LS Mold
SUPPLEMENTAL MEDICAL HEALTH REIMBURSEMENT PLAN

PLAN DOCUMENT
and
SUMMARY PLAN DESCRIPTION

(A PART OF THE LS MOLD HEALTH AND WELFARE BENEFIT PLAN)

Sponsored by:
LS Mold, Inc.
Attn: Human Resources
750 Waverly Ct
Holland, MI 49423
(616) 392-5926

Plan Supervisor:
Group Marketing Services, Inc.
P.O. Box 19040
Kalamazoo, MI 49019
(269) 343-2611

Original Supplemental Reimbursement Plan Effective Date: November 01, 2002

This Document is Effective: April 01, 2012

April 01, 2012

Dear Employee:

We are pleased to announce LS Mold Supplemental Medical Health Reimbursement Plan (the "Supplemental Reimbursement Plan"). The Supplemental Reimbursement Plan is part of the LS Mold Health and Welfare Benefit Plan (the "Main Health Plan"). This booklet describes the benefits to which you are entitled as a participant in this Supplemental Reimbursement Plan.

There may be differences between the benefits provided under this Supplemental Reimbursement Plan and those provided under the Great Lakes Employers Association group health insurance policy, so you should read this Supplemental Reimbursement Plan carefully.

The Supplemental Reimbursement Plan does not replace your coverage under the Great Lakes Employers Association group health insurance policy -- you still have coverage under that policy. Rather, this Supplemental Reimbursement Plan supplements the benefits provided by that policy. It is generally designed to provide coverage for most (but not all) expenses subject to the deductible under that policy.

Some of the words in this booklet are Capitalized. This means they have a special meaning -- check Section 5 -- "Definitions."

The benefits payable under this Supplemental Reimbursement Plan are paid by LS Mold, Inc. rather than an insurance company. Some administrative services are provided by our Plan Supervisor, Group Marketing Services, Inc.

We expect you to use the benefits provided by this Supplemental Reimbursement Plan fully when you or one of your dependents is Sick or Injured. Equally important is that you not abuse the Supplemental Reimbursement Plan, for money paid from our Supplemental Reimbursement Plan, like any other expense, is an operating cost. In short, we trust you will treat the Supplemental Reimbursement Plan money as though it were your own.

We reserve the right to change or end the Supplemental Reimbursement Plan (and the benefits it provides) at any time (with respect to any Covered Individual, including employees, dependents, disabled individuals and retirees) at our sole discretion. If the Supplemental Reimbursement Plan ends, only claims incurred before the date of termination will be considered for payment.

This Supplemental Reimbursement Plan is not an employment contract, nor is it consideration for, an inducement for, or a condition of the employment of any individual. Nothing in this booklet gives an employee the right to continued employment or limits the right of the Company to discharge the employee at any time, with or without cause.

The office staffs of LS Mold, Inc. and Group Marketing Services, Inc. are available to answer your questions and assist you in filing claims and collecting the benefits to which you are entitled. We know you will appreciate the security which the Supplemental Reimbursement Plan provides, and hope that through good health and good fortune you will seldom need these benefits.

Sincerely,

LS Mold, Inc.
(616) 392-5926

Table of Contents

SECTION 1: ELIGIBILITY AND COVERAGE

You are eligible for and covered under this Supplemental Plan during the same time that you are eligible for and covered under the Great Lakes Employers Association group health insurance policy (the Base Coverage).

Both this Supplemental Reimbursement Plan and the Base Coverage are part of the LS Mold Health Benefit Supplemental Reimbursement Plan (the "Main Health Plan").

This means that your coverage (and that of your family members) begins and ends at the same time as your (their) coverage under the Base Coverage. No additional enrollment form or contribution is required. If you continue coverage under the Base Coverage (e.g., by electing COBRA), you automatically continue coverage under this Supplemental Reimbursement Plan.

SECTION 2: COVERED EXPENSES

The following expenses are covered under this Supplemental Reimbursement Plan:

BASE COVERAGE DEDUCTIBLES.

This Supplemental Reimbursement Plan will pay the In-Network and none of the Out-of-Network Deductibles you have to pay under the Base Coverage after you pay the following amounts;

$ 1,000 for an individual
$ 2,000 for an family

Example 1.
Virg's Base Coverage has a $3,000 Deductible. Under Virg's plan that means that the Base Coverage will not pay anything on an inpatient claim until Virg incurs more than $3,000 of medical expenses, that would otherwise be covered under the Base Coverage, in a year. Virg incurs a $3,000 In-Network inpatient bill, which would have been covered by the Base Coverage if he had met his Deductible. This Supplemental Reimbursement Plan would pay $2,000 (All of the amount Virg owes under the base coverage after he pays the first $1,000).

Example 2.
Mary's Base Coverage also has a $3,000 Deductible. Mary incurs a $3,000 inpatient In-Network bill, but only $2,800 would have been covered by the Base Coverage if Mary had met her Deductible. (The other $200 was for unnecessary treatment not covered by the Base Coverage.) This Supplemental Reimbursement Plan will pay $1,800 (All of the Deductible amount Mary owes under the base coverage after she pays the first $1,000).

BASE COVERAGE CO-INSURANCES.

Even after you meet your Deductible, your Base Coverage may also require you to share in paying some of your expenses. This is known as Co-Insurance.

This Supplemental Reimbursement Plan will not pay any of the Co-Insurance you have to pay under your base coverage.

ADDITIONAL BENEFITS.

This Supplemental Plan does not cover any other expenses not listed above. Further, even coverage of the expenses listed above is subject to the other terms and conditions of the Base Coverage.

RULES:

There are certain rules that apply to Deductible coverage.

1. Only those expenses that are considered Deductibles under the Base Coverage are eligible for payment.
2. Unless specified elsewhere in this document, any expense that is excluded under the Base Coverage is not eligible. If an expense is partially excluded, the excluded part is not eligible. If the Base Coverage does not pay the expense because of a maximum or other limitation, the expense is not eligible under this Supplemental Reimbursement Plan.
3. When you incur a health expense, you or the provider normally sends the bill to Assurity, the insurance company that provides the Base Coverage. In that case, Assurity calculates any Deductible and sends that information to this Supplemental Reimbursement Plan's Supervisor, Group Marketing Services, Inc. ("GMS"). GMS will then calculate what, if anything, is due to you under this Supplemental Reimbursement Plan.

   If, for some reason, you have an expense that is not submitted to Assurity, you should follow the claims procedure in Section 4.
4. The terms and provisions of the Base Coverage apply to this Supplemental Reimbursement Plan, unless this document specifically states otherwise.

SECTION 3: OTHER IMPORTANT PROVISIONS

1. This Supplemental Reimbursement Plan is subject to all of the terms and conditions of the Base Coverage (as if they were part of this Supplemental Reimbursement Plan). It is also subject to the terms and conditions of the Main Health Plan.

2. The provisions of the Base Coverage and the Main Health Plan regarding subrogation and Rights of Recovery also apply to this Supplemental Reimbursement Plan.

3. As a Supplemental Reimbursement Plan, this Supplemental Reimbursement Plan is secondary to every other source of payment that is or may be available, including other insurance (including health, automobile, and liability) and the person who allegedly caused the expense.

4. Automobile related claims are not eligible for coverage under this Supplemental Reimbursement Plan.

5. Mental health and substance abuse related claims are not eligible for coverage under this Supplemental Reimbursement Plan.

6. If there is a specific conflict between this Supplemental Reimbursement Plan and the Base Coverage or the Main Health Plan, the terms of this Supplemental Reimbursement Plan control.

SECTION 4: CLAIMS

HOW DO I FILE A CLAIM?

In most cases, you will not have to do anything. When you or your provider properly file a claim under your Base Coverage, that will automatically trigger a claim under this Supplemental Reimbursement Plan. After your claim under your Base Coverage is determined, any remaining expenses that might be covered under the Supplemental Reimbursement Plan will be sent to the Plan Supervisor for consideration under this Supplemental Reimbursement Plan. You do not need to do anything else.

If, for some reason, you don't file a claim under your Base Coverage, the following procedure applies:

(Note: not filing a claim under your Base Coverage might result in the denial of your claim under this Supplemental Reimbursement Plan.)

You can obtain claim forms and claim information by contacting the Company or Group Marketing Services, Inc.

You should complete your portion of the form and have the Physician or provider who treated you complete his or her portion of the form. Return the completed claim form (along with bills to document the charges) to Group Marketing Services, Inc., at the address shown on the cover of this booklet.

Group Marketing Services, Inc. must receive completed claims within 90 days of when the expense was incurred or the service provided.

When Group Marketing Services, Inc. receives a completed claim form, it will review the claim and determine if it needs any additional information. Once it has all of the information, it will review the claim and calculate the benefits, if any, payable under the Supplemental Reimbursement Plan. It will then provide this information to the Company, who will review your claim, make a final decision, and inform you of its decision. If your claim is denied in whole or in part, the Company will also tell you:

(1) the specific reasons for the denial; and

(2) specific references to the provisions of the Supplemental Reimbursement Plan on which the denial is based; and

(3) what additional material or information, if any, is needed for you to perfect the claim and why it is needed; and

(4) the steps you must take to have the denial reviewed.

Once a claim is properly submitted, it will usually be processed within 30 days. In special cases, an additional 30 days may be needed -- in which case you will be notified. If you do not receive notice during this time, you should treat your claim as denied.

CLAIM DENIAL AND REVIEW

If your claim is denied (in whole or in part) and you feel the denial is wrong, you can request a review. Your request must be in writing and must include the reasons you believe your claim was improperly denied. You must request the review within 180 days from the date on which the written notice denying your claim was sent to you. Your request for review should be addressed to the Plan Administrator.

During the course of the claim review, you have the right to see any document that affects your specific claim. You can also submit any comments or arguments to the Plan Administrator in writing. You may also request a hearing on your claim before the Plan Administrator by sending a written request for a hearing to the Plan Administrator. The Plan Administrator may grant a hearing at its own discretion based on the family merits of each case. If a hearing is held, you can bring a representative on your behalf, but neither the Supplemental Reimbursement Plan nor the Company will incur any additional cost because of your presence or that of your authorized representative.

The Plan Administrator will consider all the available evidence in connection with the denied claim and issue a decision to you in writing. The decision will be written in a manner meant to be clear and understandable with the specific reasons for the decision and with specific references to the Supplemental Reimbursement Plan provisions supporting the decision. The Plan Administrator will ordinarily make a decision on your claim within 60 days of its receipt; however, an additional 60 days may be taken if special circumstances require and if the Plan Administrator notifies you of the delay.

PAYMENT OF BENEFITS

Generally, the Supplemental Reimbursement Plan will pay the provider directly. In some cases the Supplemental Reimbursement Plan may, at the discretion of the Supplemental Reimbursement Plan, pay you directly. But, if you die or become incompetent before all benefits have been paid, the remaining benefits may be paid to any person or entity which appears to the Supplemental Reimbursement Plan to be entitled to the payment. The Supplemental Reimbursement Plan has fully discharged its liability when it makes those payments.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The Plan Supervisor and this Supplemental Reimbursement Plan may, without consent or notice, release to or obtain from any insurance company, group health program, person or entity any information which may be necessary or helpful. Any person claiming Supplemental Reimbursement Plan benefits shall furnish to the Plan Supervisor and/or this Supplemental Reimbursement Plan all information either considers necessary.

PHYSICAL EXAMINATION AND AUTOPSY

While a claim is pending, the Supplemental Reimbursement Plan, at its own expense, has the right to have any family member examined by a Physician designated by it when and as often as it may reasonably require. The Supplemental Reimbursement Plan may also conduct an autopsy in case of death.

LEGAL ACTION

No action at law or in equity shall be brought against this Supplemental Reimbursement Plan more than 1 year after the date on which time a claim was incurred or before the claimant has exhausted the claim review procedure under the Supplemental Reimbursement Plan.

SECTION 5: DEFINITIONS

Base Coverage:	the Great Lakes Employers Association group health insurance policy, which is part of the Main Health Plan.
Company:	LS Mold, Inc.
Co-Insurance:	the portion designated as your Co-Insurance under the Base Coverage.
Deductible:	the portion designated as your Deductible under the Base Coverage.
ERISA:	the Employee Retirement Income Security Act of 1974, as amended, and any regulations issued under or pursuant to that Act.
Main Health Plan:	LS Mold Health and Welfare Benefit Plan.
Supplemental Reimbursement Plan:	this program of health and medical reimbursement benefits sponsored by the Company and named The LS Mold Supplemental Medical Health Reimbursement Plan. It is part of the Main Health Plan.
Plan Administrator:	LS Mold, Inc.
Plan Supervisor:	Group Marketing Services, Inc.

SECTION 6: SUPPLEMENTAL INFORMATION

Supplemental Reimbursement Plan Name

The LS Mold Supplemental Medical Health Reimbursement Plan, which is part of The LS Mold Medical Plan. This booklet only describes the provisions of the Supplemental Reimbursement Plan. Because it is part of the Main Plan, it has the same Number, Plan Administrator, and Sponsor, Agents for service of Legal Process, and Agent for Service of Legal Process as the Main Plan.

Type of Administration

Contract Administration. Administration is provided pursuant to agreements between the Company and Group Marketing Services, Inc., as Supplemental Reimbursement Plan Supervisor.

Plan Supervisor

Group Marketing Services, Inc.
P.O. Box 19040
Kalamazoo, MI 49019-0040
(269) 343-2611

SUPPLEMENTAL REIMBURSEMENT PLAN MODIFICATION, AMENDMENT, AND TERMINATION.

The Company may change or terminate the Supplemental Reimbursement Plan (and the benefits it provides) at any time (with respect to any Covered Family, including dependents, retirees and disabled families) in its sole discretion. If the Supplemental Reimbursement Plan ends, only claims incurred before the date of termination will be paid.

If Supplemental Reimbursement Plan benefits are reduced or eliminated, the reduction or elimination shall take effect with respect to all Covered Families on the date it is scheduled to take effect.

FUNDING

The benefits under the Supplemental Reimbursement Plan are provided solely from the general assets of the Company. The Supplemental Reimbursement Plan does not require the Company or the Plan Administrator to establish any fund or segregate any assets for the benefit of any participant or beneficiary. The Company reserves the right to change contribution levels at any time (with respect to any Covered Family, including dependents, disabled families, and retirees) in its sole discretion.

EMPLOYMENT RELATIONSHIP NOT AFFECTED

This Supplemental Reimbursement Plan is not an employment contract, nor is it consideration for, an inducement for, or a condition of the employment of any family. Nothing in the Supplemental Reimbursement Plan gives you the right to continued employment or limits the right of the Company to discharge you at any time, with or without cause.

SUPPLEMENTAL REIMBURSEMENT PLAN ADMINISTRATION

This Supplemental Reimbursement Plan is administered by the Plan Administrator. The Plan Administrator has full discretionary authority to: interpret the Supplemental Reimbursement Plan; determine eligibility for and the amount of benefits; determine the status and rights of participants, beneficiaries and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the power and authority contemplated by ERISA and the Internal Revenue Code with respect to the Supplemental Reimbursement Plan; employ or appoint persons to help or advise in any administrative functions; appoint investment managers and trustees; and generally to do anything needed to operate, manage and administer the Supplemental Reimbursement Plan. The Plan Administrator has full discretionary authority and control over the Supplemental Reimbursement Plan, including that contemplated by the U.S. Supreme Court's decision in Firestone Tire & Rubber Co. v. Bruch.

The Supplemental Reimbursement Plan has other fiduciaries, advisors, and service providers. The Plan Administrator may allocate fiduciary responsibility and authority among the Supplemental Reimbursement Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Supplemental Reimbursement Plan. Specifically, the Plan Administrator has delegated all of its authority regarding this Supplemental Reimbursement Plan to the Plan Supervisor, Group Marketing Services, Inc. This delegation is not exclusive, so the Plan Administrator retains its authority to exercise when it wishes.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of another Supplemental Reimbursement Plan fiduciary, to the extent provided in ERISA Section 405(a).

ENTIRE PROGRAM. REPRESENTATIONS

This document is the entire description of the benefits provided by the Supplemental Reimbursement Plan and it supersedes any previous or contemporary document, representation, negotiation, promise, understanding or agreement (whether written or oral). This document may be amended or supplemented (and any future document may be entered into) only in writing, signed by the Plan Administrator.

ACCEPTANCE: COOPERATION

All persons accepting benefits under this Supplemental Reimbursement Plan are considered to have accepted its terms.

All parties to this Supplemental Reimbursement Plan and all persons claiming any interest in or benefits from the Supplemental Reimbursement Plan agree to perform any act and to execute any documents which may be necessary or desirable to carry out this Supplemental Reimbursement Plan or any of its provisions.

NO THIRD PARTY BENEFICIARY: ASSIGNMENT

The Supplemental Reimbursement Plan is not intended to benefit any person other than Covered Families. You can not assign or alienate (voluntary or involuntarily) your rights under or interest in this Supplemental Reimbursement Plan and every such attempt is void, including any attempt to assign benefits to a health care provider. However, if you have not already paid the expense, the Plan Administrator, in its discretion, may authorize payment of benefits directly to the provider.

STATE OF MICHIGAN LICENSURE BILL STATEMENT

The families covered by this Supplemental Reimbursement Plan are not insured, and in the event that the Supplemental Reimbursement Plan or Plan Sponsor does not ultimately pay medical expenses, which are eligible for payment under the Supplemental Reimbursement Plan for any reason, the families covered by the Supplemental Reimbursement Plan may be liable for those expenses.

The Plan Supervisor merely processes claims and does not insure that any medical expenses of families covered by the Supplemental Reimbursement Plan will be paid. Complete and proper claims for benefits made by families covered by the Supplemental Reimbursement Plan will be promptly processed; but in the event there are delays in processing claims, the families covered by the Supplemental Reimbursement Plan shall have no greater rights to interest or other remedies against the Plan Supervisor than as otherwise afforded them by law.

COMPLIANCE WITH TAX LAW

This Supplemental Reimbursement Plan is intended to comply with all applicable law, including Section 105(h) of the Internal Revenue Code. It shall be considered amended to the extent necessary to comply with Section 105(h). However, neither the Supplemental Reimbursement Plan, Plan Sponsor, Plan Administrator nor any Supplemental Reimbursement Plan fiduciary represents or guarantees that the Supplemental Reimbursement Plan in fact meets the requirements of any law.

GRANDFATHERED STATUS

Group Marketing Services believes this plan is a 'grandfathered health plan' under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of the preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (269) 343-2611.

In the event the Company maintains a Grandfathered health plan(s) as the term is used in the Patient Protection and Affordable Care Act (PPACA), the Company shall not make any changes to such plan(s), including but not limited to changes with respect to the Company's Contribution levels without providing GMS advanced written notice of the intent to change such plan(s). Making changes to Grandfathered plan(s) without notice to GMS may result in the plan(s) losing Grandfathered status and significant penalties or fines.