

HOW TO FILE A CLAIM

As a participant of this Employee Benefit Plan, you have the entire responsibility for filing claims and submitting any additional information that will complete your claim file. There are many medical providers who will file for you, however, it is still your responsibility to make sure the filing has been completed.

Written proof of claims must be filed within ninety (90) days of the date services were rendered. And in no case more than 365 days from the date of service.

In order that your claim for benefits under the plan can be paid promptly, it must be filed correctly. Observe the procedures set out below. This will not only save you valuable time and effort, but will enable the Claims Office to operate more efficiently and render prompt service.

When Using PPO Medical Providers

When using a PPO provider, most of the time the medical provider will file for you. However, it is important that we have all the information. Ask the medical provider's clerk to be sure that the bills are clearly marked with the employee participant and patient's social security numbers and the name of employer.

When Using Non-PPO Medical Providers

When using a Non-PPO provider, you may be required to pay your bill and submit a claim to AIA for reimbursement. Be sure that you have itemized statements including your diagnosis and the physician's signature that are clearly marked with employee participant and patient's social security number and the name of your employer.

Accident Claims

Please include a handwritten, dated, and signed note detailing the type, date, location, and extent of the accident and your injuries and details of how and why you think that this accident happened.

When Patient is a College Student

Please include a transcript or other proof of attendance that details the qualified educational institution that the student attends as well as how many hours of course study have been taken in the past two semesters.

Payment of Benefits

All eligible expenses reimbursable under the health care coverages of the plan will be paid to the medical provider if the billing received from the provider indicates a balance due or if the patient has assigned the benefits to the provider. In all other circumstances, payment will be made to the participant.

Benefits due to any PPO provider will be considered assigned to such provider and will be paid directly to such provider, regardless of whether or not a written assignment of benefits was executed.

Mail all Claims to:



1525 Merrill Drive, Suite 2000
Little Rock, AR 72211

Contact Information:

Little Rock Local

**501-312-4650
501-312-4666**

Contact

**General Customer Service
Customer Service Facsimile**

Toll Free

**888-242-4800
Not Available**

CLAIMS DENIALS AND APPEALS PROCEDURES

If the third party administrator or the plan administrator determines that a claim should be wholly or partially denied, the claimant will be given written notification of such denial. This notice will include:

- the reason for the denial; and
- specific reference to the plan provision on which the denial is based.

A claimant may submit a written request for a review of the denied claim within sixty (60) days after receipt of written notification of denial and he / she may review any pertinent documents. Any issues and comments to be considered must be in writing and delivered to the plan's third party administrator. The third party administrator will submit all information to the plan administrator.

The plan administrator will make a decision with regard to such claim not later than sixty (60) days after the receipt of the request for review, unless special circumstances necessitate an extension of time. If such an extension is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial sixty (60) day period. The extension notice will explain the special circumstances requiring an extension and the date the plan expects to render to the decision which will be within one hundred twenty (120) days.

The decision on review will be in writing, will include the specific reason for the decision, and will reference the pertinent provisions on which the decision is based.

APPEALING A CLAIM UNDER ERISA

If you believe that you are entitled to receive a benefit under the plan, including one greater than that initially determined by the administrator, you may appeal. If your claim is denied in whole or in part, you may within 180 days after the receipt of the denial:

1. submit a written request to the third party administrator for review of the claim;
2. review the plan document; and
3. submit, to the third party administrator, in writing any issues or comments as to why you feel the claim should be considered an eligible medical expense.

You will be notified in writing of the administrator's decision together with an explanation of how the decision was made within:

1. 72 hours after receipt of a request for a review of an Urgent Care Claim;
2. 30 calendar days after receipt of a request for a review of a Pre-Service Claim;
3. 60 calendar days after receipt of a request for a review of a Post-Service Claim.

The administrator's decision can not be challenged in judicial or administrative proceedings without first complying with this appeal procedure.

A claim is any request for a plan benefit or benefits made by a covered person or by an authorized representative of the covered person in accordance with the plan's procedures for filing benefit claims.

A post-service claim is a claim that involves consideration of payment of reimbursement of costs for medical care that has already been provided.

A pre-service claim is a request for approval of a benefit in which the terms of the plan condition the receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

An urgent care claim is a claim for medical care to which applying the time periods for making pre-service claims decisions could seriously jeopardize the claimant's life, health or ability to regain maximum function or would subject the claimant to severe pain that cannot be adequately managed without the care that is the subject of the claim. If the treating physician determines the claim is urgent, the plan must treat the claim as urgent.

UTILIZATION REVIEW PROGRAM

Compliance Procedures

Benefits provided by the plan under the medical schedule of benefits are subject to compliance with the requirements of the utilization review program. These requirements are designed to encourage covered persons to obtain quality medical care while utilizing the most cost-efficient sources, however, final healthcare decisions should be made by the patient with the assistance of the medical provider irrespective of whether benefits will be approved or disapproved within this employee benefit plan.

The pre-certification and utilization review organization is:

**Physician's Medical Review
1525 Merrill Drive, Suite 2000
Little Rock, AR 72211
888-777-7241**

Compliance Procedures

Prior to any scheduled hospital admission, non-emergency surgery or out patient surgery, diagnostic testing, home health care, hospice services, skilled nursing services, physical therapy or speech therapy, the attending physician or the plan participant must phone the precertification utilization review organization and submit a description of the diagnosis and proposed treatment plan in a form acceptable to the case manager. The organization will review the proposed treatment in relation to diagnosis and patient's condition and may approve or deny benefits based on generally acceptable medical practices or may recommend an alternative care setting or second (or third) surgical opinion.

In the case of emergency hospitalizations (admission for treatment of a condition that, if treated on an out-patient basis, could lead to disability or death), the patient, doctor, or a family member of the patient must phone the utilization review organization within twenty-four (24) hours of admission or on the first business day following a weekend or holiday admission.

Concurrent review is accomplished by a representative of the utilization review organization periodically reviewing the patient's progress during an in-patient hospitalization, evaluating the method of treatment and the need for continued care, and assisting the physician in planning for a timely discharge and for any services that the patient may need after discharge.

Penalty for Non-Compliance: Failure to comply with the terms and conditions of the utilization review program will result in a penalty of an additional deductible of \$1,000.00. Any additional share of expenses that becomes the covered person's responsibility for failure to comply with these requirements will not be considered eligible medical expenses and thus will not apply to any deductible or out-of-pocket maximums of the plan.

Medical Case Management Services

A case manager will be appointed to follow the care of all patients whose diagnosis fall into certain specified categories for which case management has been proven generally effective. The case manager will review medical records, charts, files, and any other information that may be available. Based on generally accepted medical practices the case manager may propose alternative care settings, hospital discharge plans, and negotiate with providers in order to facilitate quality care in the most cost effective manner. The case manager, subject to the plan administrator's approval, may override any maximum benefit (other than the overall maximum plan benefit) at any time this procedure would facilitate quality care for the patient at a reduction of expenses for the plan. Prior to a covered person's release from the hospital, a representative of the utilization review organization may consult with the attending physician to ensure that any necessary follow-up care is received, such as home visits by nurses or therapists, arrangements for transportation, or the provision of medical equipment such as wheelchairs or walkers.

Retrospective Claims Review

Upon submission of claims for hospitalization and / or other covered services, the utilization review company may review these claims for duplications and / or other billing inaccuracies. Covered persons receiving care are encouraged to assist the representative of the utilization review organization by advising them or the contract administrator of any apparent billing errors and answering any pertinent questions about the billing.

Mothers Health Protection Act of 1998

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, plan 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).

PREFERRED PROVIDER ORGANIZATIONS (PPO)

Choice of Providers

Covered persons have a choice of obtaining health care services and supplies from providers participating in the preferred provider organization (PPO providers) or any other covered provider of their choice. When services or supplies are obtained from providers participating in the preferred provider organization, benefits may be greater than those available when using the services of a non-participating provider. The benefit differences are outlined in the further subsections of this schedule.

NOTE: Certain covered services and supplies may not be available through the preferred provider organization. Covered persons should refer to the provider directory distributed by the PPO organization in order to determine if any particular specialty is included in the Network.

If you have any questions about who the providers are or where they are located, please contact:

PPO Network

Employers Choice Health Alliance
1525 Merrill Drive
Little Rock, AR 72211

501-224-8269
888-4PPODOC (477-6362)

Little Rock, AR
National Toll Free

Access to Specialty Provider Networks

Pre-Authorization Requirement for Access to Specialty Network Provider - The covered person or his / her physician must contact the appointed utilization review company or case manager for pre-authorization or referral to a specialty network provider. Specialty network providers are those hospitals and physicians designated as specialty network providers by the case manager (subject to approval of plan administrator) that provide specialized treatments for, but are not limited to, the following specialties:

Acquired Immune Deficiency Syndrome
Burns
Cancer
Cardiology

Neonatal
Rehabilitation
Trauma

Where available, the appointed utilization review company or case manager may recommend to the covered person, or their lawful representative, a specialty network provider. If the covered person, or their lawful representative, chooses to use the specialty network provider proposed, all claims through the specialty network provider will be paid at a co-insurance level 10% greater than otherwise and will not be subject to deductible. In addition, transportation, lodging, and meals for the covered person and one companion may be covered at 100% up to a daily maximum of \$150.00 per day and \$2,500.00 total maximum.

If the covered person or their lawful representative chooses not to use a specialty network provider proposed, all claims will be paid according to the normal schedule of benefits for these services and are subject to applicable deductible, co-pays and co-insurance (out of pocket). Transportation, lodging, and meals are not covered when the covered person receives services from a non-network specialty provider. Each covered person, or his or her lawful representative, is solely responsible for deciding whether or not to use a specialty network provider.

NOTICE OF FEDERAL REQUIREMENTS(S)

Coverage For Reconstructive Surgery Following Mastectomy

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. all stages of reconstruction of the breast on which the mastectomy was performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. prostheses; and
4. treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

PLAN BENEFIT MAXIMUMS

The maximum payable for all eligible medical expenses for each covered person shall not exceed, in the aggregate, the maximum plan benefit shown below, which applies to all periods a person is covered under the plan. Any lesser maximum benefit amounts are also applicable to all periods a person is covered under the plan. Other maximums may apply to specific periods, conditions, or types or levels of care and are as specified.

Lifetime Maximum Plan Benefit	UNLIMITED
Plan Year Maximum Plan Benefit	\$5,000,000.00
Ambulance	
Ground - per occurrence	\$300.00
Air - per occurrence	\$3,000.00
Alcohol / Chemical Dependency	
Calendar Year Maximum Benefit (Inpatient)	10 DAYS
Calendar Year Maximum Benefit (Outpatient)	20 VISITS
Hazardous Recreational Activities	\$10,000.00
Maximum Benefit Lifetime	
Chiropractic	
Calendar Year Maximum Benefit	\$500.00
Durable Medical Equipment	
Calendar Year Maximum Benefit	\$2,000.00
Mental Health	
Calendar Year Maximum Benefit Mental / Nervous (Inpatient)	10 DAYS
Calendar Year Maximum Benefit Mental / Nervous (Outpatient)	20 VISITS
Home Health Care *	
Calendar Year Maximum Benefit	\$4,000.00
Hospice Care *	
Maximum Plan Benefit Lifetime	\$10,000.00
Maternity/Newborn Infant(s)	
Maximum Combined Benefits of maternity and 1 st year of newborn(s) life	\$100,000.00
Burns	
Maximum Lifetime Benefit	\$100,000.00
Nursing Services (Private Duty) *	
Calendar Year Maximum Benefit	\$5,000.00
Organ Transplants	
Maximum Benefit Lifetime	\$250,000.00
Physical Therapy/Occupational Therapy/Speech Therapy	\$2,000.00
Calendar Year Maximum Benefit (combined)	
Routine Physicals / Preventive Care	\$300.00
Calendar Year Maximum Benefit	

Temporomandibular Joint Dysfunction

Maximum Plan Benefit Lifetime \$1,000.00

Plan Benefit Maximums for Participants Eligible for Medicare

Prescription Drugs \$500.00

Calendar Year Maximum Benefit

* The maximums for these benefits may be increased at discretion of the plan administrator or an appointed case manager subsequent to a case management program. For additional information, see utilization review program.

PPO PLAN

Deductibles

	PPO Provider	Non PPO Provider
Deductible Amount Per Individual (Calendar Year)	\$500.00	\$1,000.00
Deductible Amount Per Family (Calendar Year)	\$1,500.00	\$3,000.00

Per Occurrence (Special) Deductibles

Per Visit to Primary Care Physician for Office Call Family Practice, Pediatrics, OB-GYN (Subject to In-Network Limitations)	\$20.00	N/A
Per Visit to Specialty Care Physician for Office Call	\$30.00	N/A
Emergency Room Visit	\$100.00	\$200.00

**Out Patient Prescription Drug Co-pays
(Per Occurrence)**

Per Prescription		
Generic (34 Day Supply)	\$10.00	N/A
OR Percentage Of Cost:	20%	N/A
Name Brand PREFERRED (34 Day Supply) Greater of	\$25.00	N/A
OR Percentage of Cost:	20%	N/A
Name Brand NON-PREFERRED (34 Day) greater of:	\$50.00	N/A
Or Percentage of Cost:	20%	N/A
Per Prescription (Mail Order)		
Generic (30 Day Supply)	\$5.00	N/A
OR Percentage Of Cost:	20%	N/A
Name Brand PREFERRED (30 Day Supply)	\$20.00	N/A
OR Percentage Of Cost:	20%	N/A
Name Brand NON-PREFERRED (30 Day Supply)	\$40.00	N/A
OR Percentage Of Cost:	20%	N/A

PPO PLAN

Co-Insurance / Deductible Requirements

Co-Insurance is the percentage of eligible expenses that will be paid as shown to the right of each type of services identified below, after the deductible requirement has been satisfied.

<u>ELIGIBLE MEDICAL EXPENSES</u>	<u>PPO Provider</u>	<u>Plan Deductible Applies</u>	<u>Non-PPO Provider</u>	<u>Plan Deductible Applies</u>
Chiropractic	50%	YES	N/A	N/A
Mental / Nervous Health Care	80%	YES	50%	YES
Alcoholism / Chemical Dependency	80%	YES	50%	YES
Emergency Room *After \$100.00 Special Deductible	*80%	YES	50%	YES
Hospital Services – Inpatient	80%	YES	50%	YES
Hospital Services – Outpatient	80%	YES	50%	NO
Primary Care Physician - Office Services Charges up to \$200.00	*100%	NO	50%	YES
Charges exceeding \$200.00 * After \$20.00 Special Deductible	80%	YES	50%	YES
Accident: First \$300.00 (Optional Benefit)	100%	NO	100%	NO
Accident: After first \$300.00 (Optional Benefit)	80%	YES	50%	YES
Specialty Care Physician Services Charges up to \$200.00	*100%	NO	50%	YES
Charges exceeding \$200.00 * After \$30.00 Special Deductible	80%	YES	50%	YES
Routine Physicals / Preventive Care - Office Services * After \$20.00 Special Deductible	*100%	NO	50%	YES
Allergy Injections & Serum	80%	YES	50%	YES
All Other Eligible Medical Expenses	80%	YES	50%	YES

Non Network Available Treatments

Medically necessary specialty care treatments for which there is not a network doctor within the PPO, deductibles and coinsurance will be based on PPO provider benefits, all other medical expenses.

Emergencies

If a covered person is admitted to a non-PPO facility due to an emergency condition (treatment of a condition that, if not treated immediately, could lead to disability or death), or if an ambulance transports an individual to a non-PPO facility in an emergency situation, eligible expenses will be based on usual, customary, and reasonable charges. Deductibles and coinsurances will be calculated based on PPO provider benefits, all other medical expenses

OUT - OF- POCKET MAXIMUMS

In-Network

EXCEPT as described below, once a covered person's allowed charges exceed \$10,000.00 (plus deductible and co-pays) coinsurance obligations have been satisfied.

EXCEPT as described below, once a covered family (employee and his dependents) allowable charges exceed \$20,000.00, (plus deductibles and co-pays) coinsurance obligations have been satisfied.

Out of Network

EXCEPT as described below, once a covered person's allowed charges exceed \$50,000.00 (plus deductible and co-pays) coinsurance obligations have been satisfied.

EXCEPT as described below, once a covered family (employee and his dependents) allowable charges exceed \$100,000.00, (plus deductibles and co-pays) coinsurance obligations have been satisfied.

NOTE: The following will not apply to the out-of-pocket maximums and will always be paid at the percentages shown in the schedule above: Mental Health Conditions, Alcoholism, and Chemical Dependency, Charges by Non-PPO Providers.

NOTE: The following will not be considered allowed charges when calculating out of pocket maximums: calendar year deductible requirements, ineligible charges over usual and customary, and penalties for non-compliance with the utilization review program.

NOTE: THIS IS A SUMMARY ONLY. PLEASE REFER TO THE "ELIGIBLE MEDICAL EXPENSES" AND "LIMITATIONS AND EXCLUSIONS" SECTIONS FOR MORE COMPLETE INFORMATION.

ELIGIBLE MEDICAL EXPENSES

Except as otherwise noted below or in the medical schedule of benefits, eligible medical expenses are the usual, customary, and reasonable charges for services listed below that are incurred by a covered person, subject to the "Definitions" and "Limitations and Exclusions" sections and all other provisions of the plan document. In general, services and supplies must be approved by a physician and must be medically necessary for the care and treatment of a covered sickness, accidental injury, pregnancy, or other covered health care condition.

For benefit purposes, medical expenses shall be deemed to be incurred on the latest of the following dates:

- the date a purchase is contracted;
- the date delivery is made; or
- the actual date a service is rendered.

Alcohol Dependency

Charges related to an inpatient or outpatient program designed to eliminate alcohol dependency. (See plan benefit maximums for dollar limitations on benefits).

Ambulance (Air)

Charges by a professional ambulance service for transporting the covered person from the place where the injury or sickness occurred to the nearest hospital which has equipment to furnish special treatment required for such injury or sickness, subject to the following: All air transportation must occur within the United States or Canada and the injury must be determined to be life threatening in nature for the use of an air ambulance. (See plan benefit maximums for dollar limitations on benefits).

Ambulance (Ground)

Charges for medically necessary ground ambulance services provided by a local, professional, state licensed ambulance service for transporting the covered person to the nearest hospital for treatment of a medical emergency or accidental injury emergency. (See plan benefit maximums for dollar limitations on benefits).

Ambulatory Surgical Center / Licensed Surgical Facility

Charges of ambulatory surgical centers and licensed surgical facilities.

Anesthesia

The charges made for anesthetics and by a physician or registered nurse for the administration of anesthesia.

Birthing Centers

The charges for birthing centers.

Blood

The charges for blood and blood plasma (if not replaced by or for the patient), including blood processing charges.

Breast Reconstruction

In the case of a covered participant who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and patient, for reconstruction of the breast on which the mastectomy has been performed; for surgery and reconstruction of the other breast to produce a symmetrical appearance; for prosthesis and physical complications from all stages of the mastectomy including lymphedemas. The usual Plan deductible and co-insurance requirements will be applicable to these benefits.

Casts, Splints, Trusses, and Surgical Dressing

The charges for casts, splints, trusses, and surgical dressings.

Chemical Dependency

Charges related to an inpatient or outpatient program designed to eliminate chemical dependency. (See plan benefit maximums for dollar limitations on benefits).

Chemotherapy

The charges for chemotherapy treatment.

Chiropractic-Type Care

Manipulation to correct such vertebral disorders as incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing. (See plan benefit maximums for dollar limitations on benefits). Not subject to out of network provisions.

Cosmetic Surgery Due to Accident or Birth Defect

The charges for the correction of congenital birth defects or traumatic injury sustained while covered under this plan. Treatment must be concluded within 12 months from accident or birth.

Diagnostic Services

Diagnostic laboratory and x-ray expenses, including charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar diagnostic tests generally approved by physicians throughout the United States.

Durable Medical Equipment

Charges for rental of a wheelchair, hospital bed, iron lung, or other durable medical equipment required for temporary therapeutic use, or the purchase of this equipment if economically justified, whichever is less. If equipment is purchased under the preceding sentence, it shall be owned by the plan, not by the participant or dependent who uses it. Purchase or rental of luxury medical equipment (e.g., motorized wheelchairs or other vehicles or bionic or computerized artificial limbs) is not covered when standard equipment is appropriate for the patient's condition. (see plan benefit maximums for dollar limitations on benefits).

Foot Care (Acute)

Charges for the removal of nail roots or for the treatment of a metabolic or peripheral-vascular disease.

Home Health Care

Charges made by a home health care agency for: ((See plan benefit maximums for dollar limitations on benefits).

1. Registered nurses or licensed practical nurses;
2. Certified home health aides under the direct supervision of a registered nurse;
3. Registered therapist performing physical, occupational, or speech therapy;
4. Physician calls in the office, home, clinic or outpatient department;
5. Services, drugs and medical supplies medically necessary for the treatment of the covered person that would have been provided in the hospital, but not including custodial care.

Hospice

Charges made by a hospice during a hospice benefit period for:

1. Nursing care by a registered nurse, a licensed practical nurse, a vocational nurse, or a public health nurse, all of whom are under the direct supervision of a registered nurse;
2. Physical therapy and speech therapy when rendered by a licensed physical or speech therapist;
3. Medical supplies, including drugs and biologicals, and the use of medical appliances;
4. Physician's services; and
5. Services, supplies, and treatments deemed medically necessary and ordered by a physician.

Hospital Services

For a medically necessary confinement, the plan covers:

1. Daily room and board charges based on the average semi-private room rate. If the hospital has only private rooms, the plan will cover the hospital's most standard rate for the private room; and all other medically necessary services and supplies furnished by the hospital, but not for private-duty nursing care.
2. Charges for intensive care units based on usual and customary and reasonable charges.

Maternity/Newborn Infant(s)

The combined charges incurred by mother and new born infant(s) during pregnancy, termination of pregnancy and the first year of life of the new born infant. The plan maximum is a combined limit that covers the mother and newborn infant(s). The combined limit for multiple new born infants is the same as for a single infant.

Medical Billing Review

The charges by a medical billing review company for audit of physician and hospital billings for covered services to determine potential excessive charges relating to upcoding, unbundling, and usual and customary charges.

Medical Case Management

If medical case management is approved by the plan administrator, such charges by the utilization review organization will be considered covered expenses under the plan.

Mental Health Care

Charges for psychiatric or psychological testing for evaluation of and treatment for mental retardation, attention deficit syndrome, behavioral problems, personality disorders, and hyperkinetic syndrome when such services are supplied by a physician, psychiatrist, licensed psychologist, licensed clinical social worker (LCSW) or master level social worker (MSW). (Subject to limitations, see schedule of benefits, benefit maximums, and mental health care exclusions.)

Midwife

The charges for services performed by a registered nurse midwife.

Multiple Surgeries

The plan will allow 100% of the reasonable and customary fee for the greater procedure and 50% for each lesser procedure performed during the same operative session.

Newborn Care (when newborn is enrolled as a dependent)

The hospital and physician charges for a newborn that has been enrolled for dependent coverage subject to eligibility and enrollment provisions included in this plan will be to the same extent as any illness covered.

Newborn Care (when newborn is not enrolled as a dependent)

Coverage for hospital and physician charges for a newborn dependent of a covered person that has not been enrolled for dependent coverage subject to the eligibility and enrollment provisions included in this plan will be limited to those charges incurred during the first five (5) days following birth. These charges (if applicable) are subject to all deductible, co-pay and / or coinsurance provisions as well as other provisions of the plan.

Nursing Services

The charges made by a registered nurse or licensed practical nurse for private-duty nursing services when medically necessary and prescribed in writing by the attending physician or surgeon specifically as to duration and type and when performed in the covered person's home. See schedule of benefits for limitations.

Occupational Therapy

The charges for the professional services of a licensed physical therapist, when specifically prescribed by and under the direct supervision of a physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function.. (See plan benefit maximums for dollar limitations on benefits. Limitations apply to in and out patient services).

Oral Surgery

Charges incurred for:

1. The removal of impacted teeth (no allowance for other extraction's) on a hospital outpatient basis, or if deemed to be medically necessary by the attending physician, on a hospital inpatient basis; and
2. Treatment required because of an accidental bodily injury to otherwise healthy natural teeth (excluding dentures). Such expenses must be incurred within six (6) months of the date of accident.

Orthotics

The initial purchase, fitting and repair of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital conditional or an injury or sickness. Shoe inserts are not covered.

Out-Patient Surgery

Eligible expenses incurred in connection with any surgical procedure that is performed on an out-patient basis in a hospital, ambulatory surgical center, or physician's office. Charges must be incurred on the same day as the surgery, except that tests required by the hospital because of the surgery will be covered if they are incurred within seven days prior to the surgery.

Oxygen

Oxygen and services and supplies for the administration of oxygen.

Physical Therapy

The charges for the professional services of a licensed physical therapist, when specifically prescribed by and under the direct supervision of a physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function.. (See plan benefit maximums for dollar limitations on benefits. Limitations apply to in and out patient services).

Physician Services

The services of a physician for medical care including office visits, home visits, hospital inpatient care, hospital outpatient visits and exams, clinic care, and surgical opinion consultations.

Pre-Admission Testing

The charges for diagnostic test performed on an out-patient basis prior to a scheduled hospital admission when the tests are performed within seven (7) days before admission to the hospital and the patient is subsequently admitted to the hospital.

Preferred Provider Organization

If a preferred provider organization (PPO) is shown in the schedule of benefits, usual, customary, and reasonable charges, including charges for repricing (including charges stated as "a percentage of savings") by the PPO will be considered as a claims expense and will be considered covered expenses under the plan.

Pregnancy

Medical expenses related to the pregnancy of a covered employee or covered spousal dependent are covered to the same extent as any covered sickness.

Prescription Drugs (Inpatient)

Charges for drugs that are prescribed in writing by a physician and are medically necessary for the treatment of illness or injury.

Prescription Drugs (Outpatient)

Outpatient prescription drug benefits are limited and only provided under the terms described in the "Outpatient Prescription Benefit" section.

Prescription Drugs (Physician Dispensed)

Charges for vaccines or allergy serums when injected by a physician or when dispensed by a doctor for home injection.

Private Duty Nursing

Fees of registered nurses or licensed practical nurses for private duty nursing. (See schedule of benefits, benefit maximums for limitations).

Prosthetic Appliances

The charges for initial artificial limbs or eyes required to replace natural limbs or eyes lost while a covered person is covered by this plan.

Radiation Therapy

Charges for radiation therapy and treatment.

Respiratory Therapy

The charges for the professional services of a licensed respiratory therapist, when specifically prescribed by a physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function.

Routine Physical Exams and Preventive Care

Charges for routine physical exams and preventive care. (See schedule of benefits, benefit maximums for benefit limitations.)

Second Surgical Opinion

The usual, customary, and reasonable fees of a physician for a second (or third) surgical opinion consultation and related diagnostic work, when recommended by the utilization review organization.

Skilled Nursing Facility - Pre-authorization Required

Medically necessary room and board (limited as shown below unless approved by the utilization review organization) and services and supplies provided by a skilled nursing facility, but only when the attending physician certifies the confinement as medically necessary every fourteen (14) days and when confinement:

1. Is preceded by a confinement of at least three days in a hospital,
2. Is for the same condition causing the preceding confinement; and
3. Commences within seven days of discharge from such prior confinement.

The eligible expense for daily room and board is limited to the semi-private room charge of the facility. See schedule of benefits for maximum allowable confinement.

Speech Therapy

Fees of a legally qualified physician or qualified speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an illness or injury, other than a functional nervous disorder, or due to surgery performed as the result of an illness or injury. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy. (See plan benefit maximums for dollar limitations on benefits. Limitations apply to in and out patient services).

Sterilization

The charges for tubaligations and vasectomies.

Temporomandibular Joint Dysfunction

The charges related to temporomandibular joint dysfunction are limited. (See plan benefit maximums for dollar limitations on benefits).

Transplants of Human Tissue

Benefits for organ transplants are only provided only subject to the terms and conditions described in the section of this plan titled "Organ Transplant Benefit."

Urgent Care Facilities

The charges incurred at urgent care facilities.

ORGAN TRANSPLANT BENEFIT

Transplants of human tissue will be covered according to the procedures and limitations as follows:

Pre-Authorization Requirement for Transplant Evaluation - Expenses incurred in connection with the evaluation of a covered person for any human organ or tissue transplant will be covered, but only after a referral to and pre-authorization through the appointed pre-certification company has occurred. The covered person or his physician should contact the pre-certification company for pre-authorization of an evaluation for transplant physician. A case manager will be assigned to work with the covered person closely through the transplant process.

Pre-Authorization Requirement for Transplant Procedure - After the evaluation by a transplant physician has occurred, the covered person or the transplant physician should contact the case manager. Medical information about the covered person's condition and the proposed transplant protocol will be requested for review. The case manager will coordinate the review of the medical information for medical necessity and coverage determination. The case manager will communicate the determination to the covered person and transplant physician.

The following are definitions relating to transplants of human tissue.

Covered Transplant Procedures - Covered transplant procedures are any of the following adult or pediatric human organ and tissue transplant procedures determined to be medically necessary: heart, liver, bone marrow, lung, kidney, simultaneous pancreas/kidney, and simultaneous heart/lung.

Transplant Network Providers - Transplant network providers are those hospitals and physicians that are under contract with the plan administrator to provide transplant services.

Non-Transplant Network Providers - Non-transplant network providers are those hospitals and physicians that are not under contract with the plan administrator to provide transplant services.

Transplant Services - Transplant services means any services directly related to a covered transplant procedure including, but not limited to, inpatient and outpatient hospital services, physician services, physician services for diagnosis, treatment, and surgery for a covered transplant procedure, diagnostic services, and procurement of an organ or tissue, including services provided to a living donor of an organ or tissue. Transplant services also include, but is not limited to, durable medical equipment rental outside of the hospital, prescription drugs including immunosuppressives, surgical supplies and dressings, and home health care.

The transplant benefits are paid as follows:

Transplant Network Provider - Standard plan benefits for transplant services provided through a transplant network provider with respect to the type of covered transplant procedure performed. Standard plan benefits for transportation, lodging, and meal costs for the covered person and one companion are covered for travel related to the initial evaluation, ongoing evaluations prior to transplant, and subsequent admission for a covered transplant procedure performed by a transplant network provider subject to limits included in the organ transplant provisions. If the recipient is a minor, transportation for two companions may be covered (Subject to approval by case manager appointed by the plan).

Non-Transplant Network Provider - 50% of covered charges (not to exceed reasonable and customary) for transplant services provided through a non-transplant network provider with respect to the type of covered transplant procedure performed. Transportation, lodging, and meal costs for travel related to the initial evaluation, ongoing evaluations prior to transplant and subsequent admission for a covered transplant procedure performed by a non-transplant network provider are **not** covered under the plan.

The transplant benefit maximums are as follows:

Transportation, Lodging, and Meals - \$5,000.00 for all travel, lodging, and meals related to transplant services performed by a transplant network provider. \$150.00 per day maximum for lodging and meals. Itemized receipts in a form of satisfactory to the plan administrator must be submitted by the covered person when the claims are filed for reimbursement.

Organ and / or Tissue Procurement - The payments for procurement expenses for a donor organ are covered at standard plan benefits when the covered transplant procedure is performed by a transplant network provider, but may not exceed the maximums below, per covered transplant procedure:

The payments for procurement expenses for a donor are covered at 50% when the covered transplant procedure is performed by a non-network transplant provider, but may not exceed the following maximums, per covered transplant procedure:

In all cases, procurement expenses may not exceed the following maximums, per transplant procedure:

Lung	\$10,000.00	Heart / Lung	\$10,000.00
Heart	\$10,000.00	Kidney / Pancreas	\$10,000.00
Liver	\$10,000.00	Allogeneic BMT	\$10,000.00

Maximum for all Transplant Services - The total dollar amount to be paid to or on behalf of a covered person for all transplant services including the covered transplant procedure shall be included in and the plan benefit maximum. The maximums shown for transportation, lodging, meals, and procurement are included in and accrue toward the plan benefit maximum.

The following special rules apply to organ transplants:

Exclusions: - there are no benefits for:

- a. Services and supplies of any provider located outside the United States of America, except for procurement services (subject to the amounts shown in the maximums section).
- b. Services and supplies which are payable or are to be repaid under any private or public research fund, whether or not such fund was applied for or received.
- c. Implant of an artificial or mechanical heart or part thereof, this does not include replacement of a heart valve.
- d. Services for non-human organ transplants.
- e. All other exclusions, limitations, or conditions set forth in this plan shall apply to transplant services unless otherwise provided in this transplant services section.

Case Management - The case manager will assess the continuing care in catastrophic and chronic high cost medical care and discuss with the attending physician less costly alternate means of medical care. Coverage will be provided for less costly medical services and supplies, even though such alternatives are not specifically stated in the plan. This does not, however, cover expenses that are considered experimental and investigational as set forth in the plan or are provided only as a convenience to the covered person, the covered person's family or the health care provider. Coverage for alternative care is subject to the same overall plan benefit maximum, copay, deductible, and / or co-insurance requirements that apply to the medical care being replaced. Although the case manager may suggest to the physician less costly alternative means of medical care, the final decision on patient care and treatment is the responsibility of the covered person, the family, and the attending physician. If the case manager suggests less costly alternative means of medical care, the plan will reimburse at that rate.

MEDICAL EXCLUSIONS AND LIMITATIONS

Abortion

Charges for abortions are excluded.

Air Purification Units

Charges are excluded for air conditioners, air-purification units, humidifiers, or electric heating units.

Alcohol Dependency

Charges related to alcohol dependency are limited. (See schedule of benefits, benefit maximums).

All Terrain Vehicles

Charges incurred during the operation of All Terrain Vehicles are limited. Charges are excluded for use outside the manufacture's recommendation. This includes but is not limited to, the manufacture's recommended minimum rider age and capacity. See also "Hazardous Activities".

Ambulance (Hospital to Hospital Transfers)

Charges for ambulance transportation (air or ground) of the covered person from the treating hospital or emergency room, to another hospital for treatment which can be rendered at the transferring hospital are not covered, except in instances in which the treating / transferring hospital does not possess the capability (equipment or personnel) to treat a specific illness or injury, or when the covered person is transported as part of a Case Management Program approved by the plan administrator.

Biofeedback

Charges for biofeedback treatment are excluded.

Blood

Charges are excluded for whole blood or plasma when donated or otherwise replaced by or on behalf of the patient.

Breast Reduction

Charges for breast reductions are excluded.

Charges for Non Disclosed Medical Conditions

The charges related to medical conditions that were non disclosed during the application process are excluded. This includes any condition for which the participant was treated for or which treatment, advice or consultation was sought for. Prescription drugs are considered treatments.

Charges for Non Medically Necessary Treatments

Charges are excluded for services or supplies not considered to be medically necessary.

Charges Considered over the Usual and Customary

Charges are excluded for services or supplies that are considered to be in excess of the usual and customary charge.

Charges for or relating to Pre-Existing Conditions

Charges for and relating to pre-existing conditions is provided only under the terms of the section titled "Pre-existing Conditions".

Charges for treatment/services necessitated by Provider Error

Charges are excluded for treatment/services necessitated by provider error

Chemical Dependency

Charges related to chemical dependency are limited. (See schedule of benefits, benefit maximums).

Chemical Dependency Treatment in Lieu of Fine or Imprisonment

Charges for services, treatment or care of any kind of chemical dependency (including alcohol dependency) if the participant is convicted in any court of law and is required by the court, or arranges in lieu of conviction, to undergo care or treatment as an alternative to, or in addition to, fine or imprisonment.

Contraceptive Devices

Charges for Norplant is limited to 1 purchase and placement in a consecutive 5 year period. All other devices are excluded. (See the section titled "Outpatient Prescription Drug Benefits" for covered contraceptives.) Contraceptive devices are not covered for dependent children.

Contraceptives (oral)

See section titled "Outpatient Prescription Drug Benefits" for covered contraceptives. Birth Control pills are not covered for dependent children.

Cosmetic Surgery

Charges are excluded for surgery, service, drug, or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasant or unsightly.

Custodial Care

Charges are excluded for care or confinement primarily for the purpose of meeting personal needs that could be rendered at home or by persons without professional skills or training.

Dental Care

Charges are excluded for care or treatment of or to the teeth, gingival tissue, alveolar processes, malocclusion or replacement of teeth, unless specifically included in a segregated dental plan herein.

Diagnostic Hospital Admissions

Charges are excluded for hospital confinement for diagnostic purposes only, when such diagnostic services could be performed in an out-patient setting.

Driving (operating) While Under the Influence (operation while under the influence of any vehicle, machinery or craft)

Charges resulting from or occurring during operation by the covered person while under the influence of alcohol or drugs. This includes, but is not limited to automobiles, boats, ATV's, motorcycles, airplanes, heavy equipment, etc..

Educational, Recreational, or Vocational Testing, Training, or Therapy

The charges are excluded for educational, recreational or vocational testing, training, or therapy.

Exercise Equipment

The charges are excluded for exercising equipment, vibratory equipment, or swimming or therapy pools.

Foot Care (routine)

Expenses incurred for the non-surgical treatment of the feet, treatment of corns, calluses, or toenails, or other routine foot care.

Hair Transplants

The charges are excluded for hair transplants.

Hazardous Recreational Activities

"The charges arising from injuries sustained while participating in hazardous recreational activities are limited: This includes, but is not limited to, participating in X-Games type activities, riding on or driving all-terrain vehicles (3-wheel ATV or "quad"), skydiving, hang gliding, piloting an aircraft, riding on or operating jet skis or wave runners, rock climbing, and organized or unorganized motorized racing."

Hearing Aids or Related Examinations

The charges are excluded for hearing tests, hearing aids, or other hearing related examinations, except for those relating to pediatric exams.

Impregnation

The charges are excluded for artificial insemination, in-vitro fertilization, or any other type of artificial impregnation procedure.

Infertility

Charges for or in preparation for all artificial means of conception, infertility treatment (including medications), artificial insemination, in vitro fertilization and related tests/procedures; services, supplies, or treatment related to reproductive sexual dysfunction or inadequacy.

Inpatient Private Duty Nursing

Fees of registered nurses or licensed practical nurses for private duty nursing.

Mental Health Care

The charges are excluded for psychiatric or psychological testing for evaluation, counseling, or treatment for marriage or family problems, sexual dysfunctions and inadequacies, and vocational inadequacies.

Newborn Care (when newborn is not enrolled as a dependent)

Coverage for hospital and physician charges for a newborn dependent of a covered person that has not been enrolled for dependent coverage subject to the eligibility and enrollment provisions included in this plan will be limited to those charges incurred during the first five (5) days following birth. These charges (if applicable) are subject to all deductible, co-pay and / or coinsurance provisions as well as other provisions of the plan.

Organ Transplants Other Than Expressly Included

Charges are excluded for organ transplant surgery for recipients or donors, other than those procedures and benefits described under "Organ Transplant Benefit."

Personal Comfort or Convenience Items

Charges are excluded for services or supplies provided for personal comfort and not necessary for treatment of covered sickness, accidental injury, or pregnancy including, but not limited to, the purchase or rental of telephones, televisions, orthopedic mattresses, allergy-free pillows, blankets, mattress covers, wigs, non-prescription drugs and medicines, non-hospital adjustable beds, waterbeds, motorized transportation equipment, elevators, escalators, professional medical equipment (such as blood pressure kits), or supplies or attachments for such equipment

Physician

Charges for physician or registered nurse practitioners' fees for any treatment which is not rendered by or in the physical presence of a licensed physician.

Pregnancy of a Dependent Child

Charges related to pregnancy of a dependent child are excluded.

Prescription Drugs (In-Patient)

Charges are excluded for experimental drugs, fertility drugs, non-prescription drugs, drugs that a person is entitled to receive without charge under any workers compensation law, immunization agents (other than pediatric immunizations), drugs not required for prevention of illness, Azidothymidine, AZT, Renova, Retin A, Retrovir, Tretinoin, Viagra and Zidovudine.

Prescription Drugs (Out-Patient)

Out-patient prescription drug coverage is limited and is provided only under the "Outpatient Prescription Drug Benefits" section.

Self-Procured Services

Charges are excluded for services rendered to a covered person who is not under the regular care of a physician or charges for services, supplies, or treatment, including any period of hospital confinement, not recommended, approved, and certified as medically necessary and reasonable by a physician.

Sex-Change Procedures

Charges are excluded for sex-change counseling or treatment, services incident to sex-change surgery, or any resulting problems.

Sexual Dysfunctions

Charges are excluded for treatments or surgery to correct impotency and premature ejaculation.

Sporting Activities under the influence

All charges are excluded that are related to injuries sustained while participating in any sporting activity while under the influence of alcohol or drugs.

Sterilization Reversal Surgery

Expenses are excluded for the reconstruction (reversal) of a previous sterilization procedure.

Surrogate Mother

Charges related to a surrogate mother are excluded.

Temporomandibular Joint Dysfunction

Charges related to Temporomandibular Joint Dysfunction are limited. (See schedule of benefits, benefit maximums).

Vision Care under Medical Plan

The plan does not cover vision exams, products or procedures whose purpose is the correction of refractive error, unless specifically included in a segregated vision plan herein. Radial Keratotomy and all other surgical procedures for correction of refractive errors are not covered.

Vocational Therapy

Charges are excluded for vocational, educational, recreational, art, dance, or music therapy

Weight Control and Obesity

For weight reduction and dietary control treatments and programs, nutritional counseling; treatment and supplies for obesity or morbid obesity; treatment for anorexia and bulimia; gastric bypass surgery and complications of a previous gastric bypass surgery including removal of not needed skin mass; liposuction, lipectomy and treatment relating to previous liposuction and lipectomy.

Wigs

The charges are excluded for wigs and wig maintenance.

GENERAL EXCLUSIONS

The following exclusions apply to all health benefits, and no benefits shall be payable under these health care coverages for:

Court-Ordered Confinement

Any confinement of a covered person in a public or private institution as the result of a court order.

Criminal Activities

Any injury resulting from or occurring during the covered person's commission of or attempt to commit an aggravated assault or felony or any injury resulting from a covered person's involvement in illegal activities or an illegal occupation.

Drugs in Testing Phases

Medicines or drugs that are in the Food and Drug Administration phases I, II or III testing.

Excess Charges

Charges in excess of the usual, customary, and reasonable fees for services or supplies provided.

Experimental Procedures

Services or supplies that are experimental or investigational in nature as determined by the Food and Drug Administration and American Medical Association's Council on Medical Specialty Societies, or treatments that are not a part of generally accepted health care services.

Forms Completion

Charges for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities

Services furnished to the covered person in any veteran's hospital, military hospital or any institution or facility operated by the United States government (except for treatment of non-service related disabilities), or by any state government or any agency or instrumentality of such government, for which the covered person has no legal obligation to pay.

Late-Filed Claims

Claims for services rendered that are not filed with contract administrator for handling within **90 days** after the date the expenses are incurred.

Military Service

Charges for treatment of any injury sustained or illness contracted while in the military service of any country.

Missed Appointments

Expenses incurred for failure to keep a scheduled appointment.

No Charge/No Legal Requirement to Pay

Services for which no charge is made or for which a covered person is not required to pay, is not billed, or would not have been billed in the absence of coverage under this plan.

Other Coverage

Health care services or supplies for which a covered person is entitled (or could have been entitled if proper application had been made) to be reimbursed by another benefit plan or services or supplies furnished by any plan, authority, or law of any government or governmental agency (federal, state, dominion, or province or any political subdivision thereof).

Outside United States

Charges incurred outside of the United States if the covered person traveled to such location for the sole purpose of obtaining such health care services, drugs, or supplies.

Prior Coverage

Services or supplies for which the covered person is eligible for benefits under the plan that this plan replaces.

Relative or Resident Care

Any service rendered to a covered person by a relative or anyone who customarily lives in the covered person's household.

Self-Inflicted Injury

Charges incurred in connection with self-inflicted injury, illness, or overdose regardless of whether sane or insane, as well as, injuries or illnesses which are a result of an attempted suicide.

Charges incurred for injuries sustained as the result of the misuse of a controlled substance, when the controlled substance was not prescribed by a physician.

Veteran's Hospital

See "Government-Operated Facilities."

War

Health conditions resulting from insurrection, in any way related to War, Terrorism and Mass Destruction as hereinafter stated. It is mutually agreed that the Policy shall exclude any Loss or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss or expense:

- i. War, hostilities or warlike operation (whether war declared or not); Invasion;
To the nationality of the Insured or the country in, or over, which the act occurs; Civil war; Riot; Rebellion; Insurrection; Revolution; Overthrow of the legally constituted government; Civil commotion assuming proportions of, or amounting to, an uprising; Military or usurped power; Explosion of war weapons; Utilization of Nuclear, Chemical or Biological weapons of mass destruction howsoever these may be distributed or combined; Murder or Assault subsequently proved beyond reasonable doubt to have been the act of agents of a foreign state to the nationality of the Insured whether be declared with that state or not; Terrorist activity.

For the purposes of this Exclusion, the following definitions apply:

- i. **"Terrorist activity"** shall mean an act or acts, of any person, or group(s) or persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. "Terrorist activity" can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of terrorist activity can either be acting alone, or on behalf of, or in connection with any organization(s) or governments.
- ii. **"Utilization of Nuclear weapons of mass destruction"** shall mean the use of any explosive nuclear weapon or device or the emission, discharge, dispersal, release or escape of fissile material emitting a level of radioactivity capable of causing incapacitating disablement or death amongst people or animals.
- iii. **"Utilization of Chemical weapons of mass destruction"** shall mean the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing incapacitating disablement or death amongst people or animals.
- iv. **"Utilization of Biological weapons of mass destruction"** shall mean the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which are capable of causing incapacitating disablement or death amongst people or animals.

Also excluded herein is any Loss or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, or suppressing any or all of the Exclusion listed under Exclusions Including War, Terrorism and Mass Destruction.

Work-Related Injury or Sickness

Any health condition for which the covered person has or had a right to compensation under any workers' compensation or occupational disease law or any other legislation of similar purpose.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

Outpatient prescription drugs may be purchased at participating pharmacies, subject to plan benefits described below.

For convenience and reduced cost a prescription drug card for out-patient drug purchases is provided through the following prescription drug card company:

MED Rx 1525 Merrill Drive, Suite 2000, Little Rock, AR 72211
Toll Free Customer Service (800-699-3542)
Procure Pharmacy Network

Contact the prescription drug card company for listing of participating pharmacies or to request that your pharmacy be contacted for potential participation.

To access this program, a covered person is required to use a recognized I.D. card and a participating pharmacy, and he/she must pay a co-pay toward each prescription purchase.

A list of Non-preferred drugs can be obtained from your employer.

Eligible Prescription Expenses

Eligible general prescription expenses subject to out-patient prescription drug co-pay will include:

Legend drugs, except as excluded or described below, Prenatal Vitamins, Oral Contraceptives, and the following Diabetic Supplies: Insulin, Needles and Syringes, Blood Testing Strips, Urine Testing Strips, Ketone Testing Strips, Nancets, and Lancet devices.

Eligible Injectable prescription expenses that will require that the participant pay a co-insurance payment will include:

Imitrex, Interferon	50% of Cost
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Limitations and Exclusions

Expenses due to the following are not eligible prescription expenses:

- Experimental drugs;
- All injectable drugs other than as stated in Eligible Prescription Expenses;
- Fertility drugs;
- Artificial appliances or devices;
- Hypodermic needles and syringes;
- Non-legend drugs (Over the Counter Drugs, Treatments or Medications)
- Norplant is limited to one purchase & placement in any consecutive five (5) year period;
- Therapeutic devices or appliances, including needles, syringes, support garments, and other non-medicinal substances regardless of their intended use, except those listed above;
- Prescriptions that a covered person is entitled to receive without charge under any workers' compensation law;
- Drugs labeled: "Caution -- limited by federal law to investigational use," or experimental drugs, even if a charge is made to the covered person;

- Immunization agents (except for pediatric immunizations), biological sera, blood, or blood plasma drugs dispensed while the patient is in a hospital, nursing home, clinic or other institution or any medication consumed or administered at the place where it is dispensed;
- Any quantity of drugs or medicines dispensed that exceeds a thirty-four (34) day supply when purchased at the pharmacy and sixty (60) day supply when purchased through mail order and taken in accordance with the directions of the prescriber;
- Prescription drugs not required for the treatment or prevention of illness including drugs used for cosmetic purposes;
- Prescription drug used in connection with drug addiction or weight loss
- Refills over one (1) year from the original order of the prescriber;
- Retin A, Tretinoin; Renova, Retrovir (Zovudine, AZT, Azidothymidine) and Viagra

New Drugs

Coverage for drugs that are new to the market after the effective date of this plan will be covered, limited, or excluded to the same extent that drugs of the same class are considered. The plan reserves the right to require pre-authorization for these new drugs. If you need a new drug it is recommended that you contact the plan administrator for clarification of coverage.

COORDINATION OF BENEFITS

All benefits provided under the health care coverages of this plan are subject to the following provisions and limitations, unless specifically stated otherwise.

Definitions

As used in this provision, the following terms shall have the meanings indicated:

Other Plan

Other plans include benefits, services, or treatment provided by:

- individual major medical, dental or prescription drug coverage;
- group, blanket, or franchise insurance coverage;
- group hospital or medical service pre-payment plans (HMOs, PPOs, EPOs);
- group Blue Cross and Blue Shield coverage;
- group automobile insurance;
- liability insurance;
- individual auto insurance based upon the principles of no-fault coverage;
- any coverage under labor-management trustee plans, union welfare plans, employer or professional organization plans, or employee benefit organization plans;
- any coverage under government programs including Medicare (Titles XVIII and XIX of the Social Security Act as enacted or thereafter amended), CHAMPUS, or any coverage required or provided by a statute. For purposes of implementing this provision, eligibility alone will constitute coverage; or
- any group coverage sponsored by or provided through a school or other educational institution.

This Plan

The health care coverages of this plan.

Allowable Expense

Any usual, customary, and reasonable item of expense incurred while the person for whom claim is made is covered under this plan, at least a part of which is covered under any other plan. When a plan provides benefits in the form of service rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid.

Claim Determination Period

A period that commences each January 1 and ends at 12:00 midnight on the next December 31, or that portion of such period during which the claimant has been covered under this plan.

Effect on Benefits Under This Plan

When Other Plan Does Not Contain a Coordination of Benefits Provision

As to any claim determination period to which this provision is applicable, the benefits that would be payable under this plan in the absence of this provision shall be reduced to the extent necessary so that the sum of all the benefits payable for such allowable expenses under this plan and all other plans shall not exceed the total that would have been paid under this plan. Benefits payable under the other plan includes benefits that would have been payable had claim been duly made for them.

When Other Plan Contains a Coordination of Benefits Provision

If the other plan insuring the person covered by this plan contains a similar non-duplication of benefits provision that coordinates its benefits with those of this plan and would, according to its rules and the order of benefit rules below, determine its benefits after the benefits of this plan have been determined, then the benefits of such other plan will not be considered for the purpose of determining the benefits due under this plan.

If, according to the other plan's rules and the order of benefit rules below, this plan is to determine its benefits after the other plan's benefits are determined, then the sum of all the benefits payable for allowable expenses under this plan and all other plans shall not exceed the total of such allowable expenses incurred during the claim determination period.

If the primary plan (i.e., plan that is to pay its benefits first) has a limitation for non-compliance with a utilization review-type of program, this plan will base its coordination only on the amounts that would have been paid if the participant had met the provisions of the primary plan.

If the primary plan has a PPO arrangement or a health maintenance organization (HMO) and the participant is penalized for failure to use these providers, this plan will coordinate on the amounts that would have been paid if PPO or HMO providers had been used.

Order of Benefit Determination

The rules establishing the order of benefit determination:

- the benefits of a plan that covers the patient as an active employee shall be determined before the benefits of a plan that covers such patient as a retired employee or as a dependent.
- the benefits of a plan for individuals with COBRA continuation coverage will be secondary to the plan covering the individual as an employee or a dependent of such employee.
- the benefits of a plan that covers a person as an employee who is neither laid-off nor retired, or as that employee's dependent, are determined before those of a plan that covers a person as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefit determination, the rule of the other plan will prevail;
- when claimant is a dependent child and such child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year, but:
 - a) if both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time; or
 - b) if the other plan does not have the rule described above under (a), and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits;
- when claimant is a dependent child whose father and mother are legally separated or divorced:
 - a) the benefits of a plan that covers the patient as a dependent child of the parent with custody shall be determined first;
 - b) the plan of the spouse of the parent with custody will be determined second; and the plan of the parent not having custody of the child will be determined third; or
 - c) if a court decree assigns financial responsibility for the health care expenses of a dependent child to one of the parents, the benefits of the assigned parent's plan will be determined first.

If none of the above rules establishes an order to benefit determination, the benefits of the plan that has covered the claimant for the longer period of time are determined before those of the plan that has covered that person for the shorter period of time.

When this provision operates to reduce the total amount of benefits otherwise payable to a person covered under this plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced, and such reduced amount shall be charged against any applicable benefit limit of the plan.

Right to Receive and Release Necessary Information

For the purpose of enforcing or determining the applicability of the terms of this provision of this plan or any similar provision of any other plan, the contract administrator may, without the consent of any person, release to or obtain from any insurance company, organization, or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under this plan shall furnish to the contract administrator such information as may be necessary to enforce this provision.

Special Provisions with Respect to Medicare

In accordance with the Tax Equity Fiscal Responsibility Act of 1983 (TEFRA), an active employee or spouse over age sixty-four (64) who is eligible for Medicare may elect or reject coverage under this plan. If such person elects coverage under this plan, the benefits of this plan shall generally be determined before any benefits provided by Medicare. However, whenever this plan may lawfully assume a secondary position it will do so.

When this plan may lawfully assume a secondary position and an employee or dependent becomes eligible for the program of benefits provided under Medicare, he is deemed to be covered by both Medicare parts A and B for all purposes under this plan. An employee or dependent is considered to be covered by Medicare on the earliest date any coverage of him under Medicare could have been effective had he applied for Medicare in a timely manner. When Medicare is primary, you must submit your claim to Medicare for reimbursement under Parts A & B prior to submitting your claim to this plan. When you receive your Explanation of Benefits from Medicare, submit your claim to this plan with Medicare Explanation of Benefits. We will then apply deductibles, copays and coinsurance to the charges not reimbursed by Medicare.

Examples of a claim when participant is Medicare eligible

A \$35,000 claim is incurred consisting of \$25,000 in hospital charges and \$10,000 in non-hospital charges. Medicare Part A reimburses \$24,000 and Part B reimburses \$6,000.

Charges:	35,000	
Medicare Reimbursed:	30,000	
Unreimbursed:		5,000

The Medicare Supplement plan would then reimburse as follows:

Charges after Medicare:	5,000	
Less Deductible:	500	
Balance:	4,500	
Reimburse %:		80%
Net Payable:		3,600
EE Out-of-pocket:	1,400	

The maximum lifetime benefit for participants eligible for Medicare is \$100,000.00.

NOTE: Does not include retail pharmacy charges which are reimbursed at 100% after applicable co pays to a maximum of \$500 per year.

SUBROGATION

If the plan provides benefits for accidental injury, sickness, or other loss (hereinafter "injury") to or for the benefit of a covered person, the plan shall be subrogated to all rights of recovery that the person or his heirs, guardians, executors, agents, or other representatives (hereinafter individually and collectively "injured person") may have as result of the loss. The rights of recovery to which the plan shall be subrogated include, without limitation, the injured person's rights of recovery:

- against any person or entity that caused, contributed to, or is in any way responsible for the injury;
- any way responsible for providing indemnification, coverage, compensation, or other payment as a result of the injury;
- under no-fault, personal injury protection, financial responsibility, uninsured motorist, and underinsured motorist insurance;
- under motor vehicle medical and wage loss reimbursement insurance;
- under homeowners, renters, premises and owners, and landlords and tenants insurance, including medical reimbursement coverages; and
- under group accident and health insurance and athletic team, sporting event, school, club, and other specific risk insurance coverages or accident benefit plans.

The injured person and persons acting on his behalf shall do nothing to prejudice the plan's subrogation rights and shall, when requested, provide the plan with accident-related information and cooperate with the plan in the enforcement of its subrogation rights. If the plan receives notice that it may be required to provide injury-related benefits to any person, it shall be entitled to assert a subrogation lien against responsible entities, persons, insurers, and attorneys when and as necessary to protect the rights of the plan and its members and beneficiaries. When the plan provides a notice of lien regarding a subrogation claim to any person, insurer, attorney, or other responsible party, the notice is sufficient to protect the plan's subrogation rights and, except as required by ERISA, the plan may not be compelled to initiate or to intervene in any legal action in order to establish or maintain its right of subrogation.

The amount of the plan's subrogation interest shall be deducted first from any recovery by or on behalf of the injured person. The plan shall not be responsible for expenses of participants which may be warranted by the circumstances. The plan shall not be responsible for expenses or attorney fees incurred by an injured person in connection with any recovery unless the plan shall have agreed in writing to pay those expenses or fees. The plan also reserves the right to initiate an action in the name of the plan or in the name of the injured person to recover its subrogation interest.

ELIGIBILITY AND EFFECTIVE DATES

Definitions

Dependent

The term "Dependent" means:

- A. The Participant's opposite sex spouse.
- B. A child who is determined by the plan administrator (in its sole discretion) to be an alternate recipient under Section 609 of ERISA. (This is any child of a participant who is recognized under a qualified medical child support order as having a right to enroll in the plan as a dependent of a participant.)
- C. The participant's child who meets all of the following conditions:
 1. Is a resident of the same country in which the participant resides;
 2. Is unmarried;
 3. Is a natural child, legally recognized stepchild, legally adopted child, (or child for whom legal adoption proceedings have been initiated if such child has been placed in your home) or a child who has been placed under the legal guardianship of the participant. A natural child qualifies as a dependent at the time of birth;
 4. Is considered a "Dependent" of the participant for tax exemption purposes under Section 152 of the Internal Revenue Code of 1986 as amended. This requirement is waived if the employee participant is obligated to provide medical care coverage for the child under an order or judgment of a court of competent jurisdiction or if the participant and dependent are subject to a qualified medical child support order (See section titled the same); and
 5. Is less than nineteen (19) years of age. This requirement is waived if the child is at least nineteen (19) years of age but less than twenty-three (23) years of age, is dependent upon the participant for support, and is a full-time student. The age requirement above is also waived for any mentally retarded or physically handicapped child who is incapable of self-sustaining employment and is chiefly dependent upon the participant for support and maintenance, provided the child suffered such incapacity prior to attaining nineteen (19) years of age. Proof of incapacity must be furnished to the plan administrator, or its designee, and additional proof may be requested from time to time.

The term "Dependent" excludes these situations:

- A. A spouse who is legally separated (pursuant to a valid legal separation agreement or court order) or divorced (pursuant to a valid divorce decree) from the participant;
- B. Any person on active military duty; or
- C. Any person who is covered under this plan as an individual participant.
- D. Any person who is covered under this plan as the dependent of another participant.

Employee

The term "Employee" means an individual: a) whose relationship to an employer is within the meaning of "employee" for federal tax withholding purposes; and b) who is not a leased employee, treated as an independent contractor by an Employer, or otherwise compensated by an employer outside of its normal payroll. A former employee may be treated as an employee hereunder during that time that such individual is a COBRA continuee.

Full Time Student

The term "Full Time Student" means a participant's dependent child who is enrolled in and regularly attends a secondary school, college or university, which is accredited by the state where it is located, for the minimum number of credit hours required by that secondary school, college or university in order to maintain full-time student status up to age twenty-three (23).

Participant

The term "Participant" means an employee who meets the eligibility requirements and who is properly enrolled in the plan.

Spouse

The term "Spouse" means an individual who is legally married to a participant and who is a resident of the same country in which the participant resides. An individual is treated as a spouse only if he or she is recognized as a lawful spouse under the laws of the state in which the participant resides.

Waiting Period

A prospective participant must satisfy a probation period from date of hire in order to be eligible for coverage. Please see employer application for group insurance for applicable probationary period.

PROVISIONS

Participant Eligibility

A participant eligible for coverage under the plan shall include only employees who meet the following conditions:

- a. Is employed by the company on a permanent basis for at least **thirty hours per week**;
- b. Is actively at work (see definition) on the day coverage is to begin and has satisfied the applicable waiting period;

A participant eligible for dependent coverage shall be any participant whose dependents meet the requirements to be considered an eligible dependent. Each participant will become eligible for dependent coverage on the latest of the following:

- a. The date he / she becomes eligible for participant coverage;
- b. The date on which he / she first acquires a dependent;
- c. The date he / she first becomes eligible for dependent coverage.

If both the husband and wife are employed by the company, and both have dependent children eligible for dependent coverage, either the husband or the wife but not both, may elect dependent coverage for their eligible dependent children.

Participant Effective Date

Regular Enrollment

Coverage will be effective on the first day of active employment the month following completion of the waiting period. Enrollment forms received within **thirty one days** of effective date.

Open Enrollment

Coverage will be effective on the first day of the month following enrollment. Any employee hired during the open enrollment period will be subject to the regular enrollment provisions.

Special Enrollment

Coverage will be effective on the first day of the month following enrollment.

Late Enrollment

Coverage will be effective upon the effective date of the first Plan renewal following enrollment.

Dependent Eligibility

A dependent will be considered eligible for coverage on the date the participant becomes eligible for dependent coverage, subject to all limitations and requirements of this plan, and in accordance with the following:

- a. Newborn or newly adopted children of a covered participant will be covered from the moment of birth or placement for adoption for injury or illness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a dependent of the participant within **thirty one days** of the child's date of birth or placement for adoption. This provision shall not apply to or in any way affect the normal maternity provisions applicable to the mother. **If the child is not enrolled within 31 days of birth or adoption, the child will have 5 days of coverage and will become a late enrollee.**
- b. A spouse will be considered an eligible dependent from the date of marriage, provided the spouse is properly enrolled as a dependent of the participant within **thirty one days** of the date of marriage.
- c. If a dependent is acquired other than at the time of his birth, due to a court order, decree, or marriage, that the dependent will be considered an eligible dependent from the date of such court order, decree, or marriage, provided that this new dependent is properly enrolled as a dependent of the participant within **thirty one days** of the court order, decree, or marriage.
- d. A child may become eligible for dependent coverage as set forth in a qualified medical child support order. The plan administrator will establish written procedures for determining (and shall have sole discretion to determine) whether a medical child support order is qualified and for administering the provision of the benefits under the plan pursuant to a

clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issued the order.

Dependent Effective Date

A dependent of a participant who makes a written request for dependent coverage hereunder, on a form approved by the plan administrator, shall, subject to the provisions of this section, become covered as follows:

- a. If the participant makes such written request on or before the date he / she becomes eligible for dependent coverage and is actively at work, he shall become covered, with respect to those persons who are then his / her dependents, on the date he / she becomes eligible for dependent coverage.
- b. Except as otherwise provided under "Dependent Eligibility" (i.e., for newborn, adopted, and newly acquired dependents) or as provided under "Special Enrollment", if the participant makes such written request after the date on which he is both eligible for dependent coverage and is actively at work, those persons who are then his dependents shall be late enrollees, and coverage for the eligible dependent shall not become effective until the first day of the month following the next open enrollment period.

Coverage Status Change

A covered person may not be covered as both a dependent and a participant. Any changes in coverage status do not interrupt participation in the plan and do not change a covered person's effective date of coverage for purposes of any other provision of this plan.

Participation Contribution

The plan administrator may require a contribution from participants to maintain employee participation and the participation of any dependents in the plan. Eligible participants will be advised of any required contributions at the time they apply for enrollment in the plan. Participants in the plan will be notified by the plan administrator prior to an increase in the required contribution amount. Participants in a plan that does not require participant contribution at the time they enrolled will be notified by the plan administrator prior to the date a contribution requirement is made effective.

ENROLLMENT

Regular Enrollment

An eligible employee may enroll within thirty (30) days of hire date. If an eligible employee declines coverage within that period, the open enrollment, special enrollment, or late enrollment provisions will apply. Coverage will be subject to the effective date and pre-existing condition provisions.

Open Enrollment Period

An eligible employee and his eligible dependents may enroll at anytime during the open enrollment period which is thirty days prior to the anniversary of the plan each year.

Special Enrollment

If an eligible employee and / or their dependent declined coverage hereunder at the time of initial eligibility (and stated in writing at that time that coverage was declined because of alternative health coverage) but subsequently loses coverage under the other health plan and makes application for coverage hereunder within thirty (30) days of the loss, such individual shall be a special enrollee provided such person was (a) under a COBRA continuation provision and the coverage under such provision was exhausted; or (b) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated. Individuals who lose other coverage due to nonpayment of premium or for cause (e.g., filing fraudulent claims) shall not be special enrollees hereunder. An eligible employee or dependent who seeks to enroll in the plan as a result of the acquisition of a new dependent through marriage, birth, adoption or placement for adoption shall be a special enrollee hereunder if the eligible employee or dependent enrolls within thirty-one (31) days of the acquisition of the new dependent. Coverage for a special enrollee (other than a newborn or newly adopted child) shall begin as of the first day of the calendar month following the enrollment request. Coverage for a newly adopted or newborn special enrollee shall begin as of the date of the adoption, birth, or placement for adoption.

Late Enrollees

If an eligible employee and / or their dependent declined coverage hereunder at the time of initial eligibility and do not meet the requirements of being designated as a "special enrollee", they will be considered a "late enrollee" and be subject to the late enrollee pre-existing condition limitations.

Pre-Existing Conditions Limitations

Claims resulting from Pre-Existing Conditions are excluded from coverage under the plan as specified below:

Pre-Existing Conditions

A Pre-Existing Condition is any condition for which a covered person received treatment, medical care, or advice from a physician, or a condition for which medicine or other treatments were prescribed in the period of six months prior to the earlier of the first day of the waiting period or the participant's effective date under this plan.

Pre-Existing Condition Limitation Period

There will be no coverage for a pre-existing condition until such time as the participant has been continuously covered for a period of twelve months from the earlier of the first day of the waiting period or the participant's effective date under this plan.

Pre-Existing Condition Limitation Period for Late Enrollees

There will be no coverage for a pre-existing condition until such time as the participant designated as a late enrollee has been continuously covered for a period of eighteen months from the earlier of first day of the waiting period or the participant's effective date under this plan.

Exceptions to the Pre-Existing Conditions Exclusion

- I. The pre-existing condition provisions do not apply to pregnancy expenses or the expenses of newborn or newly adopted children.
- II. A participant may submit a certificate indicating creditable coverage from a prior plan. In the event that the creditable coverage certificate is validated by the plan administrator any pre-existing condition limitation periods will be offset on a day by day basis for the time period covered under the previous plan without a significant break in coverage (see definitions).
- III. The exclusion of coverage due to the above pre-existing condition provision of this plan shall be modified to the following extent for those persons covered on the effective date of this plan and covered on the immediately preceding day under the coverage this plan replaced, whether such coverage replaced was written by an insurer or under a similar self-funding group health plan:
 - a. If the covered person incurs an expense that would be covered under the plan except for the pre-existing conditions exclusion and such expense would have been covered under the coverage replaced had that coverage been continued in force rather than replaced by this plan, this plan will pay the lesser of the amount payable for such expenses under:

1. The coverage replaced; or
 2. This plan disregarding the pre-existing conditions exclusion.
- b. In no event shall the total amount payable under this exception exceed the maximum amount payable under this plan as if the pre-existing conditions were not present.
 - c. No item of expense incurred before the effective date of this plan shall be payable under this plan.
 - d. In no event shall the term "this plan" be construed to include the coverage replaced.

TERMINATION OF COVERAGE

Participant Termination

Participant coverage terminates immediately upon the earliest of the following dates:

- a. Date the participant ceases to be in a classification (if any) shown in the Schedule of Benefits or Eligibility section;
- b. Date the participant fails to make any required contribution for coverage;
- c. Date the plan is terminated or, with respect to any benefit of the plan, the date of termination of such benefit.
- d. Date that any plan benefit maximum (as set forth in the Schedule of Benefits) has been exceeded.
- e. At midnight on the date on which the covered employee leaves or is dismissed from the employment of the employer or ceases to be eligible or engaged in active employment for the required number of hours as specified in "Eligibility and Effective Dates."

Dependent Termination

Dependent coverage terminates immediately upon the earliest of the following dates:

- a. Date the dependent ceases to be a dependent as defined in the plan;
- b. Date of termination of the participant's coverage under the plan;
- c. Date the participant ceases to be in a classification (if any) shown in the Schedule of Benefits or Eligibility section;
- d. Date the participant fails to make any required contribution for dependent coverage; or
- e. Date that any plan benefit maximum (as set forth in the Schedule of Benefits) has been exceeded.

Extension of Coverage for Handicapped Dependent Children

If an already covered dependent child attains the age that would otherwise terminate his status as a dependent, and:

- if on the day immediately prior to the attainment of such age the child was a covered dependent under the plan;
- at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation, physical handicap, or disability that commenced prior to the attainment of such age; and
- such child is primarily dependent upon the employee for support maintenance,

then such child's status as a dependent shall not terminate solely by reason of their having attained the specified age, and they shall continue to be considered a covered dependent under the plan so long as they remain in such condition and otherwise conforms to the definition of a dependent. The employee must submit to the third party administrator proof of the child's incapacity within thirty-one (31) days of the child's attainment of such age and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

Leave of Absence and Lay-Off

If an employee fails to continue in active employment due to sickness, injury, maternity leave, family medical leave, temporary layoff, or approved leave of absence, the employee may be permitted to continue health care coverage for their self and their dependents for a period of not more than **ninety consecutive days**, though employee will be required to pay the full unsubsidized cost of coverage during such absence.

Any such extended coverage offered by the employer and elected by the employee shall automatically and immediately cease on the earliest of the following dates: On the date the person becomes covered under any other group plan for benefits of a type similar to that provided by this plan. On the date of expiration of the period for which the last contribution was paid, if such contribution is required or the date of termination of this plan or at midnight on the 90th day of coverage. At the end on the ninety day period, the participant's employment will be deemed to have been terminated for the purposes of continuation of coverage under COBRA.

Family and Medical Leave Act of 1993

All previous provisions including coverage under the plan, effective date of coverage, and termination of coverage are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to the company, group health benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the employer and employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any plan provisions which conflict with FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. A participant with questions concerning any rights and/or obligations should contact the plan administrator or his employer.

Qualified Medical Child Support Orders

A "Medical Child Support Order" is a child support order of a court which requires that an employee benefit plan provide coverage for a dependent child of a participant if the plan normally provides coverage for dependent children.

When the plan receives a Medical Child Support Order, the plan administrator will provide notification of its receipt and will conduct a review of the order and will notify the participant and each named child specified in the order that the order is or is not a qualified order. If the order is a qualified order, each named child will be covered by the plan in the same manner as any other dependent child is covered by the plan.

If the order is not a Qualified Order, each named child may appeal that decision by written letter of appeal to the plan administrator. The plan administrator shall review the appeal and reply in writing within thirty (30) days of receipt of the appeal.

To be considered a Qualified Order the Medical Child Support Order must contain the following information: the name and last known mailing address of the participant and the name and address of each child to be covered by the plan; a reasonable description of the type of coverage to be provided by the plan to each named child or the manner in which the type of coverage is to be determined; the period to which the court order applies and each plan to which the support order applies.

This plan will not provide any type or form of benefit or any option not otherwise provided under the plan and all other dependent eligibility provisions. The effective date and termination provisions will apply.

COBRA Definitions

For purposes of this continuous coverage under COBRA provision, the following definitions apply:

COBRA

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

Code

The Internal Revenue Code of 1986, as amended.

Continuous Coverage

The group health plan coverage elected by a qualified beneficiary under COBRA.

Qualified Beneficiary

A qualified beneficiary means 1) a covered employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him ineligible for coverage under the plan; 2) a covered spouse or dependent who becomes eligible for coverage under the plan due to a qualifying event, as defined below; and 3) a newborn or newly adopted child of a covered employee who is continuing coverage under COBRA.

Qualifying Event

The following events which, but for continuous coverage, would result in the loss of coverage of a qualified beneficiary: 1) termination of a covered employee's employment (other than for gross misconduct) or reduction in his hours of employment; 2) the death of a covered employee; 3) the divorce or legal separation of the covered employee from his spouse; 4) the covered employee becoming entitled to Medicare coverage; or 5) a child ceasing to be eligible as a dependent child under the terms of the group health plan.

Total Disability

Totally disabled as determined under Title II or Title XVI of the Social Security Act.

Right to Elect Continuation Coverage

If a qualified beneficiary loses coverage under the group health plan due to a qualifying event, he may elect to continue coverage under the group health plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the company. A qualified beneficiary must elect the coverage within the sixty (60) day period beginning on the later of:

- a. The date of the qualifying event; or
- b. The date he was notified of his right to continue coverage.

Notification of Qualifying Event

If the qualifying event is divorce, legal separation, or a dependent child's ineligibility under a group health plan, the qualified beneficiary must notify the company of the qualifying event within sixty (60) days of the event in order for coverage to continue. In addition, a totally disabled qualified beneficiary must notify the company in accordance with the section below entitled "Total Disability" in order for coverage to continue. Failure to provide such notice(s) will result in a loss of COBRA entitlement hereunder.

Length of Continuation Coverage

- a. A qualified beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a covered employee may continue coverage under the group health plan for up to eighteen (18) months from the date of the qualifying event.
- b. A qualified beneficiary who loses coverage due to the covered employee's death, divorce, legal separation or entitlement to Medicare, and dependent children who have become ineligible for coverage may continue coverage under the group health plan for up to thirty-six (36) months from the date of the qualifying event.

Total Disability

- a. In a case of a qualified beneficiary who is determined under the Title II or XVI of the Social Security Act (hereinafter the "Act") to have been totally disabled within sixty (60) days of a qualifying event (if the qualifying event is termination of employment or reduction of hours), that qualified beneficiary may continue coverage (including coverage for dependents who were covered under the continuous coverage) for a total of twenty-nine (29) months as long as the qualified beneficiary notifies the employer:
 1. Prior to the end of eighteen (18) months of continuation coverage that he was disabled as of the date of the qualifying event; and
 2. Within sixty (60) days of the determination of total disability under the Act.
- b. The employer will charge the qualified beneficiary an increased premium for continuation coverage extended beyond eighteen (18) months pursuant to this section.
- c. If during the period of extended coverage for total disability (continuation coverage months 19-29) a qualified beneficiary is determined to be no longer totally disabled under the Act:
 1. The qualified beneficiary shall notify the employer of this determination within thirty (30) days; and
 2. Continuation Coverage shall terminate the last day of the month following thirty (30) days from the date of the final determination under the Act that the qualified beneficiary is no longer totally disabled.

Termination of Continuation Coverage

Continuation coverage will automatically end earlier than the applicable eighteen (18), twenty-nine (29), or thirty-six (36) month period for a qualified beneficiary if:

- a. The required monthly contribution for coverage is not received by the company within thirty (30) days following the due date;
- b. The qualified beneficiary is or becomes covered under any other group health plan as an employee or otherwise. If the other group health plan contains an exclusion or limitation relating to a pre-existing condition, and such exclusion or limitation applies to the qualified beneficiary, then the qualified beneficiary shall be eligible for continuation coverage as long as the exclusion or limitation relating to the pre-existing condition applies to the qualified beneficiary (or, if sooner, until the expiration of the applicable eighteen (18), twenty-nine (29), or thirty (36) month COBRA period).
- c. For totally disabled qualified beneficiaries continuing coverage for up to twenty-nine (29) months, the last day of the month coincident with or following thirty (30) days from the date of a final determination by the Social Security Administration that such beneficiary is no longer totally disabled;
- d. The qualified beneficiary is or becomes eligible for Medicare benefits;
- e. The company ceases to offer any group health plans.

Multiple Qualifying Events

If a qualified beneficiary is continuing coverage due to a qualifying event for which the maximum continuation coverage is eighteen (18) or twenty-nine (29) months, and a second qualifying event occurs during the eighteen (18) or twenty-nine (29) month period, the qualified beneficiary may elect, in accordance with the section titled "Right to Elect Continuation Coverage," to continue coverage under the group health plan for up to thirty-six (36) months from the date of the first qualifying event. In addition, if a qualified beneficiary who was a covered employee becomes entitled to benefits under Medicare (whether or not this is a qualifying event), a qualified beneficiary (other than a covered employee) may elect to continue coverage for a maximum of thirty-six (36) months from the date of the initial qualifying event, to the extent another period of continuation coverage is not required by law under COBRA.

Continuation Coverage

The continuation coverage elected by a qualified beneficiary is subject to all of the terms, conditions, limitations, and exclusions which are applicable to the group health plan offered to similarly situated covered employees and their dependents. The continuation coverage is also subject to the rules and regulations under COBRA. If COBRA permits qualified beneficiaries to add dependents for continuation coverage, such dependents must meet the definition of dependent under the group health plan.

Carryover of Deductibles and Plan Maximums

If continuation coverage under the group health plan is elected by a qualified beneficiary under COBRA, expenses already credited to the plan's applicable deductible and co-payment features for the year will be carried forward into the continuation coverage elected for that year. Similarly, amounts applied toward any maximum payments under the plan will also be carried forward into the continuation coverage. Coverage will not be continued for any benefits for which plan maximums have been reached.

Payment of Premium

- a. The plan administrator will determine the amount of premium to be charged for continuation coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.
 1. The plan administrator may require a qualified beneficiary to pay a contribution for coverage that does not exceed 102 percent of the applicable premium for that period.
 2. For qualified beneficiaries whose coverage is continued pursuant to the section entitled "Total Disability" of this provision, the plan administrator may require the qualified beneficiary to pay a contribution for coverage that does not exceed 150 percent of the applicable premium for continuation coverage months nineteen (19) to twenty-nine(29).
 3. Contributions for coverage may, at the election of the qualified beneficiary, be paid in monthly installments.
- b. If continuation coverage is elected, the monthly contribution for coverage for those months up to and including the month in which the election is made must be made within forty-five (45) days of the date of election.
- c. Without further notice from the company, the qualified beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage will be effective. If payment is not received by the company within thirty (30) days of the payment's due date, continuation coverage will terminate in accordance with section titled "Termination of Continuation Coverage," subsection A. This thirty (30) day grace period does not apply to the first contribution required under B.
- d. No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the qualified beneficiary.

DEFINITIONS

When used within, the following items shall have the meanings shown below.

Accidental Injury

Any accidental bodily injury that occurs while an individual is covered under the plan, that is caused by external forces under unexpected circumstances, and that does not arise out of or in the course of the employment of the covered person. Sprains and strains resulting from over-exertion, excessive use, or over-stretching will not be considered accidental injuries for purposes of benefit determination.

Actively at Work or Active Employment

"Actively at work" or "actively employed" means that, on a specified day, an employee is not absent from work.

Ambulatory Surgical Center

Any public or private establishment that:

- complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- has an organized medical staff or physicians;
- has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- has continuous physician services and registered professional nursing services whenever a patient is in the facility; and
- does not provide services or other accommodations for patients to stay overnight.

However, a facility existing for the prime purpose of terminating pregnancy or an office maintained by physician for the practice of medicine shall not be considered an ambulatory surgical center.

Birth Center

A special room that exists in a hospital to provide delivery, pre-natal, and post-natal care with minimum medical intervention or a free-standing out-patient facility that:

- is in compliance with licensing and other legal requirements in the jurisdiction where it is located;
- is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;
- has organized facilities for birth services on its premises;
- provides birth services that are performed by or under the direction of a physician specializing in obstetrics and gynecology;
- has twenty-four (24) hour a day registered nursing services; and
- maintains daily clinical records.

Calendar Year

A period of time commencing at 12:01 a.m. on January 1 and ending at 12:01 a.m. on the next January 1. Each succeeding like period will be considered a new calendar year.

Claimant

Any covered person on whose behalf a claim is submitted for benefits under the plan.

Creditable Coverage

Creditable coverage shall have the definition contained in ERISA Section 701(c). Under this provision, creditable coverage generally includes periods of coverage under an individual or group health plan (including Medicare, Medicaid, governmental and church plans) that are not followed by a significant break in coverage. Creditable coverage may include coverage for liability, dental and vision benefits, specified disease and/or other supplemental-type benefits.

Convalescent Hospital

See "Skilled Nursing Facility."

Covered Person

A covered employee, a covered dependent, or a qualified beneficiary (COBRA). See “Eligibility and Effective Dates” and “Continuation of Coverage Option (COBRA).”

Deductible

A specified dollar amount of covered expenses that must be incurred during a year before any other covered expenses can be considered for payment at the percentages stated in the Schedule of Benefits and this plan.

Dependent

See “Eligibility and Effective Dates.”

Eligible Expense

Expenses incurred by a covered person for any medically necessary treatments, services, or supplies that are not specifically excluded from coverage elsewhere in this plan.

Employee

An individual a) whose relationship to an employer is within the meaning of the word “employee” for federal tax withholding purposes; b) who is initially treated as an employee for federal income tax withholding purposes by an employer; and c) who is not a leased employee, treated as an independent contractor by an employer, or otherwise compensated by an employer outside of its normal payroll. A former employee may be treated as an employee hereunder during the time that such individual is a COBRA continuee.

Employer

The employer or employers participating in the plan as stated in “General Plan Information.”

Home Health Care Agency

An agency or organization that:

- is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;
- has policies established by a professional group associated with the agency or organization that includes at least one registered graduate nurse (R.N.) to govern the services provided;
- provides for full-time supervision of such services by a physician or a registered graduate nurse (R.N.);
- maintains a complete medical record on each patient; and
- has a full-time administrator.

In rural areas where there are no agencies that meet the above requirements or in areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice

A health care program providing a coordinated set of services rendered at home, in out-patient settings, or in institutional settings for a covered person suffering from a condition that has a terminal prognosis. A hospice must have an interdisciplinary group of personnel that includes at least one physician and one registered graduate nurse (R.N.) and must maintain central clinical records on all patients. A hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital

An institution which meets all of the following conditions:

- a) Is engaged primarily in providing medical care and treatment to ill and injured persons on an inpatient basis at the patient’s expense;
- b) Is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to hospitals, and is certified by Medicare;
- c) Maintains on its premises all the facilities necessary to provide for the diagnosis and surgical treatment of an illness or injury;
- d) Provides such treatment is provided for compensation by and, under the supervision of, physicians with continuous twenty-four (24) hour nursing services by registered nurses;

- e) Qualifies as a hospital, a psychiatric hospital, or a tuberculosis hospital and is accredited by the Joint Commission on the Accreditation of Hospitals (JCAH).

The following **are not** hospitals as defined in this plan:

- institutions for treatment of mental health, alcoholism, substance abuse, or rehabilitation;
- convalescent or skilled nursing facilities;
- institutions primarily for the aged, custodial care, or rest or which serve as domiciles;
- health resorts, spas, or sanitariums;
- infirmaries at schools or camps;
- hospice care facilities;
- freestanding ambulatory surgery centers;
- hospitals for the treatment of mental illness. A separate division or unit of a hospital is not considered a hospital if the average length of stay is more than thirty (30) days.

Impotency

The inability to achieve and maintain an erection that is satisfactory for intercourse on a regular basis.

In-Patient

A person physically occupying a room and being charged for room and board in facility (hospital, skilled nursing facility, etc.) that is covered by the plan document and to which the person has been assigned on a twenty-four (24) hour a day basis without being issued passes to leave the premises.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), or Intermediate Care Unit

A hospital area or accommodation, exclusively reserved for critically or seriously ill patients requiring constant observation as prescribed by the attending physician, that provides room and board, specialized registered professional nursing and other nursing care, and special equipment and supplies on a stand-by basis and that is separated from the rest of the hospital's facilities.

Medically Necessary

A service or supply furnished by a particular provider is medically necessary if the plan administrator (in its sole discretion) determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition: and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, the plan administrator will take into consideration:

- Information provided on the affected person's health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;

- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to the plan administrator's attention.

In no event will the following services or supplies be considered to be medically necessary:

- Experimental or investigational services or supplies;
- Those that do not require the technical skills of a medical, a mental health or a dental professional;
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family or any healthcare provider or healthcare facility;
- Those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Medicare

Health insurance for the aged as established by Title I of Public Law 89-98, including parts A & B, and Title XVIII of the Social Security Act, as amended from time to time.

Mental Illness

"Mental Illness" means a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a licensed or certified psychologist or a licensed, certified psychiatric social worker. A mental or nervous disorder includes, but is not limited to:

- | | |
|--------------------------------------------------|---------------------------------|
| • Alcoholism | • Panic Disorder |
| • Schizophrenia | • Major Depressive Disorder |
| • Bipolar Disorder | • Psychotic Depression |
| • Pervasive Mental Development Disorder (Autism) | • Obsessive Compulsive Disorder |

This disease must not be merely an expected response to a particular stimulus and must be defined in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association.)

Out-Patient Services

Services rendered on other than an in-patient basis or services rendered at a covered non-hospital facility.

PPO Service Area

The PPO service area is considered to be a geographical area of a fifty (50) mile radius from the primary residence of the participant. However, if a covered person is treated by a PPO Provider, regardless of location, the covered person will receive PPO provider benefits.

Physician

A doctor of medicine (M.D.) legally entitled to practice medicine and perform surgery, a licensed doctor of osteopathy (D.O.) approved by the Composite State Board of Medical Examiners, a licensed doctor of podiatric medicine (D.P.M.) legally entitled to practice podiatry, or any licensed doctor of dental surgery (D.D.S.) legally entitled to perform oral surgery.

"Physician" will also include chiropractors, optometrists, and applied clinical psychologists when licensed to practice where the care is rendered and when rendering a service within the scope of the license. For purposes of certifying total disability, "physician" will only include a D.O. or M.D.

Primary Care Physician

Doctor of medicine who routinely handles a family practice, pediatric practice or obstetrical practice practicing general medicine.

Plan

The term "plan" means the Health Benefit Plan.

Plan Administrator

The term “plan administrator” means the person or entity which is responsible for the day-to-day functions and management of the plan. Note: The third party administrator is not a party of the plan and is not the plan administrator.

Plan Document

A formal document that describes the plan of benefits and the provisions under which such benefits shall be paid to covered persons, including any amendments.

Plan Sponsor

The entity sponsoring this plan. The plan sponsor may also be referred to as the plan administrator. See “General Plan Information” for further information.

Preferred Provider Organization (PPO)

An organization that has contracted with the plan sponsor or the third party administrator to provide certain health care services to covered persons at specific rates. See the schedule of medical benefits for the special benefit level that applies to services obtained from contracted providers.

Pregnancy

Childbirth, miscarriage, or complications arising therefrom incurred by a covered person.

Semi-Private Room Charge

The standard charge by a facility for semi-private room and board accommodations, or the average of such charges if the facility has more than one established level of such charges. The lowest charge by the facility for single bed room and board accommodations if the facility does not provide any semi-private accommodations.

Sickness

Bodily illness or disease, other than mental health conditions or pregnancy, and congenital abnormalities of a covered newborn child. A condition must be diagnosed by a physician in order to be considered a sickness by this plan.

Significant Break in Coverage

The term “significant break in coverage” means a period of sixty three (63) or more consecutive days without creditable coverage. Periods of no coverage during an HMO affiliation period or waiting period shall not be taken into account for purposes of determining whether a significant break in coverage has occurred.

Skilled Nursing Facility

An institution that:

- Is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with governing laws and regulations;
- Is primarily engaged in providing accommodations and skilled nursing care twenty-four (24) hours a day for a convalescing person;
- Is under the full-time supervision of a physician or a registered graduate nurse (R.N.);
- Admits patients only upon the recommendation of a physician (other than the patient’s own physician), maintains complete medical records, and has the services of a physician available at all times;
- Has established methods and procedures for the dispensing and administering of drugs;
- Has an effective utilization review plan;
- Is approved and licensed by Medicare;
- Has a written transfer agreement in effect with one or more hospitals; and is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, or a place for custodial care, the aged, drug addicts, alcoholics, the care of the mentally ill or persons with nervous disorders, or the care of senile persons.

Special Enrollee

The term “special enrollee” means an employee or dependent who is entitled to and who requests special enrollment within thirty (30) days of losing other health coverage or for a newly acquired dependent, within thirty (30) days of the marriage, birth, adoption, or placement for adoption.

Third Party Administrator

A company that performs certain administrative duties of the plan that have been delegated by the plan administrator in accordance with the terms and conditions of an administration agreement between the contract administrator and the plan administrator. The third party administrator under this program is an independent contractor.

Total Disability

For an employee, disability resulting solely from a sickness or accidental injury that prevents the employee from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training, or experience. The employee may not, in fact, be engaged in any employment or occupation for wage or profit and be considered totally disabled.

For a dependent, disability that prevents the dependent from engaging in substantially all the normal activities of a person in good health of like age and sex.

A covered person must also be under the care of a physician (M.D. or D.O.) in order to be considered totally disabled for benefit purposes.

Urgent Care Facility

A freestanding facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

- a board-certified physician, a registered graduate nurse (R.N.), and a registered x-ray technician in attendance at all times; and
- x-ray and laboratory equipment and a life-support system.

An urgent care facility does not include a clinic located at, operated in conjunction with, or in any way made a part of a regular hospital.

Usual, Customary, and Reasonable

The designation of a charge as being the usual charge made by a physician or any other provider of services and supplies, medication, or equipment that does not exceed the lesser of the actual charge or the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a county or such other area as is necessary to obtain a representative cross section of charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill, or expertise. Any state taxes applied in connection with the rendering of medical care will be considered reasonable and customary to the extent they are not preempted by ERISA.

Waiting Period or Probationary Period

The term "waiting period" or "probationary period" means the period that must pass under this plan (or for purposes of determining creditable coverage the waiting period or probationary period under any other health plan) before an employee or dependent is eligible to be covered under the plan.

Funding Sources and Uses

Employee Obligations

The health care coverage afforded to an employee by this plan shall be at least partially funded by the employer. If an employee elects to enroll dependents under the plan, the employee may be responsible for payment of all or a portion of the dependent contributions suitable to cover such enrollment. For active employees, the employer shall deduct such costs on a regular basis from the employee's wages or salary.

Employer Obligations

The employer shall also make contributions to the plan for health care coverage. These contributions and those paid by employee, if any, shall be placed in a special account or accounts administered by the contract administrator.

Plan-Funded Benefits

The contributions will be applied to provide the benefits under the plan.

Insurance Policy

Contributions may be used to purchase insurance coverage to ensure that the plan will meet its self-funded health care coverage obligations. The policy may be reviewed upon request submitted to the third party administrator. The third party administrator is also available to answer any questions about the coverages. The provisions of the plan document in no way modify those of any insurance policy.

Administrative Expenses

Contributions will also be used to pay administrative expenses of the plan in accordance with the terms and conditions of an administration agreement between the plan sponsor and the contract administrator.

Taxes

Any premium or other taxes that may be imposed by any state or other taxing authority and that are applicable to the coverages of the plan shall be paid by the plan administrator.

Administrative Provisions

Administration

The benefits of the plan are administered by one or more contract administrators under the terms and conditions of administration agreements between the plan administrator and contract administrator.

Amendment or Termination of the Plan

The plan administrator expects the plan to be permanent, but since future conditions affecting the plan administrator or employer cannot be anticipated or foreseen, the plan sponsor must necessarily and does hereby reserve the right:

- to determine eligibility for benefits or to construe the terms of the plan;
- to alter or postpone the method of payment of any benefit;
- to amend any provision of these administrative provisions;
- to make any modifications or amendments to the plan as are necessary or appropriate to qualify or maintain the plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and
- to terminate, suspend, withdraw, amend, or modify the plan in whole or in part at any time.

Annual Statements

If required by law, the plan administrator shall furnish to each employee, within a reasonable period of time following the close of a plan year, a written statement showing the amounts paid or expenses incurred by the plan administrator for the plan benefits during the prior plan year.

Anticipation, Alienation, Sale, or Transfer

No benefit payable under the provisions of the plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to so anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge shall be void; nor shall such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of or claims against any employee, covered dependent, or beneficiary, including claims of creditors, claims, for alimony or support, or any like or unlike claims. The preceding shall not apply to a "qualified domestic relations order" defined in ERISA Section 206.

Discrepancies

In the event of a discrepancy between the booklet provided to employees (the "Summary Plan Description") and the plan document, the plan document will prevail.

Entire Contract

The plan document, any amendments, and the individual applications, if any, of covered persons shall constitute the entire contract between the parties. The plan does not constitute a contract of employment or in any way affect the rights of an employer to discharge any employee.

Facility of Payment

Every person receiving or claiming benefits under the plan shall be presumed to be mentally and physically competent and of age. However, in the event the plan determines that an employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the employee has not provided the plan with an address at which he / she can be located for payment, the plan may, during the lifetime of the employee, pay any amount otherwise payable to the employee to the husband, wife, or relative by blood of the employee or to any other person or institution determined by the plan to be equitably entitled thereto; or in the case of the death of the employee before all amounts payable have been paid, the plan may pay any such amount to one or more of the following surviving relatives of the employee: lawful spouse, child or children, mother, father, brother, or sister, or to the employee's estate, as the plan sponsor in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the plan.

If a guardian, conservator, or other person legally vested with the care of the estate of any person receiving or claiming benefits under the plan is appointed by a court of competent jurisdiction, payments shall be made to such guardian, conservator, or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the fiduciaries. To the extent permitted by law, any such payment so made shall be a complete discharge of any liability therefore under the plan.

Fiduciaries

Fiduciaries shall serve at the discretion of the plan administrator and shall serve without compensation, but they shall be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. The plan administrator may at any time and from time to time remove any fiduciary or appoint new fiduciaries. Any fiduciary may resign at any time upon thirty (30) days' notice in writing delivered to the plan administrator. Fiduciaries may act, at a meeting or without a meeting, by a majority of the fiduciaries at the time in office. The fiduciaries may appoint a member as their secretary, who shall have such powers and responsibilities relating to the administration of benefits under the plan as the fiduciaries shall delegate.

Fiduciary Responsibility, Authority, and Discretion

Fiduciaries shall discharge their duties under the plan solely in the interest of the employees and their beneficiaries and for the exclusive purpose of providing benefits to employees and their beneficiaries and defraying the reasonable expenses of administering the plan.

The fiduciaries shall administer the plan and shall have the authority to exercise the powers and discretion conferred on them by the plan and shall have such other powers and authority necessary or proper for the administration of the plan as determined from time to time by the plan sponsor.

The fiduciaries may adopt such rules and procedures for the administration of the plan as they consider advisable and shall have full power and authority to enforce, construe, interpret, and administer the plan.

In carrying out their responsibilities under the plan, fiduciaries shall have discretionary authority to interpret the terms of the plan and plan document and to determine eligibility for and entitlement to plan benefits in accordance with the terms of the plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The fiduciaries may employ such agents, attorneys, accountants, investment advisors, or other persons (who also may be employed by the employer) as in their opinion may be desirable for the administration of the plan, and they may pay any such person reasonable compensation. The fiduciaries may delegate to any agent, attorney, accountant, or other person selected by them any power or duty vested in, imposed upon, or granted to them by the plan.

Force Majeure

Should the performance of any act required by the plan be prevented or delayed by reason of any act of God, strike, lockout, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations under the plan.

Gender and Number

Except when otherwise indicated by the context, any masculine terminology shall also include the feminine, and the definition of any term in the singular shall also include the plural.

Illegality of Particular Provision

The illegality of any particular provision of the plan document shall not affect the other provisions, but the plan document shall be construed in all respects as if such invalid provision were omitted.

Incontestability

No statement made by any person covered under the plan relating to the person's good health shall be used in contesting the validity of the coverage with respect to which such statement was made after such coverage has been in force prior to the contest for a period of two years during such person's lifetime, nor unless it is contained in a written instrument signed by such person.

All statements made by the person covered shall be deemed representations and not warranties, and no statement made by any person covered shall void the coverage or be used in any contest, unless a copy of the instrument containing the statement is or has been furnished to such person or to such person's beneficiary.

Indemnification

To the extent permitted by law, employees of the employer, the fiduciaries, and all agents and representatives of the fiduciaries shall be indemnified by the plan sponsor and saved harmless against any claims and conduct relating to the administration of the plan, except claims arising from gross negligence, willful neglect, or willful misconduct. The employer reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions

No employee, dependent, or other beneficiary shall have any right or claim to benefits from the plan, except as specified herein. Any dispute as to benefits under this plan shall be resolved by the plan sponsor under and pursuant to the plan document. No action may be brought for benefits provided by the plan or an amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined by the plan, and then action may only be brought within one year after the date of such decision.

Physical Examination and Autopsy

The plan, at its own expense, shall have the right and opportunity to have a physician of its choice examine the covered person when and as often as it may reasonably require during the pendency of any claim and to make an autopsy in case of death, where it is not forbidden by law.

Reimbursements

Whenever any benefit payments that should have been made under the plan have been made by another party, the plan sponsor and the contract administrator shall be authorized to pay such benefits to the other party, provided, however, that the amounts so paid will be deemed to be benefit payments under the plan, and the plan shall be fully discharged from liability for such payments to the full extent thereof.

Right to Recovery

Whenever any benefit payments have been made by the plan in excess of the maximum amount required under the terms of the plan document, the plan shall have the right to recover all such excess amounts from any persons, insurance companies, or other payees, and the employee or dependent shall make a good-faith attempt to assist the third party administrator in such recovery.

The plan may, in its sole discretion, pay benefits for care or services covered hereunder pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent such care or services have been provided, the plan shall be entitled to recoup and recover the amount paid therefor from the covered person or the provider of service in the event it is determined that such care or services are not covered hereunder. The covered person or his parent or guardian shall execute and deliver to the plan all assignments and other documents necessary or useful to the plan for the purpose of enforcing its rights under this provision.

Rights Against the Employer

Neither the establishment of the plan, nor any modification thereof, nor any distributions hereunder shall be construed as giving to any employee or any person any legal or equitable rights against the plan sponsor or its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the employer.

Substitution

The plan administrator shall be substituted for all rights of an employee to recover attorney fees against any adverse party. Employees shall do nothing to prejudice such rights of the plan sponsor, and further, they agree to perform all acts necessary to preserve and take advantage of such rights. If payment has been made by the plan in such instances and if the adverse party reimburses the employee directly, the plan shall have the right to recover such payment from an employee.

Titles or Headings

Where titles or headings precede explanatory text throughout the plan document, such titles or heading are intended for reference only. They are not intended and will not be construed to be a substantive part of the plan document and will not affect the validity, construction, or effect of the plan document provision.

Type of Plan

This is an employee welfare benefit plan whose purpose is to provide certain welfare benefits for eligible employees of the employer, their eligible dependents, and qualified beneficiaries under COBRA.

Workers' Compensation

The benefits provided by the plan are not in lieu of and do not affect any requirement for coverage by workers' compensation insurance laws or similar legislation.

STATEMENTS OF RIGHTS OF EMPLOYEES

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The rights are:

- to examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Dept. of Labor;
- to obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies;
- to receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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 and beneficiaries.

No one, including the employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension, welfare benefit or exercising rights under ERISA.

If your claim for a pension or, welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights.

If you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to \$100 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 which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you should have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of U.S. Labor-Management Services Administration, Department of Labor.