DSRA BENEFIT TRUST

Plan Document

Amended and Restated

Effective January 1, 2018

This document, together with the insurance certificates referenced herein and listed on the final page constitute the written plan and summary plan description required by ERISA §402

GENERAL CONTACT INFORMATION

Administrative Issues

Blue Cross Blue Shield of Michigan
Third Party Administrator [TPA] (pre-65 medical/Rx, all dental and vision coverage)
27000 W Eleven Mile Rd
Southfield, MI 48034

Mercer Health and Benefits Administration LLC
Third Party Administrator (post-65 medical/Rx, voluntary life coverage)
12421 Meredith Drive
Urbandale, IA 50398

Delphi Salaried Retiree Association Benefit Trust (DSRA-BT)

Service Issues:
c/o First Person, Inc.
9000 Keystone Crossing, Suite 910
Indianapolis, IN 46240

Trust Situs:
Comerica Bank, Trustee
Mail Code 3462
411 W. Lafayette
Detroit, MI 48226

Insurance Providers

Blue Cross Blue Shield of Michigan
Under 65 Medical and Rx Insurance,
Dental, Vision, and Under 65 Medicare
27000 W Eleven Mile Rd
Southfield, MI 48034

The Hartford/Atlanta Regional Office
Over 65 Insurance
P O Box 2250
Alpharetta, GA 30023

Benistar Administrative Services
Medicare Part D Coverage (Express Scripts)
2187 Atlantic Street
Stamford, CT 06902

Reliance Standard Life Insurance Company
Voluntary Life Insurance
P.O. Box 8330
Philadelphia, PA 19101

IRS HCTC Department (general questions)
1-866-628-HCTC
www.irs.gov/individuals/index.html (click on HCTC).

Plan Questions

1-877-336-DSRA (1-877-336-3772)

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INTRODUCTION

The DSRA Benefit Trust ("DSRA-BT" or "DSRA-BT VEBA") maintains this Plan for the exclusive benefit of Eligible Retirees (as defined herein), their spouses and dependents. The Plan provides benefits through the following component benefit programs:

- Blue Cross Blue Shield Michigan Medical and Prescription Drug Plan
- Blue Cross Blue Shield Michigan Dental Plan
- Blue Cross Blue Shield of Michigan Vision Plan
- Reliance Standard Life Insurance Company, Optional Voluntary Life and Dependent Life Insurance
- The Hartford Life and Accident Insurance Company Medicare Supplement Plan
- Express Scripts Insurance Company Medicare Prescription Drug Coverage (administered by Benistar)

Some of these component benefit programs require you to make an annual election to enroll for coverage. The details of such annual elections are described in the plan summaries and booklets, and in the enrollment materials found on the DSRA-BT website.

Each of these component benefit programs are summarized in a certificate of insurance booklet issued by an insurance company or other governing document prepared by said insurance companies. Copies of each booklet, summary or other governing document are available on the DSRA-BT website. The component benefit programs may contain applicable caps or other limits on benefits under the Plan.

This document and the plan certificates and booklets constitute the Summary Plan Description ("SPD") for each of the component plans to the extent required by ERISA § 102.

GENERAL INFORMATION ABOUT THE PLAN

Plan Name

The Plan is the "DSRA Benefit Trust Plan."

Type of Plan

This is a welfare benefit plan that provides medical, prescription drug, vision, dental and voluntary life insurance benefits to Eligible Retirees. By virtue of being offered through a VEBA, the component benefit programs offered for those under 65 years of age are intended to be qualified to take advantage of Health Coverage Tax Credits ("HCTC"). The Plan also offers alternative coverage for Eligible Retirees who are or who become Medicare eligible (see restrictions herein) when Eligible Retirees are enrolled in Medicare Parts A & B.

Plan Year

The plan year is January 1st – December 31st.

Plan Identification Number

Plan Number: 501

Plan Sponsor

The DSRA-BT VEBA is the Plan Sponsor. All communications to the Plan, other than service of legal process, should be sent to the Plan's Third Party Administrator listed in the Ready Reference Page.

Plan Sponsor's Employer Identification Number

(EIN): 26-4594868

Plan Administrator

The DSRA-BT VEBA Board of Directors ("VBOD") administers the Plan. Communications for service of legal process should be sent to:

DSRA Benefit Trust
Board of Directors
150 Bastian Road
Rochester, NY 14623

The members of the VBOD shall change from time to time. The identity of the members of the

Board will be provided upon written request to the VBOD. The VBOD has the authority to contract out and manage the operation and administration of the Plan.

Third Party Administrator

The VBOD has contracted with the Plan's Third Party Administrator to administer the benefits under the Plan. You may contact the Plan's Third Party Administrator at the address and phone number shown on the General Contact Information Page.

Type of Administration of the Plan

The Plan is administered independently from the DSRA-BT VEBA through the Plan's Third Party Administrator under the guidance of the VBOD.

Insurance Issuer

The benefits and insurance for all participants are provided through group insurance policies. The names and addresses of the insurance issuers are listed in the Ready Reference Page.

Plan Fiduciaries

The VBOD shall have the authority to control and manage the Plan. The members of the VBOD shall be the "named fiduciaries," within the meaning of Section 402(a) of ERISA, of the DSRA VEBA.

Source of Plan Financing

The Plan is funded through a VEBA Trust set up by the Official Delphi Section 1114 Committee ("1114 Committee") with monies obtained solely from Delphi Corporation pursuant to a Stipulation and Agreed Order entered between Delphi Corporation and the 1114 Committee (entered in Case No. 05-44481, United States Bankruptcy Court, S.D. New York, as may be modified from time to time) (hereinafter "Settlement Agreement") and by premiums contributions from Eligible Retirees. Pursuant to the Settlement Agreement, in part, Delphi paid $7,250,000.00 to the VEBA Trust on or before November 1, 2009 ("Settlement Proceeds"). An additional $500,000.00 was paid by Delphi to pay expenses incurred with respect to the operation of the VEBA Trust and/or Plan, payment of trustees, professional expenses, fidelity, other bonding expenses and other costs attendant to the maintenance of the DSRA-BT VEBA and Plan. Delphi also paid $1,000,000.00 to the DSRA VEBA for the establishment of a hardship fund for certain Eligible Retirees. The Trust also received funding through the Early Retiree Reinsurance Program (ERRP) established by the Affordable Care Act.

The benefits (other than certain administrative and/or incidental costs) with respect to the component benefit programs are paid through the contributions of premiums by Eligible Retirees. The DSRA-BT VEBA will determine and periodically communicate your cost of the benefits provided through each component benefit program, which may change from time to time. Eligible

Retirees (including participating spouses and dependents) are wholly responsible for any deductibles, coinsurance and copayment amounts applicable under each component benefit program.

Notwithstanding the above responsibility of Eligible Retirees to pay for the full costs of benefits and premiums, pursuant to the terms of the DRSA VEBA Trust, the Settlement Proceeds provided to the DSRA-BT VEBA may be used to pay a portion of Current Retirees' (as that term is defined herein) benefits and premiums and/or by means of Hardship Funds provided to qualifying Current Retirees. The amount of subsidies provided by the DSRA-BT VEBA to Current Retirees may change from year to year or may be eliminated entirely.

Discretionary Authority of the VBOD

In carrying out its responsibilities under the VEBA Trust, the VBOD will have absolute discretionary authority to terminate the Plan or any portion thereof, including but not limited to any of the component benefit programs (consistent with the DSRA-BT VEBA), to amend or eliminate benefits offered through the Plan, to make factual determinations, to interpret and construe the terms of the Plan (and any related documents and underlying policies or regulations), to determine eligibility and entitlement to Plan benefits (and the amounts thereof) in accordance with the terms of the Plan, and to determine monthly retiree subsidies to the Current Retirees (as defined herein) on actuarial recommendations concerning the amounts that can be subsidized while still preserving the required assets needed for long-term funding of the DSRA-BT and in amounts that the VBOD decides in its discretion that the Current Retirees (as defined herein) are entitled to as subsidies and/or Hardship Funds. All such decisions shall be final and legally binding on all parties affected thereby. Any interpretation, determination, or other action of the DSRA VEBA and/or the VBOD shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Accepting any benefits or making any claim for benefits under this Plan constitutes an agreement with and consent to any decision that the VBOD makes, in its sole discretion and, further constitutes an agreement to the limited standard and scope of review described herein. If the Plan is terminated, the assets held by the DSRA VEBA will be allocated and disposed pursuant to the terms of the DSRA-BT VEBA.

Important Disclaimers

Benefits hereunder are provided pursuant to insurance or PPO arrangements, HMO contracts or pursuant to other governing plan documents adopted by the DSRA VEBA. If the terms of this document conflict with the terms of such insurance or HMO or governing plan documented, then the terms of the insurance contracts, PPO arrangements, HMO contracts or other governing plan document will control over this document, unless otherwise required by law.

Some of the component benefit programs offered through the Plans are designed to take advantage of available Health Coverage Tax Credits solely by virtue of offering certain benefits through a VEBA structure set up in conjunction with the bankruptcy of the Eligible Retirees' former employer and otherwise to the extent currently provided by applicable law. The DSRA VEBA does not guarantee that any Eligible Retiree or class of retirees will be eligible for the HCTC program nor the timing or amount of any HCTC credit and/or reimbursement, nor should any

information reflected herein be considered tax advice with respect to any Eligible Retirees seeking to take advantage of an HCTC program.

PLAN SUMMARY

For those Eligible Retirees under 65 years of age, the Plan offers medical, drug, vision, dental and voluntary life insurance in every State. Because the Plan is offered through a VEBA created in conjunction with the bankruptcy of Delphi Corporation, some or all of the benefits offered to Eligible Retirees (not otherwise qualified for Medicare) are intended to qualify for Health Coverage Tax Credits, so that Eligible Retirees can take full advantage of the subsidies (or tax credits) that the United States government provides through the HCTC program. As noted below, vision and dental insurance may not qualify for HCTC unless they are obtained as part of bundled medical and prescription drug coverage also obtained through the Plan. The Plan also offers medical, prescription drug, vision and dental coverage to Eligible Retirees when they become Medicare eligible. When Eligible Retirees become eligible for Medicare coverage, you must enroll in Medicare Parts A & B; otherwise you will not be able to receive benefits under this Plan after you are Medicare eligible.

NOTE: With respect to Certain Union Retirees, no coverage can be provided to those Eligible Retirees who are Medicare Eligible by virtue of a medical disability, but only those Certain Union Retirees who become Medicare Eligible by virtue of turning 65 years of age.

PLAN ELIGIBILITY

Eligible Retirees (as that term is used herein shall include the following persons):

- **Current Retirees**: Delphi Salaried Retirees who are receiving a Delphi pension benefit under the Delphi plan (and/or as currently trusteed or otherwise provided by the PBGC) and whose: (1) retiree benefits were sought to be eliminated and/or reduced by Delphi Corporation during its bankruptcy proceedings or (2) who were receiving or eligible to receive subsidized retiree benefits (as that term is defined in Section 1114 of the Bankruptcy Code) from Delphi prior to or on April 1, 2009.

- **Future Retirees**: Delphi Salaried Retirees who retired on or after April 2, 2009 under a Delphi plan and do not otherwise qualify as a Current Retiree.

- **Other Retirees**: Delphi Salaried Retirees who are receiving a Delphi pension benefit under a Delphi plan (and/or as currently trusteed by the PBGC) and do not otherwise qualify as a Current Retiree or Future Retiree. Other Retirees also includes the ex-spouse of a disabled or retired employee of Delphi who is or becomes a PBGC recipient from a Delphi to participate in the Plan for medical, dental, or vision coverage after the divorce assuming that the ex-spouse is HCTC eligible or is over the age of 65 and a subsidy is not required by the insurance carrier for the relevant component benefit plan(s) at issue.

- **Certain Union Retirees**: Delphi bargaining unit employees belonging to either the International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers, AFL-ClO, a Division of the Communication Workers of America (hereinafter the "IUE-CWA) and/or who were members of the United Steelworkers Local 87 (“USW 87”) and who are between the ages of 55 through 64 and otherwise eligible to receive Health

Coverage Tax Credits ("HCTC") (as modified by the American Recovery and Reinvestment Act of 2009 and the Trade Preferences Extension Act of 2015), namely Pension Benefit Guaranty Corporation (PBGC) payees who are 55 years old or older and Trade- affected individuals whose former employers are Trade Adjustment Assistance (TAA) certified.

- **Spouses**: Subject to further criteria reflected below, the spouses and/or surviving spouses of Current Retirees, Future Retirees, Other Retirees and/or Certain Union Retirees are also eligible to participate in the Plan. Spousal eligibility is based on the terms and conditions of each component benefit program.

- **Dependents.** Dependent children are eligible for medical/prescription, dental and vision benefits. A dependent child is defined as an unmarried child up to age 26. The dependent child can remain on the coverage through the end of the calendar year during which they were no longer eligible. Note that a disabled child is not subject to the age limitation so long as he or she was enrolled in coverage prior to becoming disabled if beyond the maximum age limitation.

NOTE: Certain component benefit programs offered through the Plan require that you make an annual election to enroll for coverage. Information about enrollment procedures, including when coverage begins and ends for the various component benefit programs is found within the Attachments, the annual enrollment materials, and on the DSRA-BT website. If you are an Eligible Retiree, you may begin participating in the Plan upon your election to participate in a component benefit program in accordance with the terms and conditions established for that program.

AGE GROUP ELIGIBILITY

Certain component benefit programs are open only to Eligible Retirees who are **under the age of 65**, while other programs are only open to Eligible Retirees **age 65 or older**.

SPOUSES AND DEPENDENTS

Current Retirees, Future Retirees, Other Retirees and Certain Union Retirees (or surviving spouses of the aforementioned groups) shall be responsible for premiums of any participating spouse and/or dependent (unless a divorced spouse is paying for premiums by virtue of the COBRA event).

Spouses and Dependents of Eligible Retirees who otherwise meet the definition of an eligible spouse or dependent are allowed to elect medical, prescription drug, dental, and vision coverage offered under the Plan even if the Eligible Retiree has not elected to participate in that coverage. However, to the extent that the Eligible Retiree elects a particular coverage option, his or her participating spouse and dependents must be enrolled in the same coverage option as the Eligible Retiree.

For example, if an Eligible Retiree elects to enroll in the pre-65 medical/Rx plan and chooses the Silver plan option, his or her spouse who is also enrolled must choose the Silver plan option. However, if the Eligible Retiree chooses not to enroll in dental and vision coverage, his or her

spouse is still permitted to enroll in dental and/or vision coverage if desired.

Depending on the terms established by the insurance carrier, each participating Eligible Retiree, spouse, and/or dependent may have his or her own set of contributions, deductibles, copayments, and coverage limitations (if applicable).

CHANGES IN MARITAL SITUATION (SPOUSE)

An acquired spouse may be added to your coverage upon marriage. A former spouse is eligible if he or she provides a statement from the PBGC confirming that he/she has become a pension recipient in his or her own right due to the divorce. A former spouse is not eligible for coverage in the medical, dental or vision plans unless eligible for PBGC pension as described herein, except for a former spouse who is a QFM within 24 months of divorce. A former spouse is NOT eligible for voluntary term life insurance.

YOUR DEPENDENTS

Dependent children are eligible for medical, prescription, dental, and vision benefits. A dependent child is defined as an unmarried child up to age 26, and includes the Retiree's natural born child, stepchild, adopted child, or grandchild. If the dependent child is enrolled in the Plan on his 26th birthday, he can remain on the coverage through the end of the calendar year during which the child attains age 26. A disabled child is not subject to the age limitation, subject to proof of disability upon request.

Dependents also include, in accordance with Federal law, coverage to certain children (called alternate recipients) if directed to do so by a qualified medical child support order (QMCSO) issued by a court of state agency of competent jurisdiction (see the description of QMCSO procedures in Section III below).

SAME-SEX DOMESTIC PARTNERS AND THEIR CHILDREN

Because same-sex marriages are now legally recognized in all 50 states, effective January 1, 2018, same-sex domestic partners and their children are not eligible for coverage. Notwithstanding the foregoing, if you covered a same-sex domestic partner and their children, if applicable, as of January 1, 2018, your qualified same-sex partner will continue to be eligible.

SPONSORED DEPENDENTS

You also may be able to enroll certain individuals for medical coverage as a Sponsored Dependent if you are able to, and do, legally claim them as exemptions on your federal income tax return. You pay the full cost of such coverage. The following individuals may be enrolled for sponsored dependent coverage:

A. Your child or your current spouse's child who:

1. is not married,
2. lives with you, and
3. does not satisfy the age test;

B. Minor child(ren) living with you and for whom either you or your current spouse is the court-appointed guardian because both natural parents of the minor child(ren) are deceased; or

C. Minor child(ren) living with you and who is the child(ren) of one of your enrolled dependent child(ren).

INDEPENDENT SPOUSES AND DEPENDENTS COVERAGE IN HCTC PROGRAM

Qualified Family Members of Eligible Retirees (as defined by the applicable IRS regulations relating to its HCTC plans) are entitled to participate and enroll in the Plan as otherwise allowed herein whether or not the Eligible Retiree has enrolled or is enrolled in the Plan's HCTC component benefit program if any of the following conditions are met:

- The Eligible Retiree died within 24 months of the spouse and/or dependent seeking enrollment;
- The Eligible Retiree became Medicare eligible within 24 months of the spouse and/or dependent seeking enrollment; or
- The spouse was divorced from the Retiree within 24 months of the spouse seeking enrollment.

Eligibility of any person (retiree, spouse or dependent) may be subject to different and/or additional eligibility criteria by the insurance companies offering the various component benefit programs referenced herein. In such cases, the insurance companies or other entities having control over such component benefit programs will be controlling as it relates to any and all final eligibility determinations (if inconsistent with the terms herein) and will take precedence over the eligibility terms herein to the extent not otherwise prohibited by law.

Enrollment Periods

I. NON-MEDICARE PLANS

A. Annual Open Enrollment Periods:

All Eligible Retirees may enroll during the Annual Open Enrollment Period every year. The dates of the Annual Open Enrollment Period are determined annually by the DSRA-BT Board of Directors and are communicated to members no later than September 30th of each year. Eligible Retirees should contact the DSRA Board on or after September 30th to determine if the Annual Open Enrollment Period has been modified in the event that written notification of same is not received.

An Eligible Retiree may enroll during an Annual Open Enrollment Period if all of the following criteria are met:

1. The Eligible Retiree had Qualifying Health Care Coverage until no more than 30 days before the Eligible Retiree (spouse or dependent) requests to enroll during the Annual Open Enrollment Period; and

2. The Spouse or Dependent Eligible Retiree must be currently enrolled and/or seek enrollment at the same time (unless enrollment is being sought by surviving spouse or Qualified Family Member within 24 months of the death, divorce or Medicare eligibility of the Eligible Retiree.)

3. The effective start for coverage for Annual Open Enrollment will start on January 1st of the next year if all information required to be submitted has been received by the Plan on or before that time. A delay of providing required information to the Plan could delay or otherwise prevent enrollment.

NOTE: Eligible Retirees who are covered under the Plan at the time of an Annual Enrollment Period may change their coverage options under the Plan during Annual Open Enrollment Periods (subject to any and all other applicable restrictions herein) when already enrolled in the Plan (i.e. such as changes to medical plans).

B. Mid-Year Enrollment:

Eligible Retirees who meet each of the following requirements may change or enroll in coverage under the Plan outside of the Annual Enrollment Period if the Eligible Retiree experiences a Qualifying Life Event. Qualifying Life Events include:

1. Gaining or losing a dependent (e.g. marriage, divorce, birth or adoption of a child, etc.)
2. Involuntary loss of other insurance coverage (e.g. exhaustion of COBRA coverage, loss of eligibility under another employer's plan.)
3. Gaining or losing eligibility for HCTC.

If the Qualifying Life Event is gaining or losing a dependent, the Eligible Retiree may change coverage tier (e.g. Single, Two Person, Family), but cannot change the plan(s) in which the Eligible Retiree is enrolled.

If the Qualifying Life Event is involuntary loss of other coverage, the Eligible Retiree may enroll in coverage or change coverage tier, but cannot change the plan(s) in which the Eligible Retiree or family member is enrolled.

If the Qualifying Life Event is becoming HCTC eligible (e.g. beginning to collect a PBGC pension or receive TAA, ATAA, or RTAA benefits), an Eligible Retiree may enroll in or change the plan(s) in which he or she is enrolled (e.g. move from a Sliver to Gold BCBSM plan).

NOTE: *If a Retiree or eligible Dependent meets each of the above conditions, he or she may enroll*

during a Qualifying Enrollment Period within 30 days of the date he or she loses other Qualifying Health Care Coverage. The effective date of coverage for Eligible Retirees who enroll during a Qualifying Enrollment Period will be the first day of the month beginning after the Plan's receipt of a completed request for Qualifying Enrollment (including proof of other qualifying health care coverage).

C. Special Enrollment Periods

Otherwise Eligible Retirees and Qualified Family Members may enroll in the Plan if they: (1) loose eligibility for Children's Health Insurance Program Authorization Act of 2009 or (b) become eligible to participate in a premium assistance program under Medicaid or State Children's Health Insurance Program ("SCHIP"). Request for enrollment pursuant to these criteria must be made within 60 days from the date of eligibility. Please note that this Special Enrollment Period is allowed when becoming eligible for Medicaid or SCHIP. *Enrollment in Medicaid or SCHIP, however, will render a participant <u>ineligible</u> to participate in the HCTC program offered through the Plan.*

NOTE: If a Qualified Family Members timely enrolls (having met the applicable criteria herein) the Qualified Family Members may remain enrolled in the Plan after such time that they may no longer qualify for HCTC, however, said Qualified Family members will be responsible for the entire premium amount (i.e. not the **27.5%** portion usually paid by HCTC participants) and only for so long as such participants are under age 65.

D. Re-Entry Permitted

An individual who terminates participation in the non-Medicare plan will be allowed to re-enter the non-Medicare plan at a later date, subject to the following re-entry rules:

- If the member wants to return during the plan year, this is permitted if the member experiences a "qualifying event" as set forth in the certificate of coverage for the pre-65 non-Medicare plans (including medical, dental, and vision coverage). Qualifying events include a change in marital status, acquisition of a dependent, and loss of other group coverage due to termination of employment, reduction in hours, or other loss of eligibility.

- Members who do not experience a qualifying event but wish to re-enroll in the non-Medicare medical, dental, or vision plan will be permitted to do so, but must wait until the next annual open enrollment period to enroll in one of the coverage options offered for the next plan year. Enrollments received during the annual open enrollment period will be effective on the first day of the next plan year.

<u>II. ENROLLMENT IN PLAN(S) FOR RETIREES 65 YEARS OR OLDER</u>

For Current Retirees, Future Retirees and Other Retirees, if you or your spouse are eligible for Medicare (on any qualified basis), you may enroll in the component programs offered through the

Plan for Medicare Eligible Retirees. *Certain Union Retirees and/or spouses may only enroll in the component programs offered through the Plan for Medicare Eligible Retirees if Medicare eligible based on age (i.e. aged 65 or older).* The supplemental Medicare benefits offered through the Plan are designed to help you cover the cost of medical expenses in conjunction with Medicare Part A and Part B coverage.

Please remember that if you are eligible for Medicare, you must enroll in Medicare Parts A and B in order to receive benefits under this Plan.

Medicare Enrollment Coordination

All Eligible Retirees must have filed Medicare applications within the time applicable time limits governed by the applicable Medicare laws and regulations in order to enroll in the enrollment periods reflected below.

Subject to the above requirements, you may enroll for coverage for benefits offered through the component benefit programs for Medicare Eligible Retirees:

A. General Enrollment Period

Subject to otherwise applicable Medicare enrollment rules, if you did not previously enroll in Medicare Part B when you first became eligible, you may seek enrollment during the General Enrollment Period is from January 1st through March 31st of each year. Your coverage will begin the first day of the month after the plan gets your enrollment form.

B. Initial Enrollment Period (Turning 65 Years old)

Subject to otherwise applicable Medicare enrollment rules, the Initial Enrollment Period starts when you first become eligible for Medicare (the seven-month period that begins three months before the month you turn age 65, includes the month you turn age 65, and ends three months after the month you turn age 65).

"Age Up" Rules and Process. Once you turn age 65, your coverage in the Under Age 65 medical/prescription drug plan will terminate, and you will be required to apply for enrollment in the Post-65 group medical and drug plan offered by DSRA-BT. You will receive an enrollment kit prior to your event date (65th birthday). If you carry dental and vision coverage through DSRA-BT, your enrollment in those plans can continue. In addition, if your spouse or dependent are covered in the Pre-65 medical, prescription drug, dental and vision plans, their coverage may continue subject to a valid election.

C. Annual Enrollment Period

Subject to otherwise applicable Medicare enrollment rules, there will be an annual enrollment period each year during a timeframe consistent with the Medicare enrollment period.

Eligible Retirees already covered under the Plan at the time of an Annual Enrollment Period may also change certain coverage options (limited as provided below) under the Plan when more than one option is otherwise available. During this time, an Eligible Retiree and/or Dependent may move from a lower premium plan to a higher premium plan. (i.e., from Standard or Lower to Premium or Higher plan options). Also, at all times, a retiree and participating spouse must have the same plan types.

Changes made during the Annual Enrollment Period will become effective the first day of January following the Annual Enrollment Period provided you submit a properly completed enrollment application to the Plan's Third Party Administrator that was received by the end of the Annual Enrollment Period.

In addition, Eligible Retirees or eligible Dependents who meet the following requirement may also enroll during the Annual Enrollment Period:

> Eligible Retirees who maintained such other Qualifying Health Care Coverage and other Creditable Prescription Drug Coverage that was continuous from their initial Medicare Enrollment Period until no more than 60 days before the Retiree or eligible Dependent requests enrollment under the Plan. In addition, except as provided in Section II(D) below, a Retiree is not eligible if he or she was previously enrolled in the Post-65 group medical/prescription drug program under this plan and terminated that coverage.

D. Re-Entry

If a Medicare-eligible Retiree who is enrolled in a component medical benefit program chooses to drop such coverage during the enrollment period and purchase an individual medical policy by utilizing the Plan's Mercer/SelectQuote individual coverage shopping option, he or she will be provided a one-time re-entry opportunity. This one-time re-entry opportunity is only available for the first 12 calendar months after the Medicare-eligible Retiree's purchase of individual medical coverage through SelectQuote.

III. SPECIAL INFORMATION ABOUT THE HCTC BENEFITS

A. HCTC Overview

The HCTC helps make health insurance more affordable for retirees, certain workers who are receiving their pension benefits from the Pension Benefit Guaranty Corporation (PBGC) payees, and their families by paying 72.5% of health insurance premiums.

Generally speaking, once fully registered for the monthly HCTC program through the IRS, you'll pay **27.5%** of your qualified premiums, and the government pays **72.5%.** The HCTC is a refundable tax credit - it is paid in full no matter how much federal income tax a recipient owes. The HCTC is generally available on a monthly basis to help you pay for health insurance as you go, or on a yearly basis when you file your federal tax return, in which case the credit will be applied as a refund or toward your year-end taxes.

NOTE: The HCTC benefits offered through the Plan are significantly based on the American Recovery and Reinvestment Act (ARRA) of 2009 and the Trade Preferences Extension Act of 2015, and are subject to change and/or expiration. Accordingly, the Plan does not currently represent or guarantee that it can continue to offer HCTC benefits after December 31, 2019, the current expiration date of the 2015 legislation.

B. HCTC Advance Monthly Payment Program ("AMP")

The AMP allows you to receive the health care tax credit in advance rather than waiting for a refund when you file your annual tax return. Under the AMP, you will pay your 27.5% share of premium to the IRS directly. The IRS will then pay the entire premium to the DSRA-BT designated TPA (BCBSM) directly on a monthly basis. To initiate AMP, you must complete IRS Form 13441-A and provide proof of health care coverage to the IRS. For more information, visit the DSRA-BT website at www.dsrabenefittrust.net or www.IRS.gov.

C. HCTC Eligibility

HCTC eligibility is determined by Federal law. To be eligible for HCTC, Eligible Retirees (and Qualified Family Members) must meet certain criteria, including but not limited to being a worker who lost their job due to foreign trade (as confirmed by an authorized governmental agency) or if you are an Eligible Retiree and your pension was taken over by the PBGC. Other "General HCTC Requirements" include that you *not* be Medicare eligible (or otherwise enrolled in Medicare), *not* claimed as a dependent on another's Federal tax return and that you be enrolled in a Qualified HCTC plan, obtain your benefits through a VEBA or through COBRA, that you are *not* enrolled in Medicare or SCHIP, and *not* enrolled in employer sponsored group coverage if the employer pays more than 50% of the premium.

HCTC is available to Qualified Family Members ("QFM") if they: meet the same "General HCTC Requirements" as the Current Retiree, Future Retiree, Other Retiree or Certain Other Retiree ("Eligible Individuals") and are claimed as dependents on the Eligible Individual's tax return or is a spouse and the Eligible Individuals are also enrolled in a qualified HCTC Plan. Note: the HCTC is only available to a QFM for 24 months after the retiree reaches age 65.

Qualified Family Members must meet all of the following General HCTC Requirements:

- You are covered by a qualified plan for which you pay more than 50% of the premiums.
- You cannot receive Medicare benefits and or otherwise not enrolled in Medicare Part A, B, or C.
- You are not enrolled in Medicaid, or the State Children's Health Insurance Program (CHIP).
- You are not enrolled in Federal Employees Health Benefits Program (FEHBP) or eligible to receive benefits under the U.S. military health system (CHAMPUS/TRICARE).

- You are not in prison under federal, state, or local authority.

- You cannot be claimed as a dependent on someone else's federal tax return unless you are a Qualified Family Member who is applying for the HCTC after the PBGC payee or TAA recipient has enrolled in Medicare, finalized a divorce, or passed away. Married retirees filing jointly is allowed and will not make you in- eligible for HCTC.

Acceptance of enrollment into the Plan does not guarantee or necessarily mean that any Eligible Retiree or Qualified Family Member will be eligible for HCTC. If and to the extent an Eligible Retiree is not eligible for HCTC for any reason, the Eligible Retirees is nevertheless required to pay the entire premium amount associated with any and all component benefit programs they have enrolled for and/or of their Qualified Family Member.

Currently, the premiums for vision and dental benefits are not eligible for HCTC unless those component benefit programs are bundled together with medical and prescription drug coverage. Accordingly, if Eligible Retirees enroll solely for dental and/or vision benefits without plans including medical and prescription drug coverage through this Plan, the premiums for those dental and/or vision benefits will not be eligible for HCTC treatment.

D. Determination of HCTC Eligibility

Nothing herein is intended nor should be construed to expand or alter the eligibility of any Eligible Retiree or Qualified Family Member for HCTC program benefits. HCTC Eligibility and/or the timing thereof with respect to individuals seeking to participate in the Plan shall be determined by reference to the Federal laws defining same and by incorporation of all other criteria reflected in the written policies of the component benefit programs identified herein and all applicable IRS regulations and code provisions relating to HCTC Eligibility.

E. Important Information Regarding Hospitalization for Childbirth

Newborn and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

F. Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 includes important protection for breast

cancer patients who elect breast reconstruction in connection with a mastectomy. Our coverage complies with this legislation and includes the following:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to the Plan's annual Deductibles and Coinsurance provisions. If you have any questions about whether the Plan covers mastectomies or reconstructive surgery, please contact the Plan's Third Party Administrator at the phone number shown in the General Contact Information at the beginning of this document.

IV. QUALIFYING HEALTH CARE COVERAGE

Evidence of Qualifying Health Care Coverage (as that term is used herein) may be required by the Plan for various reasons in association with enrollment periods.

The following types of coverage will be considered other qualifying health care coverage:

1. Coverage under a group health plan.
2. Health insurance coverage, whether the coverage is offered in the group market, the individual market, or otherwise. For this purpose, health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any policy, certificate, or contract offered by an insurance company, insurance service, insurance organization, or HMO that is licensed to engage in the business of insurance in a state and subject to state law that regulates insurance.
3. Medicaid coverage, except for coverage consisting solely of those associated with the Social Security Act's program for distributing pediatric vaccines;
4. Medical coverage for members and certain former members of the uniformed services (the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service) and their dependents under Title 10, Chapter 55 of the United States Code;
5. Health care benefits through the U.S. Department of Veterans Affairs (VA);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A "state health benefits risk pool," which includes:
    a. Any organization qualifying under Code Section 501(c)(26),

b. A qualified high risk pool described in Section 2744(c)(2) of the Public Health Service Act, or

c. Any other arrangement sponsored by a state if the membership composition is specified by the state and the arrangement is established and maintained primarily to provide health insurance coverage for individuals who are residents of that state and who, because they have or have had a medical condition, cannot obtain medical coverage for that condition through insurance or from an HMO or are able to obtain such coverage only at a rate that is substantially higher than the rate for coverage through the membership organization;

8. A health plan offered under the Federal Employees Health Benefits Program;

9. A public health plan, which includes any plan established or maintained by a state, county, or other political subdivision of a state that provides health insurance coverage to individuals who are enrolled in the plan; or

10. A health benefits plan under Section 5(e) of the Peace Corps Act.

The following types of coverage are **not** considered other qualifying health care coverage:

1. Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits.

2. Coverage limited to a specific disease or illness (such as a cancer-only policy or other fixed-dollar indemnity, for example, $200 per day) if:

   a. It is provided under a separate policy, certificate, or contract of insurance;

   b. Its benefits are not coordinated with any other group health plan offered by the same plan sponsor; and

   c. Benefits are payable with respect to an event regardless of whether they also may be payable under any other group health plan maintained by the plan sponsor.

3. Long-term care benefits that are:

   a. Either subject to state long-term care insurance laws or for qualified long-term care services under Code Section 7702B(c)(1);

   b. Provided under a qualified long-term care insurance contract as defined under Code Section 7702B(b); or

   c. Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

4. Coverage to supplement group health plan coverage, such as Medigap or Medsupp

insurance, if provided under a separate policy, certificate, or contract of insurance.

5. Accident-only coverage (including accidental death and dismemberment).

6. Disability income insurance.

7. Liability insurance, including general liability insurance and automobile liability insurance.

8. Coverage issued as a supplement to liability insurance.

9. Workers' compensation or similar insurance.

10. Automobile medical payment insurance.

11. Credit-only insurance (such as mortgage insurance).

12. Coverage for only a specified disease or illness (such as cancer-only) (i) that is provided under a separate policy, certificate, or contract of insurance; (ii) that has no coordination between the provision of the benefits and an exclusion of the benefits under any group health plan maintained by the same plan sponsor; and (iii) for which the benefits are paid.

13. Coverage under a flexible spending account (FSA).

14. The portion of any group health plan consisting of one or more of any of the other benefits in this list.

V. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

As noted above, the Plan provides coverage to Eligible Retirees' dependent children as long as they meet the eligibility requirements of the Plan. Coverage is also offered to certain children (called alternate recipients) if the DSRA-BT is directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction.

Under this law, courts may require an employee, in certain events such as a divorce, to provide coverage to a child who might not otherwise be covered.

A QMCSO is a "medical child support order" that is "qualified" under requirements of the Omnibus Budget Reconciliation Act of 1993. A medical child support order:

- Is any decree, judgment, or order (including approval of settlement agreement) from a state court with jurisdiction over the child's support or an order or administrative notice from a state agency with such jurisdiction under state law.

- Recognizes the child as an alternate recipient for plan benefits.

- Provides, based on a state domestic relations law (including a community property law), for the child's support or health plan coverage.

- Specifically requires a plan to provide coverage. A medical child support order is qualified if it creates or recognizes the existence of an alternate recipient's right to receive plan benefits and specifies the employee's name and last known address.

- Each alternate recipient's name and address (or, if the order provides, the name and address of a state official or an agency may be substituted for the alternate recipient's address).

- A reasonable description of the coverage to which the alternate recipient is entitled.

- The effective date of the coverage.

- How long the child is entitled to coverage.

- That this Plan is subject to the order.

When the DSRA-BT receives a medical child support order, it promptly will notify both the Eligible Retiree and the alternate recipient that the order has been received and what procedures the DSRA-BT will use to determine whether the order is qualified. Then the DSRA-BT will decide, based on written procedures and within a reasonable time, whether the order is qualified. Once the decision is made, the employee and alternate recipient will be notified by mail. If the medical child support order is a QMCSO, the DSRA-BT will notify the employee and each alternate recipient specified in the QMCSO of the Plan's procedures and will allow the alternate recipient an opportunity to designate a representative to receive copies of any notices due under the QMCSO. Coverage for the alternate recipient will begin on the date specified in the QMCSO. This is not necessarily the first day of a calendar month. If the medical child support order is not a QMCSO, the DSRA-BT will notify the Eligible Retiree and each alternate recipient within a reasonable time of the specific reasons that the medical child support order does not qualify as a QMCSO and the procedures for submitting a corrected medical child support order.

VI. GRIEVANCE INFORMATION

Each of the component benefit plans offered through the Plan has its own unique grievance procedures. To the extent not reflected herein, the grievance procedures are contained in the component benefit plan documents set forth in the Attachments to this Summary Plan Description.

A. Grievance Procedures with Respect to Component Plans Offered Through Blue Cross/Blue Shield Michigan.

Your Right to Request Review of an Adverse Benefit Determination

Most questions or concerns about decisions we make on claims or requests for benefits can be resolved through a phone call to one of our customer service representatives. You can locate the phone number in the top right hand corner of the first page of your explanation of benefits

statement or in the letter we send to notify you that we have not approved a request for benefits. In addition, the Employee Retirement Income Security Act of 1974 protects you by providing you the opportunity to request review of an adverse benefit determination.

An adverse benefit determination is a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial based on your eligibility to participate in your employer's health plan. You may request a review of an adverse benefit determination on a pre-service claim, an urgent care claim or a post-service claim.

- "Pre-service claim" means a claim for a benefit where your plan conditions receipt of the benefit, in whole or in part, on obtaining approval in advance of receiving medical care.

- "Urgent care claim" means a claim for medical care or treatment where the time periods for non-urgent predeterminations could seriously jeopardize your life, health, ability to regain maximum function or, in the opinion of a physician who knows your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking.

If a physician with knowledge of your medical condition determines that the claim is one involving urgent care, we will treat it as such. Absent a determination by your physician, we will determine whether a claim is one involving urgent care by using the judgment of a prudent layperson with average knowledge of health and medicine.

- "Post-service claim" means all other claims that are not "pre-service claims" or "urgent care claims."

To obtain review of an adverse benefit determination, you must follow the review procedures below. These procedures vary, depending on whether you are asking for review of a decision on a pre-service, post-service or urgent care claim.

All requests for review of adverse benefit determinations must be in writing, except requests for review of urgent care claims, which may be made orally. Normally, for all three types of claims, you must exhaust our internal review procedure before you can initiate a civil action under section 502(a) of ERISA to obtain benefits.

1. Review Procedure - Post-service claims

Under the review procedure for post-service claims, you are entitled to a two-step appeal process. We must provide you with a written determination within 30 calendar days of our receipt of your written requests for review at each level.

The review procedure for post-service claims provides two levels of review:

a. To initiate level 1 review, you or your authorized representative must send us a written statement explaining why you disagree with our determination. Please include in your request all documentation, records or comments you

believe support your position. You must request review no later than 180 calendar days after you receive our claim decision. Mail your written request for review to the address found in the top right hand corner of the first page of your explanation of benefits statement or to the address in the letter we send notifying you that we have not approved a benefit or service you are requesting. We will respond to your request for review in writing within 30 days, unless we have notified you in writing that we need additional information to complete our review. If you agree with our response, it becomes our final determination, and the review ends.

b. If you disagree with our response to your level 1 appeal, you may then proceed to level 2. You must request level 2 reviews in writing no later than 30 calendar days after you receive our level 1 determination.

Mail your request to the address specified in the letter we send notifying you we have not approved your level 1 appeal.

Again, please provide all documentation, records and comments that support your position. We will provide you a written determination within 30 days of receipt of your request for level 2 review, unless we notify you in writing that additional information is needed for us to complete our review. Our written level 2 determination will be our final determination.

c. If you disagree with our final determination, or if we fail to issue our determination at each level within the 30-day time frame or otherwise fail to comply with the review procedures for level 1 or level 2, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

2. Review Procedure – Pre-service claims

a. The review procedure for pre-service claims is identical to the review procedure for post-service claims, except that we must provide you with written determinations within shorter time frames. Appeals of pre-service claims also are handled in a two-step process. We will issue our determination within 15 calendar days of receipt of your level 1 review requests and within 15 calendar days of your level 2 review requests. You still have 30 days after receipt of the level 1 determination to file your level 2 appeals.

b. If you disagree with our final determination, or if we fail to issue our determination at each level within the 15-day time frame or otherwise fail to comply with the review procedures for level 1 or level 2, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

3. Review Procedure – Urgent care claims

The review procedure for urgent care claims is as follows:

a. You or your physician may submit your request for an internal review orally or in writing.

b. We must provide you with our decision as soon as possible, taking into account the medical exigencies, no later than 72 hours after receipt of your request for review. All necessary information will be transmitted to you or to your authorized representative by telephone, facsimile or other available similarly expeditious method. If our decision is communicated orally, we must provide you or your authorized representative with written confirmation of our decision within two business days.

c. If you disagree with our final determination, or if we fail to issue our determination within 72 hours or otherwise fail to comply with the review procedures, you have the option to bring a civil action under section 502(a) of ERISA to obtain your benefits.

In addition to the information found above, the following requirements apply to review of pre-service, post-service and urgent care claims:

1. In writing, you may authorize another person, including but not limited to a physician, to act on your behalf at any stage in the standard internal review procedure.

2. We do not impose any review fees or costs.

3. Although we have set time frames within which to give you our final determination on all three types of claims, you have the right to allow us additional time if you wish.

4. We will provide you, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

5. You may submit written comments, documents, records and other information relating to your claim for benefits, and we will consider this information even if it was not submitted or considered in the initial benefit determination.

6. The person who reviews your adverse benefit determination will be someone other than the person who issued that determination. The determination we make on review will be a new determination; the initial determination we made on your claim will not be afforded deference in the review.

7. If your request for review involves an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational or not

medically necessary or appropriate, we will consult with a health care professional who has appropriate training and experience in the medical field or specialty involved.

8. Upon request, we will identify the medical experts whose advice was obtained in connection with the adverse benefit determination, even if we did not rely on that advice in making the determination.

9. On review, we will advise you of the specific reason for an adverse determination with reference to the specific plan provisions on which the determination is based.

10. If we rely on an internal rule, guideline, protocol or other similar criterion in making the adverse determination, we will advise you and provide a copy of the rule, guideline, protocol or other similar criterion free of charge upon request.

11. If the adverse benefit determination is due to lack of medical necessity or to experimental treatment, or similar exclusion, we will advise you and provide an explanation of the clinical judgment free of charge upon request.

12. If your health plan provides for any voluntary appeal procedures beyond the level 2 review, we will advise you of those procedures in our level 2 response.VI. Grievance information

13. Each of the component benefit plans offered through the Plan has its own unique grievance procedures. To the extent not reflected herein, the grievance procedures are contained in the component benefit plan documents set forth in the Attachments to this Summary Plan Description.

VII. RIGHT OF RECOVERY

If a benefit payment is made by any of the Plan's contracted providers, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the Plan, this Plan has the right: to require the return of the overpayment on request; or to reduce, by the amount of the overpayment, any future benefit payments made to or on behalf of that person or another person in his or her family. Such right does not affect any other right of recovery the Plan may have with respect to such overpayment.

VIII. MEDICAL OUTCOMES

Neither the Plan's Third Party Administrator nor the VBOD assumes responsibility for the outcome of any covered services or supplies. They make no express or implied warranties concerning the outcome of any covered services or supplies.

IX. NO LIABILITY FOR THE PRACTICE OF MEDICINE

The VBOD and its designees are not engaged in the practice of medicine, and have no control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. The VBOD and its designees bear no liability for loss or injury caused by any health care provider by reason of negligence, failure to provide care or treatment, or otherwise.

X. PLAN LIABILITY

Health expense coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that the Plan will pay benefits only for expenses incurred while this coverage is in force and only to the extent otherwise provided and described in the component benefit programs. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated, even if the expenses were incurred as a result of an accident, injury or disease which occurred, commence or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished. When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by the Plan's Third Party Administrator. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

XI. RIGHT TO MODIFY OR TERMINATE BENEFITS OR PLAN

The Plan Administrator has the sole discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may require in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan, in accordance with and consistent with the VEBA Trust.

The VBOD reserves the right to terminate, suspend, withdraw, amend, or modify the Plan and Plan benefits in whole or in part at any time, subject to the applicable provisions of the VEBA Trust agreement. In the event that the Plan is discontinued, the Administrative VBOD will use the remaining assets of the Plan to provide benefits, pay administration expenses, and carry out the purpose of the Plan in an equitable manner pursuant to the provisions of the VEBA Trust until the Plan assets have been disbursed.

XII. POWER AND AUTHORITY OF INSURANCE COMPANY

Certain benefits under the Plan are fully insured or provided by contract with insurance companies, identified in the Attachments. The insurance companies (or HMOs if applicable) are responsible for (a) determining eligibility for and the amount of any benefits payable under their respective component benefit plans; and (b) prescribing claims procedures to be followed and the claims forms to be used by Eligible Retirees that are participating in the respective component benefit

plans.

XIII. TERMINATION OF COVERAGE

A. General Provisions Applicable to All

Coverage for you and your eligible dependents under the Plan ends as described below:

- If the Plan is canceled, your coverage will end.

Coverage will terminate if you or an eligible dependent:

- Makes repeated and unreasonable demands for services that are not Plan services.
- Threatens the life or well-being of a treatment provider's personnel.

Coverage will terminate immediately on written notice if you or an eligible dependent:

- Acts in a disruptive manner that prevents orderly Plan operations.
- Knowingly furnishes fraudulent or deceptive enrollment information to the DSRA-BT, or Third Party Administrator (including, but not limited to, your or your dependent's date of birth, date of hire, or relationship to another covered individual).

If your coverage terminates for any of these other reasons, you will be ineligible to continue coverage.

Failure to pay premiums when due pursuant to the terms of the component benefit program that you are participating in.

B. Termination Provisions Relating to Pre-65 Plans

When a Current Retiree, Future Retiree, Other Retiree, Certain Union Retiree, eligible spouse and/or dependent enrolled in the Pre-65 HCTC welfare benefit plan (or other plan only offered to Eligible Retirees under the age of 65) becomes 65 years of age, is otherwise eligible for Medicare or otherwise no longer eligible to receive HCTC, said participant's coverage under such Pre-65 component benefit programs offered through the Plan shall terminate. However, with respect to Qualified Family Members and Spouses of Retirees, they may continue in Pre-65 component benefit programs (so long as they meet all of the other Plan eligibility criteria) but will be responsible to pay for 100% of the health insurance premiums at such time as they are no longer entitled to HCTC insurance premium subsidies from the U.S. Government.

C. Termination Provisions Relating to Medicare Eligible (65 or Older) Plans

Upon the death of or divorce from an Eligible Retiree, spouses (and their qualified dependents)

may continue to obtain coverage through the Plan if they are receiving and so long as they are receiving pension benefits from the PBGC.

XIV. 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 employee benefit 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

STATEMENT OF ERISA RIGHTS

As a Participant in the DSRA-BT VEBA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits:

1. Examine, without charge, at the office of the Plan's Third Party Administrator and at other specified locations, such as the DSRA-BT website and the addresses identified in the General Information section of this Plan Documents and all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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;

2. Obtain, upon written request to the Plan's Third Party Administrator, 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 updated summary plan description. The Administrator may make a reasonable charge for the copies; and

3. Receive a summary of the Plan's annual financial report. The Plan's Third Party Administrator is required by law to furnish each Participant with a copy of said summary annual report. This document may be found on the DSRA-BT website.

Nothing herein, however, is intended nor should be construed to increase any rights to receive information other than that prescribed by law under ERISA.

Enforce Your Rights

If your claim for a welfare benefit 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.

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 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's Third Party 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 administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting the Plan's appeal process. You may file suit in Federal court, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

If you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical

child support order. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights. 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.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan's Third Party 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's Third Party 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, DC 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.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that the Plan protect the confidentiality of your private health information. The Plan maintains a Notice of Privacy Practices, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Notice, please contact the Plan's Third Party Administrator.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated. If you have questions about the privacy of your health information, or if you wish to file a privacy violation complaint, please contact the Plan's Privacy Official at the address of the Plan's Third Party Administrator listed in the Ready Reference on Page 6.

A. Permitted Uses and Disclosures of PHI by the Plan Sponsor

The Plan may disclose information that is protected by HIPAA (known as "protected health information" or "PHI") to the Administrative Board or Plan Sponsor, only to enable the

Administrative Board or Plan Sponsor to carry out Plan administration functions or as otherwise permitted by the Standards for Privacy of Individually Identifiable Health Information ("HIPAA Privacy Rule"). Only persons involved with Plan administration functions may have access to any information disclosed under this Section. If the persons to whom information is disclosed violate this Section, or applicable law, the Plan shall cease disclosing such information. Unless otherwise indicated, any definitions under this Section shall have the meaning given them under the HIPAA Privacy Rule.

B. Certification

The Plan may disclose protected health information to the Plan Sponsor only in accordance with this Section. The Plan Sponsor certifies the following:

Further Disclosure Plan Sponsor agrees not to use or further disclose the information obtained under this Section other than as permitted or required by this Summary Plan Description and Plan Document, or as required by law.

1. **Agents**. Plan Sponsor will require that any agents, including any subcontractors, to whom it provides protected health information received under this Section agree to the same restrictions and conditions that apply to Plan Sponsor with respect to such information.

2. **Employment Actions**. Plan Sponsor agrees not to use or disclose any information received under this Section for employment-related actions and decisions, or about any other benefit or employee benefit Plan sponsored by Plan Sponsor.

3. **Duty to Report**. Plan Sponsor will report to the Plan any use or disclosure of information that is inconsistent with the uses or disclosures provided for under this Section of which it becomes aware.

4. **Access**. Plan Sponsor will make available any information it holds under this Section in order for Plan to comply with the access requirements under the HIPAA Privacy Rule.

5. **Amendment**. Plan Sponsor will make available any information it holds under this Section in order for Plan to comply with the amendment requirements under the HIPAA Privacy Rule, and will incorporate any amendments to Protected Health Information it holds, as required under the HIPAA Privacy Rule.

6. **Accounting**. Plan Sponsor agrees to document and provide a description of any disclosures of protected health information, and information related to such disclosures, as would be required for Plan to respond to a request by an individual for an accounting of disclosures of protected health information in accordance with the HIPAA Privacy Rule.

7. **Internal Books**. Plan Sponsor agrees to make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services, for purposes of the Secretary determining the Plan's compliance with the HIPAA Privacy Rule.

8. **Return of Information**. Plan Sponsor will, if feasible, return or destroy all protected health information received from Plan that Plan Sponsor maintains in any form, and retain no copies of such information, when it is no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, Plan Sponsor will limit further uses or disclosures of the information to those purpose that make the return or destruction of the information infeasible.

9. **Adequate Separation**. Plan Sponsor will establish adequate separation between the Plan Sponsor and the Plan, as required under the HIPAA Privacy Rule Plan Sponsor will limit access to protected health information to those individuals or classes of individuals entitled to use or disclose such information and will require that these individuals may use or disclose such information only for Plan administration functions.

10. **Noncompliance**. Plan Sponsor will resolve issues of noncompliance with the terms of this Section by persons entitled to use or disclose protected health information in a timely manner.

C. HIPAA Security Standards

1. **Safeguards**. The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information, as defined in the HIPAA Security Standards, 45 CFR Parts 160, 162 and 164, that it creates, receives, maintains, or transmits on behalf of the Plan, as required in the HIPAA Security Standards.

2. **Agents**. The Plan Sponsor will ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect such information.

3. **Security Incidents**. The Plan Sponsor will report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.