce your cost of these benefits prior to the beginning of each plan year. You pay the premium for these benefits with *after-tax* compensation through payroll deductions in approximately equal installments during the plan year.

BENEFIT PROGRAMS

HEALTH CARE PROGRAM

The Plan provides health care coverage to eligible employees through a self-insured program. The booklet posted on the company website or previously distributed explains this program. The program includes the following benefits:

- Hospitalization and basic medical benefits (medical coverage).
- Dental benefits.
- Vision care benefits.

You may not elect dental coverage or vision coverage separate from hospitalization and basic medical coverage under the Plan. Your dental coverage and vision coverage will be at the same level as your medical coverage. You may not elect family coverage for dental coverage, for example, if you have single coverage under the medical program.

LIFE INSURANCE PROGRAM

The Plan provides life insurance benefits to eligible employees on a fully funded and self-insured basis. Basic Life is a fully funded plan and Supplemental Life benefits are self funded and paid for entirely by employee contributions. These benefits are not guaranteed by a contract or policy with an insurance company. Benefits are provided in the following forms:

- *Basic Life Insurance*

The Company offers a basic life insurance protection with a death benefit of \$10,000 for all employees meeting the eligibility and enrollment requirements of the Plan. Basic life insurance coverage is provided to all Plan participants who enroll for coverage at no cost to the employee.

- ***Supplemental Life Insurance***

Participants may purchase, at the participant's expense, additional amounts of life insurance in increments of \$10,000 up to a total of \$90,000 of supplemental life insurance protection. The cost of this benefit is set forth in the information form provided to you at the time of hire or during the annual enrollment period each year.

You may elect supplemental life insurance when you first become eligible to participate in the Plan. You may also elect supplemental life insurance and increase your level of coverage during each open enrollment period. You may decrease or drop your coverage at any time. You must pay for the cost of the supplemental life insurance on an after-tax, payroll deduction basis.

- ***Basic and Supplemental Life Insurance Beneficiary Information***

You may designate your beneficiary for these benefits. If more than one beneficiary is designated and their interests are not specified, benefits will be paid in equal installments to all named beneficiaries. You may change your beneficiary at any time in writing. Beneficiary changes must be received and recorded at the office of the Plan administrator to be effective. If any beneficiary does not survive you by 10 days, the benefits of the named beneficiary will be shared equally by the remaining named beneficiaries, if any. If no beneficiary survives you, benefits will be paid in the following order of priority:

- Your spouse, or if none,
- Your children equally, or if none,
- Your parents equally, or if none,
- Your estate.

The amount will be paid in a lump sum. No benefits will be paid and no increased benefit amount will be effective if death occurs within 24 months of the commencement

of coverage or the increase in the benefit amount if the death is caused by, contributed to by, or resulting from, suicide, or due to self-inflicted injury or resulting from a pre-existing condition. A pre-existing condition means any medical condition for which you received medical treatment, advice, diagnosis, care, or services, including diagnostic measures, or took prescribed drugs or medicine within the 12 months prior to:

- Your initial date of insurance;
- The day that any increased or additional insurance is effective.

No benefits will be paid if death is caused by or results from:

- Participation in a riot, insurrection, assault or felony;
- Any act or accident of war, whether declared or undeclared;
- Travel or flight in any aircraft unless you are a fare paying passenger on a licensed passenger aircraft provided by a licensed passenger carrier on a regularly scheduled flight between established airports or travel on an aircraft owned, chartered, or leased by any employer participating in this Plan; or
- Military service for any country or government.

Basic insurance coverage and increases in your supplemental life insurance coverages will be delayed if you are not actively employed because of injury, sickness, temporary layoff or leave of absence on the date the basic insurance coverage or an increase in supplemental coverage would otherwise become effective. The coverage or the increase will become effective when you resume active employment.

Beneficiaries must submit notices of claims to the Company within 31 days after the date of death or as soon thereafter as reasonably possible, but in no event more than 12 months after the date of death. Claims must be accompanied by a death certificate.

Your life insurance coverage will generally terminate on the occurrence of the events described in **WHEN DOES PLAN PARTICIPATION TERMINATE?**, above. However, if the plan administrator determines you have a terminal illness or injury that is

projected to take your life within six (6) months at the time of your cessation of active employment and you continue to pay your premiums for supplemental coverage on a weekly basis, you may continue your supplemental life insurance coverage for up to twelve (12) months following your last day of active employment with the Company. You must contact the Benefits Department of your participating employer or the plan administrator within 15 days of the date these circumstances occur if you want to continue coverage.

SHORT-TERM DISABILITY INCOME PROTECTION PROGRAM

The Plan provides short-term disability income protection benefits to eligible employees who **elect and pay** the cost of coverage. These benefits are provided on a self-insured basis. These benefits are not guaranteed by a contract or policy with an insurance company. The short-term disability income protection program continues a portion of your wages during periods in which you are not able to perform the essential duties of your job because of illness or injury that is not related to your work for the Company. You must be a regular, full-time employee at the time your injury or illness occurs and you must be under the direct and continuing care of a physician.

It is the employee's responsibility to request application paperwork from the Benefits Department. Once the paperwork is returned from the doctor, the Benefits Department will review and will either approve or decline the claim.

Benefits under the short-term disability insurance protection program will be equal to 60% of your "**average weekly compensation.**" Your basic weekly earnings are the average of your gross wages earned in the 52 weeks prior to the illness or injury. Benefit payments begin after seven (7) days of sickness or injury (retroactive to the later of the first day of sickness or injury or the first day after Company provided sick days have expired). Short-term disability payments will be available for up to 13 weeks. The maximum benefit in the case of childbirth is six (6) weeks or eight (8) weeks in the case of a cesarean delivery. No benefits will be paid until Company-provided sick days, if any, have expired. Benefits for short-term disability income protection will cease at the earliest of the date:

- you return to work.
- you are no longer disabled.
- you perform work of any kind for wage or profit.
- on which the maximum benefits period is exhausted.

If you return to normal full-time work and have additional absences separated by less than three (3) months that are due to the same injury or accident, your absences will

be treated as a relapse of that injury or illness and you will be eligible for benefits for only one (1) period of disability. If you return to normal full-time work for at least one (1) full week and are then absent from work due to an injury or sickness entirely unrelated to your previous disability, you will be considered to have two (2) periods of disability and will be eligible for benefits for each period of disability. You will be entitled to a maximum of 26 weeks of short-term disability leave during any three (3) consecutive plan years.

All premiums must be paid in full before your application for benefits is made. No benefits will be paid unless the injury occurs or illness begins after you have been covered and have paid premiums for at least three (3) months. You must apply in writing for benefits and present proof of disability. No payments will be made until we have received satisfactory proof of your illness or disability. You must have a doctor certify that you have been ill or suffered an accident that prevents you from being able to work and you must provide periodic updates on your status. Payments will not commence or will be suspended if your doctor does not give us timely reports. We may require you to undergo a physical examination by a physician selected by us as a condition of commencing or continuing benefit payment. If you refuse to have the examination at our request, your short-term disability benefits will be discontinued. The Company reserves the right to require certification from your physician or a physician selected by us indicating that you have recovered from your illness or injury and are able to return to work.

You are not eligible for short-term disability payments during periods in which you are eligible for worker's compensation, unemployment compensation, or any similar benefits paid for in part by us. No benefits will be paid if you are receiving any welfare or public assistance or if the injury is eligible for coverage under any no-fault or other motor vehicle insurance. No benefits will be paid for any injury or illness incurred while you were on leave of absence that is not an FMLA leave or while absent from work due to disciplinary reasons. No benefits will be paid for any illness that occurs within 12 months of the commencement of coverage if the illness is caused by, contributed by, or resulting from a pre-existing condition. See the **LIFE INSURANCE PROGRAM** section for the definition of a pre-existing condition. No benefits will be paid for absences resulting from:

- Your use of alcohol, narcotics or other controlled substances;
- Your commission of an assault, felony, or other illegal action or while engaged in any illegal occupation;
- Service in the armed forces of any country or caused by war or any act of war, whether declared or undeclared;
- Your participation in a riot or similar situation;
- A self-inflicted injury or illness.

You must pay the cost of the short-term disability income protection program. The amount is set forth in the enrollment information. You pay this by payroll deduction on an after-tax basis. You may elect short-term disability income protection when you first become eligible to participate in the Plan or at any open enrollment period. **You may drop this coverage at any open enrollment period, but if you drop this coverage, you may not elect coverage at any future date.**

MEDICAL EXPENSE REIMBURSEMENT PROGRAM

Under current tax laws, medical and dental expenses that are less than 7.5% of your adjusted gross income are not tax deductible and must be paid with "after-tax dollars." Refer to **FLEXIBLE BENEFIT FEATURES** for additional information about the effect on your taxes.

Each year you may elect to contribute a portion of your compensation to a medical expense reimbursement account, and that amount will be deducted from your pay "pre-tax". The amount that you elect to contribute will be deducted from your compensation before it is taxed. The amount in your account will be used to reimburse you for healthcare expenses incurred by you or your dependents that are not covered by any other health care program. Eligible expenses include medical, dental, hearing, and vision expenses:

- Prescription and over-the-counter drugs and items purchased for personal use to alleviate or treat personal injuries or sickness are also eligible.
- Deductible and coinsurance amounts that you pay for your health care treatments.

Except for over-the-counter medications, these expenses must be eligible for Federal income tax deduction but you may not claim them as deductions if they are reimbursed under this program.

Eligible expenses do not include:

- The cost of qualified long-term care expenses or premiums; or
- The cost of other health care programs, such as premiums paid under plans maintained by your spouse's employer or individual policies maintained by you or your spouse.

- Expenses for cosmetic surgery or cosmetic items, maternity items or wigs;
- Vacation or travel expenses, even if for rehabilitation;
- Meals or lodging (unless included as part of a hospital bill or while traveling between distant hospitals) at a location away from home or received as an outpatient;
- Vitamins or health aids used for general health purposes and not used to treat a specific injury or illness; or
- Cosmetic procedures such as teeth whitening.

A more complete list of eligible and ineligible benefits is available from the Plan Administrator.

The amount allocated to this account may not exceed an amount determined and announced by us from year to year. This limit is currently \$5,000 per year. The amount credited to this account may only be used to reimburse you for medical expenses that you and your dependents incur for services rendered during the plan year and before your termination date, if you terminate during the plan year. Medical expenses incurred before you become a participant or after your termination date are not eligible for reimbursement. The reimbursement amount available at any time during the year is the annual amount that you elected, less the amount of reimbursements previously received for the plan year. **If you do not submit claims up to the amount that you elected for the year, then any remaining amount in your account will be forfeited and these forfeitures will be used to pay the administrative expenses of the Plan.**

DEPENDENT CARE REIMBURSEMENT PROGRAM

You may elect to contribute a portion of your compensation to a dependent care reimbursement account and this amount will be deducted from your compensation before it is taxed. The amount in your account will be used to reimburse you for dependent care expenses that are employment related and incurred for services rendered during the plan year. This includes expenses for your children or other dependents under age 13, as well as your spouse or any other dependents who are physically or mentally incapable of self-care. Employment related expenses for services outside of your home are eligible only if incurred for children under age 13 or for an individual who is age 13 or older and who regularly spends at least eight (8) hours a day in your household.

The amount allocated to this account may not exceed your earned income, your spouse's earned income or \$5,000 (\$2,500 if you are married but you and your spouse file separate returns), whichever amount is smaller. The amount available for reimbursement at any time is limited to the amount of your year-to-date contributions, less prior reimbursements to you. **If you do not submit claims up to the amount that you elected for the year, then any remaining amount in your account will be forfeited.**

- ***"Employment-Related" Expenses***

Employment related expenses are expenses that you incur to permit you to continue working. Generally, you may not receive reimbursement under this program if you are married and your spouse does not work. If, however, your spouse is a full-time student or unable to work, other rules permitting contributions often apply. Contact the benefits department of your participating employer for details.

Employment-related expenses include expenses for the care of a dependent inside your home and expenses incurred outside your home for babysitters, nursery schools, or day care centers. This does not include educational expenses for children in first grade or beyond or for food, clothing, and transportation expenses. Services provided by day care centers that care for six (6) or more individuals are eligible for reimbursement only if the center complies with all applicable state and local laws. Payments to your child if the child is under age 19 or to any other relative you claim as a dependent on your tax return are not eligible for reimbursement.

- ***Other Options for Dependent Care Expenses***

If you have dependent care expenses, you may also be eligible for the federal child care tax credit. The federal child care tax credit can be claimed for a percentage of your eligible expenses (from 20% to 35%) depending upon your income level. Eligible expenses are limited to \$3,000 for one child and \$6,000 for two or more children. The amount of your child care tax credit eligible expenses is reduced, dollar for dollar, by the amount of dependent care expenses that are reimbursed through this Plan. To claim the federal child care tax credit, you must file Form 2441 - Credit for Dependent Care Expenses - with your tax return.

You may have greater tax savings if you use the federal child care tax credit instead of receiving reimbursement for dependent care expenses from the Plan. Families with low income generally obtain more tax relief using the federal child care tax credit than families with higher income. A worksheet

for estimating your tax savings under both options is available from the personnel department of your participating employer or you may contact your tax advisor to determine the method that is best for you.

Whether you use the dependent care expense account in the Plan or the federal child care tax credit, you must report the child care provider's name, address and taxpayer identification number (or social security number) on your income tax form. You must also report on your income tax form the social security number of your dependents.

CLAIM AND APPEAL PROCEDURES

IN GENERAL

We are the "**plan administrator**" and have the responsibility and discretionary authority for interpreting the terms of the Plan. We will resolve all disputes with respect to the interpretation of the Plan in accordance with the claim and appeal procedures for the Plan.

We also have the responsibility and discretionary authority to approve or deny all claims for self-insured benefits and other claims not involving insured benefits. Each insurance carrier has the discretionary authority to interpret its insurance policies and approve claims for its insured benefits. Our decisions and the decisions of the insurance carrier will be final. Claims may be filed by participants and beneficiaries ("**claimants**") and will be resolved as insured benefit claims or self-insured benefit claims.

INSURED BENEFIT CLAIMS

The insurance carriers, not the Company, are responsible for paying claims with respect to the insured programs. Each insurance carrier is responsible for:

- determining eligibility for and the amount of any benefits payable under its contract and benefit program, and
- prescribing claims procedures to be followed and claims forms to be used by participants for its benefit program.

Each insurance carrier is a "**fiduciary**" under the Plan with full power to interpret and apply the terms of the Plan and its insurance contract as they relate to the benefits it provides under the contract.

The insurance carrier will decide insured benefit claims in accordance with its claims procedures, as required by ERISA. The insurance carrier has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the insurance carrier denies a claim, in whole or in part, claimants will receive a written notification setting forth the reasons for the denial.

You must submit all claims for insured benefits to the insurance carrier providing the benefit and follow that insurance carrier's claim and appeal procedure with respect to the benefits it provides. The insurance carrier may require the claimant to complete, sign, and submit a written claim on the insurer's form. These forms are available from Benefits Department.

Claims for benefits from an insured benefit program will be resolved under the claims procedures applicable to each insured program as described in the certificates, contracts or booklets attached or previously distributed. The insurance carriers providing benefits under the Plan are listed in the **GENERAL INFORMATION** section.

SELF-INSURED AND OTHER NON-INSURED BENEFIT CLAIMS

- ***Claims administered by our TPA***

Under our self-insured programs, we pay claims for expenses. We have appointed a TPA to process claims for certain benefits. In the case of benefits administered by a TPA, the TPA will act in our place in responding to initial claims. A claimant must complete, execute and submit a written claim on the form available from the TPA or from the Benefits department of your participating employer. All claims must be supported by written evidence. Each claimant must provide to us or the TPA a written release of all medical records that are pertinent to the claim. We have the right to secure independent medical advice and to require such other evidence as we deem necessary to decide the claim.

The plan booklet for the medical benefit program describes the procedures for submitting claims that are initially resolved by a TPA. The identification of the TPA and the programs administered by TPA are listed in the section entitled "**General Information.**" See the plan booklet for a description of the procedures for submitting claims to a TPA.

- ***Claims we administer***

In the case of our self-insured programs that are not administered by the TPA, and other issues not involving insured benefit claims, we will review claims and advise claimants of the amount of their benefits. You will receive a response within 90 days after we receive an application for benefits, unless we determine that special circumstances require an extension of time of up to 90 days to process your claim. If additional time is needed, we will notify claimants of the special circumstances requiring the additional time and the date by which we will make a decision.

If the claimant is not eligible for a benefit, we will give the claimant an explanation in writing or electronically of why the claim is not eligible, and refer to the specific plan provisions upon which our determination is based. We will also describe any additional material or information necessary for us to process the claim and an explanation of why the material or information is necessary.

SPECIAL RULES FOR REIMBURSEMENT CLAIMS

Claims for reimbursement of eligible expenses under the medical expense and dependent care reimbursement programs may be submitted to the TPA at any time during the plan year and will be paid on a regular basis. Claims for reimbursement of expenses incurred during a plan year must be submitted to the TPA not later than 90 days following the end of the plan year.

We may specify a minimum claim amount. You may submit a smaller amount if you certify that it is the last claim for the plan year. Claims must be submitted to the TPA on approved forms, accompanied by bills or other proof of acceptable expense claim. A written statement that the amount has not been reimbursed and is not reimbursable from any other plan must be submitted. The TPA will make payment of covered claims directly to you.

If you die during the plan year, we will pay amounts eligible for reimbursement to your surviving spouse, if any, or to your estate. Your surviving spouse or the personal representative of your estate must submit claims along with invoices or proof of payment in order to receive reimbursement.

When your employment terminates, you will no longer be eligible to participate in the Plan, except as noted below. You may submit claims for reimbursement only for those expenses incurred prior to your date of termination. You must submit claims no

later than 90 days following the end of the plan year in which your employment terminates.

APPEALS FROM DENIALS OF INSURED BENEFIT CLAIMS

If an insurance company denies a claim, the claimant may appeal to the insurance company for a review of the denied claim. The insurance company will decide appeals in accordance with its appeal procedures, as required by ERISA. See the certificate of insurance or booklet attached or previously distributed for more information about how to file a claim and for details regarding the insurance company's claims procedures.

APPEALS FROM DENIALS OF SELF-FUNDED BENEFIT CLAIMS AND OTHER CLAIMS THAT ARE NOT INSURED BENEFIT CLAIMS

If a claim is not appealed on time, claimants will lose their right to file suit in a court due to failure to exhaust their internal administrative appeal rights. Following the internal appeal process is generally a requirement to bringing a suit in court.

In the case of benefit programs administered by a TPA, generally the TPA processes initial claims and we hear and decide appeals. Some TPAs have an internal appeal process. For programs administered by a TPA, see the booklet describing the specific benefit programs to determine if the TPA has an internal review process and the procedures for obtaining internal review.

The procedure for filing an appeal with us is:

- At their request, we will provide claimants or their authorized representatives reasonable access to and copies of all documents, records and other information relating to their claims for benefits;
- Claimants must file a **written** notice of appeal with us within 60 days after receiving a notice of denial. Claimants must file **in writing** all the documents, comments, records and other information relating to their appeals that they wish to have considered in the appeal with their notice of appeal;
- Appeals will be reviewed taking into account all comments, documents, records, and other information that are submitted relating to the claim without regard to whether it was submitted or considered in the initial determination.

- Unless there are special circumstances requiring more time, we will advise claimants of our decision within 60 days after receipt of the notice of appeal. If an extension is necessary, we will notify claimants before the end of the initial 60-day appeal period of the special circumstances requiring the extension and the date by which our determination will be made. The extension will be for 60 days or less.
- We will notify the claimant of our decisions **in writing** in a manner that can be understood by the claimant. We will describe the reasons for the decision and refer the claimant to the specific plan provisions upon which the decision is based. The notice will contain a statement that the claimant may request reasonable access to and copies of all documents, records and other information relevant to the claim for benefits.

SPECIAL RULES FOR DISABILITY DETERMINATIONS

Determinations regarding self-insured disability benefits will be made in the same manner as other claims except that we will respond within 45 days after receipt of the claim. This period may be extended for two (2) additional periods of up to 30 days each in the same manner as other claims are extended. The notice of these extensions will specifically explain the standards for making disability determinations, the unresolved issues preventing a decision and the additional information needed to resolve these issues, and claimants will have 45 days in which to provide the additional information.

Claimants may appeal an adverse determination of disability status in a manner similar to appeals on other claims. However, claimants will have 180 days following receipt of notification of notice of denial of the claim to give written notice of the appeal. In matters involving health, we will consult with a health care professional with appropriate training in the medical field involved in the medical judgment and identify all medical and vocational experts that advise us in our determination. The medical professional will be different from and independent of the professional consulted at the time of the initial claim. We will respond to claims for disability benefits in the same manner as we respond for other claims except that a period of 45 days applies instead of 60 days for our response and extension, if any.

SPECIAL RULES FOR HEALTH CARE DETERMINATIONS

If the claim is for a benefit under an insured or self-insured program providing healthcare coverages other than medical expense reimbursement benefits, claimants will generally proceed under the claims procedure described in the booklet for that program.

SPECIAL RULES FOR MEDICAL EXPENSE REIMBURSEMENT DETERMINATIONS

If a claim for reimbursement under the medical expense reimbursement provisions of the plan is wholly or partially denied, the claims procedure described below will apply.

Determinations will be made regarding the medical expense reimbursement account benefits in the same manner as other self-insured claims except that a response will be sent within 30 days after receipt of the claim. This period may be extended for an additional period of up to 15 days in the same manner as other claims are extended. The notice of these extensions will specifically explain the standards for making the medical expense reimbursement determinations, the unresolved issues preventing a decision and the additional information needed to resolve these issues, and the claimant will have 45 days in which to provide the additional information.

Claimants may appeal an adverse determination of their eligibility for these benefits in a manner similar to appeals on other claims. However, claimants will have 180 days following the receipt of notification of an adverse benefit determination in which to give written notice of an appeal. In matters involving health, we will consult with a health care professional with appropriate training in the medical field involved in the medical judgment and identify all medical and vocational experts that advise us in our determination. The medical professional will be different from and independent of the professional consultant at the time of the initial claim. We will respond to claims for medical expense reimbursement in the same manner as for other claims.

WHAT IF YOUR APPEAL IS DENIED?

If your appeal is denied, you may file a lawsuit to recover plan benefits. Claimants may not file a lawsuit to recover plan benefits before the expiration of 60 days after they have filed a claim in accordance with the requirements of this Plan and have exhausted the Plan's claim and appeal procedures. Claimants may not file a lawsuit after the expiration of 18 months after the earlier of the date the covered services were rendered, the claim was made or the claim otherwise arises, or such other date as provided in the incorporated booklets, insurance certificates or policies of insurance that apply to the benefit that is the subject of the claim.

COBRA CONTINUATION OF COVERAGE

Under COBRA, you, your spouse or your dependent children have a right to elect continuation coverage under the health care programs in which you were participating at the time of the events described below. A "**dependent child**" for COBRA continuation purposes includes a child born to you or placed with you for adoption during the COBRA coverage period. Continuation rights are as follows:

HEALTH CARE PROGRAM CONTINUATION COVERAGE

- ***18 Months***

You, your spouse, and/or your dependent children have a right to elect continuation coverage for a period of 18 months if coverage under the Plan is lost because of a reduction in your hours of employment or your employment terminates for reasons other than gross misconduct on your part.

If you, your spouse, or dependent are determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage, the 18-month period may be extended to 29 months.

The 18-month period may also be extended for a maximum period of 36 months for your spouse or dependent children if they elect coverage at this time and one of the events described below occurs within the initial 18-month period.

If you become entitled to Medicare coverage in the 18-month period before you lose coverage due to a termination of employment or reduction in hours, your spouse and children who are qualified beneficiaries may elect continuation coverage for the 36-month period beginning on the date of your Medicare entitlement.

- ***36 Months***

Your spouse and dependent children have the right to elect continuation coverage for a period of 36 months if coverage is lost for any of the following reasons:

- Death of the participant;
- Divorce or legal separation from the participant; or
- You become entitled to Medicare.

In addition, the dependent child of a participant in the Plan has the right to elect continuation coverage on his or her behalf for a period of 36 months if coverage is lost because he or she ceases to be a "dependent child" under the terms of the Company's program.

The 18, 29, and 36-month periods are measured from the date of the first event that causes the loss of coverage.

REDUCTION OF COVERAGE PERIOD

Continuation coverage will cease on the earliest of the 18, 29 or 36 month periods described above or on the day any of the following events occur:

- Failure to pay the required premium.
- You or your covered dependents become covered by another group health plan that does not contain a pre-existing conditions limit or exclusion that affects you, your spouse or your dependents or at the time the exclusion or limitation expires.
- You or your covered dependents become covered by Medicare after electing continuation coverage.
- If you or your covered dependent have extended coverage for the additional 11-month period due to disability and it is determined that the disability no longer exists.
- We no longer provide group health coverage to any of our employees.

YOUR NOTICE OBLIGATIONS

You or your covered dependent must inform the benefits department of your participating employer of a divorce, legal separation, child losing dependent status under

the terms of the Plan, or entitlement to Medicare within 60 days of the event. You or your covered dependent must also notify us if you are determined to have been disabled under the Social Security Act at any time during the first 60 days of continuation coverage. You must notify us within 60 days after the date of the determination and before the end of the 18-month coverage period. **If you or your covered dependent fail to notify us within the 60-day periods described above, continuation coverage or additional continuation coverage will not be available.**

The notice must include your name, the name of any dependents experiencing the qualifying event, and the type and date of the qualifying event. If the event is a divorce or legal separation, the notice must include a copy of the judgment, decree or order of divorce or legal separation. If it is a disability determination extension, the notice must include a copy of the Social Security Administration disability determination.

In order to protect your family's rights, you must notify the Benefits Department or your participating employer in writing of any changes in address for any family member.

Provide information to: Michigan Trucking, LLC
Benefits Department
6000 Clay Ave SW
Grand Rapids MI 49548

ELECTION PERIOD

You or your covered dependents have 60 days from the later of the date of the election notice or the date coverage terminates to complete the election form provided by us and return it to us. If continuation coverage is not elected, coverage will end as stated in notice. If coverage is elected and required premiums are paid, coverage will continue for up to the applicable continuation period.

TYPE OF COVERAGE

Continuation coverage is provided with respect to any employee benefit program of the Company that pays health care expenses. The continuation coverage provided will be identical to the coverage provided under the Plan to similarly situated active employees. This applies to Health, Dental and Vision coverages.

MEDICAL EXPENSE REIMBURSEMENT COVERAGE

Continuation coverage under the medical expense reimbursement program may be elected *only* if the maximum amount required to be paid for continuation coverage for the remainder of the plan year is less than the maximum benefit available to you under the medical expense reimbursement program for the remainder of the year. This continuation coverage may continue *only* for the plan year in which the qualifying event occurs. The cost for medical expense reimbursement coverage for the balance of the Plan year will be 102% of the amount you elected prior to the beginning of the Plan year. Contributions paid after termination of employment are paid on an after-tax basis.

COST OF CONTINUATION COVERAGE

You or your covered dependents will be responsible for the "**cost**" of continuation coverage. The cost will be established by us for each plan year and may be adjusted for rate changes that take place during the plan year. The cost of coverage is an amount equal to 102% of the actual premium cost. During the additional 11 months of coverage due to disability, the cost will be increased to 150% of the actual premium cost for coverage of an individual.

The cost of continuation coverage must be paid monthly. The amount due for continuation coverage from the qualifying event to the date of the election must be paid within 45 days after the coverage is elected. The cost for the succeeding months must be paid within 30 days after the first day of each month. **If you or your covered dependent fails to make the payments on a timely basis, continuation coverage will terminate.**

TRADE ACT ASSISTANCE

- ***Special Second Election Period***

Special COBRA rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA 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 an eligible employee becomes eligible for the health coverage tax credit, but only if the election is made within the six (6) months immediately after the eligible employee's group health plan coverage ended. If you qualify or may qualify for the health coverage tax credit, contact the Benefits Department of your participating employer for additional information. **You must contact the Benefit's Department**

promptly after qualifying for the health coverage tax credit or you will lose your special COBRA rights.

- ***Health Coverage Tax Credit***

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance. Under the next tax provisions, eligible individuals can either take a credit or get an advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care 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 is also available at www.doleta.gov/tradeact/202act_index.asp.

YOUR RIGHTS AS A PARTICIPANT

YOUR "ERISA" RIGHTS AND PROTECTIONS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). You are entitled to:

- ***Receive Information About The Plan and Your Benefits.***

You may:

- Examine, without charge, at our office and other specified locations all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) 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 us, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary

plan description. We will charge you a reasonable amount for the copies.

- Receive a summary of the Plan's annual financial report. We are required to furnish you with a copy of this summary annual report (SAR).
- Continue health care coverage for yourself, spouse or dependents if coverage is lost as a result of a qualifying event. You or your covered dependents generally have to pay for this coverage. Review this Summary and other documents governing COBRA continuation rights.
- Receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under the group health programs if you or your covered dependents have creditable coverage from another plan.
- Receive a certificate of creditable coverage, free of charge from the group health program or health insurance issuer as follows:
 - when you lose coverage under the group health care program;
 - when you become entitled to elect COBRA continuation coverage;
 - when your COBRA continuation coverage ceases;
 - if you request it before losing coverage; and
 - if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you or your covered dependents may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

- ***Prudent Actions by Plan Fiduciaries.***

ERISA imposes duties on the people who are responsible for the operation of the Plan. These people are called "**fiduciaries**" and they have

a duty to administer the Plan prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from the Plan or exercising your rights under ERISA.

- ***Enforce your Rights.***

If an application for a benefit is denied or ignored, in whole or in part, the claimant has 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. See the section entitled **CLAIM AND APPEAL PROCEDURES** for the schedules that apply to an appeal of a claim for benefits.

Under ERISA, there are steps claimants can take to enforce their rights:

- Claimants may file a suit in federal court if they request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days (unless the reason they did not receive them is beyond our control), or they disagree with the Plan's decision (or lack thereof) concerning the qualified status of a domestic relations order.
- Claimants may file suit in a state or federal court if they followed the Plan's application and appeal procedures and their claim for benefits is denied or ignored, in whole or in part.
- Claimants may seek assistance from the U.S. Department of Labor or file suit in a federal court if the fiduciaries misuse the Plan's money or they are discriminated against for asserting their rights.

The court will decide who should pay court costs and legal fees and may impose fines on the plan administrator. If claimants are successful, the court may order the person they have sued to pay these costs and fees. If they lose, the court may order them to pay these costs and fees.

- ***Assistance with Your Questions.***

If you have any questions about the Plan, you should contact the Benefit's Department. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents, you may contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, which is 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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the "Publications Hotline" of the Employee Benefits Security Administration.

The West Michigan office is located at 30 College SE, 2nd Floor, Grand Rapids, Michigan 49503.

OTHER RIGHTS UNDER THE PLAN

- **Minimum Health Care Rights**

You have certain minimum rights under your health care coverage as follows:

Maternity Benefits. The minimum length for any hospital stay in connection with childbirth for the mother or the newborn is 48 hours following a vaginal birth and 96 hours following a cesarean birth. If the mother and the attending physician agree, the mother or the newborn may be discharged sooner. Hospital stays longer than 48 or 96 hours must be authorized under the Plan's medical necessity provisions.

Women's Health and Cancer Benefits. If you receive benefits in connection with a mastectomy and elect reconstructive surgery, you may receive the following benefits:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications resulting from the mastectomy, including lymphedemas.

You will determine appropriate treatment in consultation with your attending physician. Coverage is subject to the same annual deductibles and coinsurance provisions that apply to the other medical and surgical benefits under this Plan. See the booklet attached or previously distributed for details.

Changes in the Level of Benefits. The level of benefits provided under our health care program may change from time-to-time. If we make changes in the level of coverage, you will be notified in supplements to this Summary Plan Description. If you are notified electronically, you may obtain a paper copy of the supplement, free of charge, from the benefit's department of your participating employer.

Qualified Medical Child Support Order. The health care and medical expense reimbursement programs will be provided to your children when ordered by a court in a "**qualified medical child support order**." If we receive an order from a court of competent jurisdiction involving these programs for your children, we will determine whether the order satisfies the requirements of a "**qualified**" medical child support order. If the order is qualified, we will comply with its terms.

If we receive an order from a court that is a "**national medical support notice**," we will treat the notice as a qualified medical child support order as required by law. We will comply with the order and enroll the individuals named in the notice as your dependents for the required coverage within the date specified in the notice.

The cost of providing coverage under a qualified medical child support order will be paid by you. We will revoke your current election for coverage and enter a new election on your behalf that will provide the coverage necessary to comply with the order. We will adjust your compensation and deductions to pay your cost for the coverage in the same manner as similarly situated participants who elect family coverage at the same level you are required to provide under the order. The adjustment will be effective beginning with the next payroll period after we determine that the order is qualified.

You may obtain, free of charge, a copy of a more detailed description of our procedures for review of these orders from the Benefits department of your participating employer.

Privacy Rules. The privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) apply to the health care provisions of the plan but not to those provisions addressing non-health benefits, such as disability

or life insurance. We will provide you with a separate Notice of Privacy Practices describing in detail the manner in which we and the Plan use and disclose protected health information, your rights to inspect, copy and correct medical records concerning you, and the procedure for filing complaints if you think your privacy rights have been violated.

The insurance companies providing health care benefits will prepare and distribute notices of privacy practices describing how they use and disclose medical information. We may use summary health information for the purpose of obtaining premium bids for health insurance coverage or for modifying, amending, or terminating the Plan. We may also share information on whether you are enrolled or un-enrolled from coverage with the health insurance issuer or HMO offered by the Plan.

RIGHTS UPON MILITARY SERVICE LEAVES OF ABSENCE

If you take an authorized leave of absence for military service and your medical care coverage terminates, you and your dependents may elect to continue coverage under COBRA or under provisions of federal law governing military service that are similar to COBRA permitting continuation at your expense for up to 24 months. This law is known as the Uniformed Services Reemployment Rights Act of 1994 ("USERRA"). For more information about your benefit rights and about other coverage options see the following websites:

For Army Reserve: www.army.mil/wellbeing/family

For National Guard: www.army.mil/soldier_resources

OTHER IMPORTANT INFORMATION

THE COST OF THE BENEFITS

The costs of providing benefits under the Plan are the direct payments to the service providers and the payments you receive from your reimbursement accounts. You and the Company share these costs. We will notify you about your share of the cost for each benefit program before each annual enrollment period.

HOW ARE BENEFITS FUNDED AND PAID?

Some benefits under the plan are self-funded and some are fully insured. Under our self-funded programs, we pay claims for expenses. Because we pay these amounts, they are not guaranteed by a contract or policy with an insurance company. If health care program benefit claims exceed a certain dollar amount, an insurance carrier provides "stop-loss coverage." In this circumstance, the insurance carrier pays these excess amounts to us and we will, in turn, pay the claims. We have hired a "third party administrator" or "TPA" to administer health care program claim payments. With our approval, the TPA reviews claims and pays benefits from the money we provide. Our TPA is described in the **GENERAL INFORMATION** section on the last page of this summary.

ARE THERE LIMITATIONS ON BENEFITS?

- ***Exclusion for Pre-existing Conditions***

The Plan may not cover claims for advice or treatment you or your covered dependents receive for a condition that existed prior to the time of your enrollment. For example, advice or treatment you or your dependents receive in the 12 months after your enrollment date for a medical condition that existed in the 6 months prior to your enrollment date are not covered. The booklets attached or previously distributed explain limitations on coverage for pre-existing conditions for some of the benefits offered under the Plan. Other limitations are described at **LIFE INSURANCE PROGRAM** and **SHORT TERM DISABILITY INCOME PROTECTION**.

- ***Proof of Insurability***

You will not be required to provide proof of insurability if you enroll in the Plan at the time you first become eligible to participate in the Plan. If you enroll in any insurance program after you are first eligible, you and any covered dependents may be required to provide proof to the insurance company or us that each of you is in good health before you will become insured. This paragraph does not apply to any of the health care programs.

- ***Duplicate Coverage Prohibited***

You cannot be covered under the health care benefits of the Plan as both an employee and a dependent, or as a dependent of more than one employee. If we employ more than one family member who is eligible to participate in the Plan, one family member will be covered as the participant and the other family members will be covered as dependents. Each family member may also be covered as a single employee.

- ***Enrollment***

No benefits will be payable until after you have satisfied all enrollment requirements of the program you have elected and until after you have received acknowledgement of enrollment and the effective date of enrollment from the insurance company in the case of insured benefits and from us in the case of benefits that are not insured.

LIMITATIONS

The Plan is only an employee benefit plan. It does not constitute a contract of employment between you and us, and does not give you any right to continued employment with us. If your employment with us terminates for any reason, you will be entitled to the benefits you have earned under the Plan in accordance with these terms and conditions. The provisions of the Plan as described in this summary will apply only to persons who are employed by us on or after April 1, 2010.

The terms of this Plan are contained in a written document and may not be modified by the oral statement of any person, including an oral statement from any insurance company, the TPA, or us. The Plan does not give you any claim, right, or cause of action, either at law or at equity, against the Plan for the acts of any service provider, such as a hospital or physician.

AMENDMENT AND TERMINATION

The Plan may be amended at any time and from time to time. If the amendment significantly changes the provisions of the Plan outlined in this summary plan description, a new summary plan description or supplement will be furnished to participants and beneficiaries.

Although we intend to continue this Plan on a permanent basis, we reserve the right to terminate the Plan or any benefit program provided under the Plan. If the Plan is

terminated, all claims incurred prior to the date of termination will be paid in accordance with the regular Plan procedures.

DEFINITIONS

Annual Open Enrollment Period. The period of at least 8 days beginning not earlier than February 1 and ending not later than March 31 each year during which you may enroll yourself or your dependents for benefits or revise your elections.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Dependent.

Health Care Programs. For purposes of any health care coverage benefit (including the medical expense reimbursement program) of this Plan, this term refers to a person who is not on active military duty and who is your legal spouse or your unmarried child. See the booklet from the medical program TPA for restrictions on coverage of your children as dependents.

Dependent Care Reimbursement Program. A dependent for the dependent care reimbursement program is an individual who meets the requirements for a dependent under the health care programs who does not have income in excess of the deduction amount under the Internal Revenue Code (\$5,000 in 2010) and who does not file a joint income tax return with the individual's spouse income tax.

Disability. A physical or mental condition that prevents you from performing the usual duties for us or the duties of any position or job we make available to you and for which you are qualified by reason of training, education, or experience. You will not be considered disabled for purposes of this Plan if your condition consists of current use of alcohol, narcotics, or other controlled substances, or consists of or results from intentionally self-inflicted injury or criminal conduct in which you were engaged.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

Full-time Employee. For employees other than drivers, an employee who works a minimum of 35 hours per week. A full-time driver is a driver who is scheduled to drive five (5) full days per week.

Health Care Coverage. Coverage under the medical, dental and vision programs of the Plan.

HIPAA. The federal Health Insurance Portability and Accountability Act of 1996 which, among other things, requires a health plan to provide special enrollment rights to participants, spouses, and beneficiaries under certain circumstances.

Medical Coverage. Coverage under the health care program of the Plan including hospitalization and basic medical, physician services and prescription drug coverage. The term "medical coverage" does not include dental or vision coverage.

National Medical Support Notice. A form of qualified medical child support order that we will enforce without further action.

Newborn. A child 30 days old or younger.

Plan Administrator. Michigan Trucking, LLC is the plan administrator. We have the authority to control and manage the operation and administration of the Plan.

Plan Document. The written document that addresses the establishment, administration and other aspects of the Plan.

Plan Year. The 12-month period beginning each April 1 and ending each March 31 on which records of the Plan are kept.

Pre-existing Condition. Any medical condition for which the individual received medical treatment, advice, diagnosis, care or services, including diagnostic measures, or took prescribed drugs or medicine within twelve (12) months prior to enrollment date.

Qualified Medical Child Support Order (QMCSO). A court order, judgment or decree issued by a court of competent jurisdiction providing for child support or health benefit coverage for a child of a participant, provided the order, judgment or decree meets all requirements established under ERISA.

Spouse. The person of the opposite sex with respect to whom you have met all of the requirements for a valid marriage contract in the state of your marriage and all of the requirements of the Federal Defense of Marriage Act (1USC Section 7).

TPA. The third-party administrator with whom we have contracted to perform some of the administrative duties for the Plan.

We, Us, Our or Company. Michigan Trucking, LLC.

You, Your or Yourself. The participant enrolled in the Plan as an employee.

GENERAL INFORMATION

Plan Sponsor:	Michigan Trucking, LLC
Plan Administrator:	Michigan Trucking, LLC.
Address:	6000 Clay Avenue, S.W. Grand Rapids, MI 49548
Phone:	(616) 530-8558
Name of Plan:	Michigan Trucking, LLC Employee Benefit Plan
Type of Plan:	This is a welfare benefit plan
Plan Year:	April 1 through March 31
Plan Number:	501
Employer ID Number:	27-1248467
Agent for Service of Process:	President Michigan Trucking, LLC 6000 Clay Avenue, S.W. Grand Rapids, MI 49548

Insurance Carrier:

*Universal Life, Accident,
Critical Illness and Income
Protection*

Allstate Workplace Division
1776 American Heritage Life Dr
Jacksonville FL 32224
Phone: 800-521-3535

Third-Party Administrators ("TPAs"):

Medical

BC/BS of Michigan
600 E Lafayette Blvd, MC B340
Detroit MI 48226
Phone: 888-890-5707

Dental

MetLife
P.O. Box 14587
Lexington, KY 40512
Phone: 800-942-0854

Vision

VSP
P.O. Box 997105
Sacramento, CA 95899-7105
Phone: 800-877-7195

*Medical Expense and Dependent Care
Reimbursement*

Corporate Benefit Strategies, Inc
5001 Plainfield Ave NE, Suite A
Grand Rapids, MI 49525
Phone: 866 - 365-2413

Other Participating Employers:

Michigan Trucking, LLC
GTS Transportation, LLC.
Super Service, LLC
LCT Transportation, LLC
Freight Brokers of America, LLC