SUMMARY OF MATERIAL MODIFICATIONS TO THE
Universal Management Company, LLC
GROUP BENEFIT PLAN

Re:	Health Reform Act Changes for Grandfathered and Nongrandfathered Group Health Plans
Plan Sponsor:	Universal Management Company, LLC
Address:	2570 Seminole Ann Arbor, MI 48105
EIN:	27-3349493
Plan No.:	501

On March 23, 2010, the Patient Protection and Affordability Care Act of 2010 (known as "PPACA" or the "Health Reform Act") was signed into law. PPACA made many sweeping changes to group health plans. The following is a summary of the changes that affect your Group Health Plan effective on or before September 1, 2013. Please note that group health plans that were in effect on March 23, 2010 are called "grandfathered" plans; group health plans that are adopted or modified in certain respects after March 23, 2010 are called "nongrandfathered" plans. The changes described below identify the different rules for grandfathered and nongrandfathered plans.

WHEN DO BENEFITS BEGIN?

A. Health Benefits/ Medical Insurance: Your major medical group health plan currently **is not** a grandfathered plan.

Eligible Spouse/Child	The eligible employee's spouse, or if applicable, same sex domestic partner and the employee's dependent children until the end of the calendar year in which the child reaches age 26.

B. Health Benefits/Prescription Drug Insurance: Your prescription drug group health plan currently **is not** a grandfathered plan.

Eligible Spouse/Child	The eligible employee's spouse, or if applicable, same sex domestic partner and the employee's dependent children until the end of the calendar year in which the child reaches age 26.

WHAT IS THE CLAIMS PROCEDURE FOR HEALTH BENEFITS?

Claims for benefits under the health Plan must be made in writing by you or your authorized representative on forms supplied by the Plan Administrator (or other designated claims representative). Claims must be submitted to the claims administrator in the manner described in your health benefit booklet and this summary. The claims administrator has sole and exclusive discretionary authority to construe and interpret the terms of the Plan, make factual determinations and decide all questions of eligibility and the amount, manner and time of any benefit payment as described below.

- Urgent Care. An urgent care claim is a claim in which a delayed determination: (1) could seriously jeopardize the life or health of the affected individual or the ability of the individual to regain maximum function, or (2) in the opinion of an informed physician, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Approval or denial of an initial urgent care claim will be furnished to you as soon as possible taking into account the medical urgency, but not later than 72 hours after receipt of the claim if the Plan is a grandfathered health plan pursuant to the terms of the Patient Protection and Affordable Care Act ("PPACA"). If the Plan is not a grandfathered health plan pursuant to PPACA, then this approval or denial of an initial urgent care claim will be furnished to you as soon as possible taking into account the medical urgency, but not later than 24 hours after receipt of the claim. Any denial will contain a description of the expedited review process. This notice may be given orally, in which case a written notice will be sent within 3 days of the oral notice.

  If more information is needed from you, the claims administrator will notify you not later than 24 hours after receipt of the claim of the specific information necessary to complete the claim. You then have at least 48 hours to provide the information. The claims administrator will notify you of the decision not later than 48 hours after the earlier of: (1) the receipt of the specified information, or (2) the end of the period afforded you to provide the additional information.

- Concurrent Care. Any request you make to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided as soon as possible taking into account the medical necessity, and you will be notified of the benefit determination within 24 hours after receipt of the claim, provided your claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Approval or denial of a non-urgent initial claim involving concurrent care will be sent to you sufficiently in advance of the reduction or termination of the benefit to allow you to appeal and obtain a decision on review before the benefit is reduced or terminated. Benefits for an ongoing course of treatment will not be reduced or terminated without providing advance notice and an opportunity for advance review.

- Pre-Service Claim. A pre-service claim is a claim that requires pre-approval as a condition of coverage. Approval or denial of an initial pre-service claim will be sent to you within 15 calendar days after receipt of the pre-service claim, unless an extension is required. The 15-day period may be extended once up to 15 calendar days. You will be notified of any such extension before the expiration of the initial 15 day period. If the extension is required due to your failure to provide the necessary information, the claims administrator will describe the required information. You will have at least 45 calendar days from receipt of the notice to provide the information.

- Post-Service Claim. A post-service claim is a claim that does not require pre-approval as a condition of coverage. Approval or denial of an initial post-service claim will be sent to you within 30 calendar days after receipt of the post-service claim, unless an extension is required. The 30-day period may be extended once up to 15 calendar days. If the extension is required due to your failure to provide the necessary information, the claims administrator will describe the required information. You will have at least 45 calendar days from receipt of the notice to provide the information.

WHAT IF THE INITIAL CLAIM IS DENIED?

- Denial of Claim. If your initial claim is denied in whole or in part, the denial will:

    - be sent to you by written or electronic notice;
    - set forth the specific reasons for the denial;
    - reference the pertinent Plan provisions on which the denial is based;
    - describe any additional material or information necessary for you to complete the claim and explain why such information is necessary;
    - contain a description of the Plan's appeal procedures and time limits applicable to the procedures; and
    - provide the following free of charge upon request:

        - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the denial; and
        - an explanation of the scientific or clinical judgment used for a denial of a case involving medical necessity or that is based on an experimental treatment or a similar exclusion or limit.

If the Plan is not a grandfathered health plan pursuant to PPACA, then the denial will also:

- identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable) the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- include the denial code and its corresponding meaning as well as a description of the Plan's standard, if any, that was used in denying the claim;
- contain a description of available internal appeal processes, including information on how to initiate an appeal; and
- disclose the availability of and contact information for any office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals.

- Appealing a Denial. You may request a full and fair review of the initial decision denying the claim. The review will not be conducted by the person who made the initial adverse benefit determination or that person's subordinate and will not be obligated to follow the initial adverse benefit determination. If the Plan is not a grandfathered health plan pursuant to PPACA, then the Plan will also ensure that all claims and appeals are decided in a manner designed to ensure the independence and impartiality of the persons involved in making the decision, and decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support a denial of benefits.

An appeal for review of a denied claim must be requested in writing and filed with the claims administrator within 180 calendar days after the initial denial of the claim. In the case of a claim involving urgent care, the appeal of the initial denial may be requested by telephone and the claims administrator will conduct an expedited review process. All necessary information regarding urgent care, including the decision on review, will be transmitted between the claims administrator and you by telephone, facsimile, or other available similarly expeditious method.

On appeal you may:

- submit written comments, documents, records, and other information relating to the claim for benefits;
- have reasonable access (free of charge upon request) to copies of all documents, records and other information relevant to your claim for benefits; and
- require that the review take into account all comments, documents, records, and other information submitted by you or your authorized representative relating to the claim, even if such information was submitted or considered in the initial benefit determination.

If the Plan is not a grandfathered health plan pursuant to PPACA, then you may also submit testimony and will be allowed to review the claim file.

On appeal the claims administrator will:

- consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment if the

adverse benefit determination was based in whole or in part on a medical judgment. The health care professional will not be the person who was consulted in connection with the adverse benefit determination that is the subject of the appeal or that person's subordinate; and

- identify the medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, even if the advice was not relied upon in making the benefit determination;

If the Plan is not a grandfathered health plan, then the claims administrator will also:

- provide you, free of charge (upon request), with any new or additional information considered, relied upon, or generated by the Plan in connection with your claim, as soon as possible but sufficiently in advance of the date in which the final determination is made so you have time to respond prior to that final determination; and
- provide you, free of charge, with any new or additional rationale, as soon as possible but sufficiently in advance of the date in which the final determination is made so you have time to respond prior to that final determination.

Time Frame for Determining Appeals. The time frame for determining your appeal is described below. Your specific carrier may have a 2-tier level of review or a shorter period for making an appeals determination. You will be given a full description of the appeals procedure if your initial claim is denied. The claims administrator will make a decision involving your appeal as follows:

- urgent care - not later than 72 hours after receipt of your request for review of an adverse benefit determination.
- pre-service claim - not later than 30 calendar days after receipt of your request for review of an adverse benefit determination.
- post-service claim - not later than 60 calendar days after receipt of your request for review of an adverse benefit determination.

State law may require a shorter period for making a claims determination under the Plan. In that event, the claims procedure will comply with the period that is most favorable to the claimant.

WHAT IF THE APPEAL IS DENIED?

If you are denied a benefit on review, the claims administrator will provide you written or electronic notice of the following:

- the specific reason for the denial;
- a reference to the pertinent Plan provisions on which the denial is based; and
- a statement of the following:

- that you will be provided reasonable access, free of charge (upon request), to copies of all documents, records and other information relevant to your claim for benefits;
- that a copy of the internal rule, guideline, protocol, or other similar criterion relied upon in making the denial on review is available free of charge upon request;
- an explanation of the scientific or clinical judgment used for making the denial on review of a case involving medical necessity or that is based on an experimental treatment or a similar exclusion or limit is available free of charge upon request; and
- of your right to bring a civil action under Section 502(a) of ERISA following a final adverse benefit determination.

If the Plan is not a grandfathered health plan, then the claims administrator will also provide you with written or electronic notice of the following:

- a discussion of the decision to deny the claim, including the denial code and its meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;
- identification of the claim involved (including the date of service, the health care provider, the claim amount (if applicable) the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- a description of available external review processes, including information on how to initiate such a review;
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman that can assist with the external review process;

If the Plan is not a grandfathered health plan and the Plan fails to adhere to the requirements of this claims procedure with respect to your claim, then you will have been deemed to have exhausted all internal appeal processes described in this claims procedure and you may immediately initiate an external review or pursue remedies under Section 502(a) of ERISA or under State law, as applicable.

You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office, the Employee Benefits Security Administration, or your State insurance regulatory agency.

Please contact the Plan Administrator with any questions you have regarding the Health Reform Act.