*Employee Name:* _____

*Effective Date:* _____

*Plan Deductible Elected:* _____

*Plan deductible is as of effective date above but may be changed each year at renewal. See HR Administrator for plan deductible currently in effect.*

# SAELENS CORPORATION

## HEALTH BENEFIT PLAN

## SUMMARY PLAN DESCRIPTION

**GROUP NUMBER: 8302**

**Effective Date: November 1, 2007**

**Original Effective Date: November 1, 2006**

Administrative Service Manager:
Custom Benefit Administrators
305 5th Avenue South, Suite 206
P.O. Box 1385
La Crosse, WI 54602-1385
Phone: 800-944-2188 or 608-784-2442

# RECORD OF SUMMARY PLAN DESCRIPTION (SPD) RECEIPT

To the Employee:

Please sign and date below, remove this page and return to the Human Resources Department.

**********

I hereby acknowledge the Saelens Corporation Health Benefit Plan has been explained to me. Specific provisions explained included, but were not limited to,:

- Maximum Lifetime benefit of $100,000
- A closed enrollment
- Low deductible and a high deductible plan option;
- Employee contribution and payroll deduction for each plan option
- Spousal Carveout (See Dependent Eligibility on page 3/2)
- Waiting period - The first of the month following 90 days
- Utilization Management Cost Containment program (page 1-14)
- The summary of benefits.

This Plan supersedes any prior written or oral communication. Any questions on Plan benefits should be directed to Custom Benefit Administrators. Provisions contained in this document may be modified. Written notice of future changes to the Plan will be provided to all covered Employees by the Plan Administrator.

_____ _____

Employee Signature Date

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# IMPORTANT MESSAGES

This Plan supersedes any prior written or oral communication. Any questions on Plan benefits should be directed to Custom Benefit Administrators. Provisions contained in this document may be modified. Written notice of future changes to the Plan will be provided to all covered Employees by the Plan Administrator.

It is important that ANY CHANGE OF ELIGIBILITY for You and/or any of Your eligible Dependents be reported to Your Employer, as soon as possible.

Changes of eligibility include:

- Marriage or divorce
- Death of any Dependent
- Birth of a child
- Adoption or placement for adoption of a child
- Dependent child reaching the limiting age
- IRS ineligible Dependent child
- Total Disability
- Retirement
- Change of address
- Medicare eligibility

For specific details regarding eligibility/enrollment, termination and continuation of coverage, refer to SECTION 3 - ELIGIBILITY of this Summary Plan Description.

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# TABLE OF CONTENTS

## SECTION 2 - DEFINITIONS



## SECTION 3 - ELIGIBILITY



## SECTION 4 - GENERAL PLAN INFORMATION

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# SECTION 1

# MEDICAL BENEFITS

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Note: Throughout this Summary Plan Description, CBA means Custom Benefit Administrators, Inc., the Plan's Administrative Service Manager.

# PREFERRED PROVIDER ORGANIZATION PROVISIONS

## WHAT IS A PREFERRED PROVIDER ORGANIZATION?

Preferred Provider Organizations (PPO) are Networks of Hospitals, Qualified Treatment Facilities, Qualified Practitioners and other providers ("PPO Providers") that are contracted to furnish, at negotiated fees, medical services for Employees (and their covered Dependents) of participating Employers. In return, the PPO Providers receive a higher volume of patients due to the Plan's incentives to use PPO Providers. Using PPO Providers will, in most cases, reduce Your costs.

## REASONS TO USE A PPO PROVIDER

1. The PPO negotiates fees for medical services resulting in lower costs for You when You use Hospitals, Qualified Treatment Facilities, Qualified Practitioners and other providers in the PPO network.

2. In addition, You may receive a better benefit and Your out-of-pocket expenses will be minimized.

3. You will have a wide variety of selected Hospitals, Qualified Treatment Facilities, Qualified Practitioners and other providers in the PPO network to help You with Your medical care needs.

The highest level of benefits under this Plan is available for services through PPO Providers; however You may choose any provider You wish for Your care.

Any provider who is not a member of the PPO Network at the time You received care or treatment is a Non-PPO Network Provider ("Non-PPO Provider").

## HOW TO SELECT A PROVIDER

Your Plan Administrator has contracted with HealthEOS to provide services to this Plan in the areas where it has Covered Persons. The PPO network that is applicable to You is shown on Your medical ID card. A directory of the participating Hospitals, Qualified Treatment Facilities, Qualified Practitioners and other providers in Your PPO network is available at www.HealthEOS.com. The provider directory is separate from this Plan and is subject to change. To confirm that Your Hospital, Qualified Treatment Facility, Qualified Practitioner and other provider is a current participant in Your PPO Network, You must call the number listed on Your medical ID card.

If You are traveling or need Emergency care and are unable to access care from Your PPO Provider, benefits will be paid at the non-Preferred Provider level.

## SCHEDULE OF BENEFITS

**OUTLINE OF MEDICAL COVERAGE** **LOW DEDUCTIBLE**

| Benefit | PPO Providers | Non-PPO Providers |
|---|---|---|
| Lifetime Maximum | $100,000 | |
| Deductible (per Calendar Year) | Individual: $500<br>Employee + 1: $1,000 (for one or both)<br>Family: $1,500 (for one or all insureds) | Individual: $1,000<br>Employee + 1: $2,000 (for one or both)<br>Family: $3,000 (for one or all insureds) |
| Coinsurance Percentage Payable (except as noted) | 80% after Deductible up to the Maximum Out-of-Pocket Limit per Calendar Year, 100% thereafter | 60% after Deductible up to the Maximum Out-of-Pocket Limit per Calendar Year, 100% thereafter |
| Maximum Out-of-Pocket (per Calendar Year) | Individual: $2,500<br>Employee + 1: $3,750 (for one or both)<br>Family: $5,000 (for one or all insureds) | Individual: $3,000<br>Employee + 1: $4,500 (for one or both)<br>Family: $6,000 (for one or all insureds) |
| Physician/Clinic Office Call | Covered Expenses subject to a $25 copayment* per visit, 100% thereafter, for office charges only. Related x-ray/lab charges are subject to Deductible and reimbursed at coinsurance percentage. | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. |
| Wellness Benefit (Preventive Care) | Covered Expenses subject to a $25 copayment* per visit, 100% thereafter, for office charges only. Related x-ray/lab charges are subject to Deductible and reimbursed at coinsurance percentage. | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. |
| Well Child Care (Up to age 18) | Covered Expenses subject to Deductible, 100% thereafter. | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. |
| Physician/Clinic Other Services Including:<br>- Durable Medical Equip.<br>- Home Health Care | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. |
| Hospital Services<br>- Inpatient Charges<br>- Outpatient Charges | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. |
| Emergency Room Charges | Covered Expenses subject to Deductible and coinsurance percentage. | Covered Expenses subject to Deductible and coinsurance percentage. |
| Prescription Drugs<br><br>*MEDICATIONS REQUIRING A DOCTOR PRESCRIPTION* | *Retail:* Patient pays the greater of 25% or copayment* as follows (maximum of $75 per Drug): $10 generic, $25 formulary, or $50 brand name, up to a 30 day supply.<br>*Mail Order*: Patient pays the greater of 25% or copayment* as follows (maximum of $150 per Drug): $20 generic, $50 formulary, or $100 brand name, for a 90-day supply. | |
| Mental or Nervous Conditions and Substance Abuse | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. |
| Accident Benefit | Covered Expenses are payable at 90% (no Deductible) up to a $500 Maximum per Calendar Year. | Covered Expenses subject to Deductible and coinsurance. |

* Deductible, coinsurance and maximum out-of-pocket do not include any copayments for physician/clinic office calls, Emergency room charges, and prescription Drugs, any charges for services listed under the Limitations and Exclusions section, or any charges that are over the Customary, Usual and Reasonable amount on services received from non-Network providers.

# SCHEDULE OF BENEFITS

## OUTLINE OF MEDICAL COVERAGE — HIGH DEDUCTIBLE

| Benefit | PPO Providers | Non-PPO Providers |
|---|---|---|
| Lifetime Maximum | $100,000 | |
| Covered Charges payable at 100% per Calendar Year (before Deductible applies) | Individual: First $500<br>Employee + 1: First $750 (for one or both)<br>Family: First $1,000 (for one or all insureds) | Individual: None<br>Employee + 1: None<br>Family: None |
| Deductible (per Calendar Year) | Individual: Next $1,750<br>Employee + 1: Next $3,500 (for one or both)<br>Family: Next $4,500 (for one or all insureds) | Individual: $3,000 per Calendar Year<br>Employee + 1: $4,500 (for one or both)<br>Family: $6,000 (for one or all insureds) |
| Coinsurance Percentage Payable (except as noted) | 90% after Deductible up to the Maximum Out-of-Pocket Limit per Calendar Year, 100% thereafter | 60% after Deductible up to the Maximum Out-of-Pocket Limit per Calendar Year, 100% thereafter |
| Maximum Out-of-Pocket (per Calendar Year) | Individual: $4,000 per Calendar Year<br>Employee + 1: $6,000 (for one or both)<br>Family: $8,000 (for one or all insureds) | Individual: $5,000 per Calendar Year<br>Employee + 1: $8,500 (for one or both)<br>Family: $12,000 (for one or all insureds) |
| Physician/Clinic Office Call | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. |
| Wellness Benefit (Preventive Care) | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. |
| Well Child Care (Up to age 18) | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. |
| Physician/Clinic Other Services Including:<br>- Durable Medical Equip.<br>- Home Health Care | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. |
| Hospital Services<br>- Inpatient Charges<br>- Outpatient Charges | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. |
| Emergency Room Charges | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. | Covered Expenses subject to Deductible and coinsurance percentage. |
| Prescription Drugs<br><br>*MEDICATIONS REQUIRING A DOCTOR PRESCRIPTION* | *Retail:* Patient pays the greater of 25% or copayment* as follows (maximum of $100 per Drug): $15 generic, $30 formulary, or $55 brand name, up to a 30-day supply.<br>*Mail Order*: Patient pays the greater of 25% or copayment* as follows (maximum of $200 per Drug): $30 generic, $60 formulary, or $110 brand name for a 90-day supply. | |
| Mental or Nervous Conditions and Substance Abuse | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. | Covered Expenses subject to Deductible and reimbursed at coinsurance percentage. |
| Accident Benefit | Covered Expenses are payable at 90% (no Deductible) up to a $500 Maximum per Calendar Year. | Covered Expenses subject to Deductible and coinsurance. |

* Deductible, coinsurance and maximum out-of-pocket do not include any copayments for prescription Drugs, any charges for services listed under the Limitations and Exclusions section, or any charges that are over the Customary, Usual and Reasonable amount on services received from non-Network providers.

**Schedule of Benefits (continued)**

## MEDICAL BENEFITS — LOW DEDUCTIBLE ONLY

Lifetime Maximum: $100,000 per Covered Person.

| | PPO PROVIDERS | NON-PPO PROVIDERS |
|---|---|---|
| Deductible per Calendar Year: | | |
| Individual | $500 | $1,000 |
| Employee + 1 * | $1,000 | $2,000 |
| Family * | $1,500 | $3,000 |

* Individual Plan limits only apply to one person coverage. Under an Employee + 1 or Family Plan, claims from all covered family members accumulate toward the appropriate deductible listed above and one family member could be responsible for up to the full deductible amount.

| | | |
|---|---|---|
| Coinsurance: | 80% (You pay 20%) | 60% (You pay 40%) |

After You satisfy the deductible for the Calendar Year, the Plan will then pay the applicable percentage of Covered Expenses as shown above until the Out-of-Pocket Limit listed below is met, and 100% thereafter for the remainder of the same Calendar Year, subject to Plan maximums.

| | | |
|---|---|---|
| Out-of-Pocket Limit: | | |
| Individual | $2,500 | $3,000 |
| Employee + 1 * | $3,750 | $4,500 |
| Family * | $5,000 | $6,000 |

* Individual Plan limits only apply to one person coverage. Under an Employee + 1 or Family Plan, claims from all covered family members accumulate toward the appropriate out-of-pocket limit listed above and one family member could be responsible for up to the full out-of-pocket amount.

The out-of-pocket limits shown do not apply to expenses in connection with prescription Drugs, and the copayments paid will not accrue toward satisfaction of these limits.

The out-of-pocket limit amounts represent the total dollars paid by You and Your covered family members toward satisfaction of the Deductible and coinsurance provisions. When You reach the limit, the Plan will then pay 100% of Covered Expenses, subject to Plan Maximums, for the remainder of the same Calendar Year. If You or Your covered Dependents use a combination of PPO and Non-PPO Providers, the amount of Deductible and eligible coinsurance You have paid for PPO Providers will also be credited to the out-of-pocket limit for Non-PPO Providers, so that the combined out-of-pocket amounts will not exceed the Non-PPO Provider out-of-pocket limit.

## COVERED EXPENSES

**The benefits under this Plan are intended to cover a wide range of services. In the section, "Medical Covered Expenses," You will find important additional information on the types of services covered under this Plan. Please also refer to the section, "Limitations and Exclusions" for information on expenses not covered. In addition, You may find the "Definitions" section helpful in understanding the terms used in this Summary Plan Description. Please remember that payment for these services will only be available if they are Covered Expenses that are medically Necessary and are not Experimental/Investigative.**

**Information in this section is intended to give You a convenient outline of the Plan provisions and is not all-inclusive. Unless otherwise stated, all Covered Expenses are subject to the Deductible and coinsurance shown in the Schedule of Benefits. Charges for services received from Non-PPO Providers are subject to Customary, Usual and Reasonable guidelines.**

**Schedule of Benefits (continued)**

Qualified Practitioner's Benefits

PPO Providers

Office Visits ..... $25 copayment per visit, then 100%, for the office visit charges only. This $25 copayment is not applied towards the deductible, coinsurance or out-of-pocket limits.

Other services when obtained or performed during a Qualified Practitioner's office visit are subject to the Deductible and coinsurance listed above and may include drugs, vials, injections, minor surgery, surgical supplies and x-ray and laboratory tests.

Inpatient/Outpatient Charges ..... Subject to Deductible and coinsurance.

Non-PPO Providers

Office Visits ..... Subject to Deductible and coinsurance.

Inpatient/Outpatient Charges ..... Subject to Deductible and coinsurance.

Wellness Benefit (Age 18 and over)

PPO Providers..... $25 copayment per visit, then 100%, for the office visit charges only. This $25 copayment is not applied towards the deductible, coinsurance or out-of-pocket limits.

Other services when obtained or performed in conjunction with the office visit are subject to the Deductible and coinsurance listed above and include drugs, vials, injections, minor surgery, surgical supplies and x-ray and laboratory tests.

Non-PPO Providers..... Subject to Deductible and coinsurance.

Well Child Care Benefit ..... This benefit includes immunizations. Coverage is limited to 5 visits from birth to 12 months of age, 3 visits from ages 12 months to 24 months, and an annual visit from ages 24 months to 18 years.

PPO Providers..... Subject to the Deductible, then 100%. Other services when obtained or performed in conjunction with the office visit are subject to the Deductible and coinsurance listed above and include drugs, vials, injections, minor surgery, surgical supplies and x-ray and laboratory tests.

Non-PPO Providers..... Subject to Deductible and coinsurance.

Prescription Drug Benefits

Retail Pharmacy (up to 30 days) ..... You pay the greater of 25% of drug cost or copayments as follows: $10 for generic Drugs, $25 for formulary Drugs or $50 for brand name Drugs, up to a maximum responsibility of $75 per prescription.

Mail Order (90 days)..... You pay the greater of 25% of drug cost or copayments as follows: $20 for generic Drugs, $50 for formulary Drugs or $100 for brand name Drugs. Maximum responsibility is $150 per a prescription

**Schedule of Benefits (continued)**

| **MEDICAL BENEFITS** | | **HIGH DEDUCTIBLE** |
|---|---|---|
| Lifetime Maximum | $100,000 per Covered Person. | |
| | **PPO PROVIDERS** | **NON-PPO PROVIDERS** |
| Covered Charges payable at 100% (before Deductible applies): | | |
| Individual | First $500 | None |
| Employee + 1 * | First $750 | None |
| Family * | First $1,000 | None |
| Deductible per Calendar Year: | | |
| Individual | Next $1,750 | $3,000 |
| Employee + 1 * | Next $3,500 | $4,500 |
| Family * | Next $4,500 (Aggregated) | $6,000 (Aggregated) |

* Individual Plan limits only apply to one person coverage. Under an Employee + 1 or Family Plan, claims from all covered family members accumulate toward the appropriate deductible listed above and one family member could be responsible for up to the full deductible amount.

| | | |
|---|---|---|
| Coinsurance: | 90% (You pay 10%) | 60% (You pay 40%) |

After You satisfy the deductible for the Calendar Year, the Plan will then pay the applicable percentage of Covered Expenses as shown above until the Out-of-Pocket Limit listed below is met, and 100% thereafter for the remainder of the same Calendar Year, subject to Plan maximums.

| | | |
|---|---|---|
| Out-of-Pocket Limit: | | |
| Individual | $4,000 | $ 5,000 |
| Employee + 1 | $6,000 | $ 8,500 |
| Family | $8,000 | $12,000 |

* Individual Plan limits only apply to one person coverage. Under an Employee + 1 or Family Plan, claims from all covered family members accumulate toward the appropriate out-of-pocket limit listed above and one family member could be responsible for up to the full out-of-pocket amount.

The out-of-pocket limits shown do not apply to expenses in connection with prescription Drugs, and copayments paid will not accrue toward satisfaction of these limits.

The out-of-pocket limit amounts represent the total dollars paid by You and Your covered family members toward satisfaction of the Deductible and coinsurance provisions. When You reach the limit, the Plan will then pay 100% of Covered Expenses, subject to Plan Maximums, for the remainder of the same Calendar Year. If You or Your covered Dependents use a combination of PPO and Non-PPO Providers, the amount of Deductible and eligible coinsurance You have paid for PPO Providers will also be credited to the out-of-pocket limit for Non-PPO Providers, so that the combined out-of-pocket amounts will not exceed the Non-PPO Provider out-of-pocket limit.

## COVERED EXPENSES

**The benefits under this Plan are intended to cover a wide range of services. In the section, "Medical Covered Expenses," You will find important additional information on the types of services covered under this Plan. Please also refer to the section, "Limitations and Exclusions" for information on expenses not covered. In addition, You may find the "Definitions" section helpful in understanding the terms used in this Summary Plan Description. Please remember that payment for these services will only be available if they are Covered Expenses that are medically Necessary and are not Experimental/Investigative.**

**Information in this section is intended to give You a convenient outline of the Plan provisions and is not all-inclusive. Unless otherwise stated, all Covered Expenses are subject to the Deductible and coinsurance shown in the Schedule of Benefits. Charges for services received from Non-PPO Providers are subject to Customary, Usual and Reasonable guidelines.**

**Schedule of Benefits (continued)**

| | |
|---|---|
| Qualified Practitioner's Benefits | Subject to applicable Deductible and coinsurance. |
| Wellness Benefit (Age 18 and over) | Subject to applicable Deductible and coinsurance. |
| Well Child Care Benefit | Subject to applicable Deductible and coinsurance. This benefit includes immunizations. Coverage is limited to 5 visits from birth to 12 months of age, 3 visits from ages 12 months to 24 months, and an annual visit from ages 24 months to 18 years. |
| Prescription Drug Benefits | |
| Retail Pharmacy (up to 30 days) | You pay the greater of 25% of drug cost or copayments as follows: $15 for generic Drugs, $30 for formulary Drugs or $55 for brand name Drugs, up to a maximum responsibility of $100 per prescription. |
| Mail Order | You pay the greater of 25% of drug cost or copayments as follows: $30 for generic Drugs, $60 for formulary Drugs or $110 for brand name Drugs. Maximum of $200 per prescription |

| **COVERED EXPENSES** | **BOTH LOW DEDUCTIBLE AND HIGH DEDUCTIBLE** |
|---|---|

**The benefits under this Plan are intended to cover a wide range of services. In the section, "Medical Covered Expenses," You will find important additional information on the types of services covered under this Plan. Please also refer to the section, "Limitations and Exclusions" for information on expenses not covered. In addition, You may find the "Definitions" section helpful in understanding the terms used in this Summary Plan Description. Please remember that payment for these services will only be available if they are Covered Expenses that are medically Necessary and are not Experimental/Investigative.**

**Information in this section is intended to give You a convenient outline of the Plan provisions and is not all-inclusive. Unless otherwise stated, all Covered Expenses are subject to the Deductible and coinsurance shown in the Schedule of Benefits. Charges for services received from Non-PPO Providers are subject to Customary, Usual and Reasonable guidelines.**

| | |
|---|---|
| Hospital Benefits | Semi-private room and board, intensive care or coronary care and miscellaneous charges. |
| Assisting the Primary Surgeon | 25% of the allowable fee for primary surgeon. |
| Pre-admission Testing | Payable at 100% when in lieu of testing on admission. |
| Outpatient Hospital Benefits | Subject to applicable Deductible and coinsurance. |
| Emergency Room Medical Care | Subject to applicable Deductible and coinsurance. |
| Ambulatory Surgical Center/ Free Standing Surgical Facility | Subject to applicable Deductible and coinsurance. |
| X-ray and Laboratory Tests | Subject to applicable Deductible and coinsurance. |
| Ambulance Service Benefit | Subject to applicable Deductible and coinsurance. |
| Pregnancy Benefit | Subject to applicable Deductible and coinsurance. |
| Newborn Benefits | Subject to applicable Deductible and coinsurance. Refer to "Section 3 – Eligibility" of this SPD for important information on Dependent Coverage. |
| Birthing Center Benefit | Subject to applicable Deductible and coinsurance. |
| Skilled Nursing Home Benefit | Subject to applicable Deductible and coinsurance for up to a Maximum of 30 days per occurrence. |
| Home Health Care Benefit | Subject to applicable Deductible and coinsurance, with benefits are available for up to 40 visits per Calendar Year when visits are in lieu of a covered Confinement in a Skilled Nursing Home or Hospital. |
| Hospice Care Benefit | Subject to applicable Deductible and coinsurance, with benefits are available when Hospice Care is in lieu of a covered Confinement in a Hospital or Skilled Nursing Home, up to a Maximum Lifetime benefit of $10,000. |
| Mental or Nervous Conditions, Substance Abuse Benefit | |
| Inpatient Charges | Subject to applicable Deductible and coinsurance. |
| Transitional Charges | Subject to applicable Deductible and coinsurance. |

**Schedule of Benefits (continued)**

| | |
|---|---|
| Outpatient Charges | Subject to applicable Deductible and coinsurance. |
| Accident Benefit | |
| PPO Providers | Paid at 90% (no Deductible), up to a $500 benefit per Calendar Year Maximum. |
| Non-PPO Providers | Subject to Deductible and coinsurance. |
| Chiropractic Care Benefit | Subject to applicable Deductible and coinsurance, up to a Maximum of 25 visits per Calendar Year. Not available for routine or maintenance care. |
| Other Covered Expenses | Subject to applicable Deductible and coinsurance. |

**For information on other types of services and supplies, please see the Medical Covered Expense section and the Exclusions and Limitations section.**

# HOW TO FILE A MEDICAL CLAIM

You will receive a Plan identification (ID) card showing Your name, Your group number and Your effective date of coverage.

Show Your ID card to the Hospital, clinic or Qualified Practitioner's office at the time medical services are rendered. Claims should be directed to the address shown on Your ID card by or You or Your provider. CBA does not require special claim forms. In the event that the service provider does not file the claim, You may submit the claim directly to CBA at the address shown below. Claims filed with CBA must be in writing and delivered by mail (postage prepaid), by fax or by e-mail.

Claims should be submitted to CBA at the address indicated below or to the address listed on the Covered Person's ID card, if different, in order for the claim to be deemed submitted.

Attention: Claim Department
Custom Benefit Administrators
P.O. Box 1385
La Crosse, WI 54602-1385

Phone: 608-784-2442 or 800-944-2188
Fax: 608-785-0063
E-mail: info@custombenefit.net

Claims submissions must be in a format acceptable to CBA and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable Federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by the Plan.

Post-Service Claims must be complete. They must contain, at a minimum:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges, which reflect any applicable PPO repricing;
6. The name of the Plan;
7. The name of the Covered Employee; and
8. The name of the patient.

Presentation of a prescription to a pharmacy does not constitute a claim. If a Covered Person pays the cost of a covered prescription Drug, however, a claim may be submitted to CBA for that purchase. A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure is covered by the Plan, prior to providing treatment, is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits. Payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable, if any, under the Plan.

Each Covered Person claiming benefits under the Plan will be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion determines that the Covered Person has not Incurred a Covered Expense or coverage is not available under the Plan, or if the Covered Person fails to furnish such proof as is requested, no benefits shall be payable under the Plan.

## PAYMENT OF CLAIMS

All claims and questions regarding health claims should be directed to CBA. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the provisions of the Plan and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Covered Person is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to CBA; provided, however, that CBA is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

## ASSIGNMENTS

The Plan will make direct payment to the provider of service, unless the claim has already been paid, in which case payment will be made to the covered Employee or such other person determined by the Plan Administrator to be the appropriate recipient. Such claim must contain adequate documentation of the prior payment, and the payment will discharge the Plan from any further liability with respect to the claim.

Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the provider; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

## CLAIM FILING LIMIT

You must provide the plan with written proof of Your claim. Proof should be provided within 90 days after the claim was Incurred. Your claim will not be denied if it was not reasonably possible to give such proof within 90 days, however, except in the case of legal incapacity, written notice must be given no later than 12 months after the date the claim was Incurred.

If the Plan is terminated, written proof of loss for any claims Incurred prior to the termination must be filed with the Plan Administrator within 90 days of the termination. Any claim received by the Plan Administrator more than 90 days after this Plan is terminated will not be a Covered Expense.

## PRESCRIPTION DRUG CHARGES

### Retail Pharmacy

Present the RESTAT drug card and the prescription to a participating pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the copayment for each prescription You receive as shown on the Schedule of Benefits. The balance of the transaction will be handled by Your pharmacy.

If You are without Your RESTAT drug card or are at a non-participating pharmacy, You must pay for the prescription and submit a claim for reimbursement to:

RESTAT
Patient Reimbursement
P.O. Box 758
West Bend, WI 53095-0758

Claim forms are available from CBA or from RESTAT. For more information regarding Your benefits or to check for a participating pharmacy, please contact RESTAT at 1-800-248-1062.

### Mail Order

The mail service program provides participants with an easy and convenient way to obtain Your maintenance medicine. An order form, which explains the mail service program is greater detail, is available. Please contact Your Human Resource Department or RESTAT at the number on the order form if You have any questions regarding this program.

For more information on RESTAT see their website: www.restat.com

# MEDICAL BENEFITS

## DEDUCTIBLE AND COINSURANCE INFORMATION

Covered Expenses are payable, after satisfaction of the Deductible, at the coinsurance percentages, up to the Maximum benefits, shown on the Schedule of Benefits and contained in the "Medical Covered Expenses" section.

### Individual Deductible

This is the amount of Covered Expense You must pay before the Plan will reimburse Covered Expenses in excess of the Deductible amount. The Deductibles apply to each Covered Person, each Calendar Year. The amount of each Deductible is shown on the Schedule of Benefits.

### Employee + 1 Deductible

This is the total amount of Deductible expense You must pay for Yourself and one (1) covered Dependent during a Calendar Year. There is a separate maximum for PPO Provider Deductible expenses and Non-PPO Provider Deductible expenses; however, the total You pay for both PPO Provider Deductibles and Non-PPO Provider Deductibles will not exceed the maximum for Non-PPO Provider Deductible expense. The maximum family Deductible amounts are shown in the Schedule of Benefits. Once You have paid the applicable maximum family Deductible, no further Deductibles will be applied during that Calendar Year.

### Family Deductible

This is the total amount of Deductible expense You must pay for Yourself and all of Your covered Dependents during a Calendar Year. There is a separate maximum for PPO Provider Deductible expenses and Non-PPO Provider Deductible expenses; however, the total You pay for both PPO Provider Deductibles and Non-PPO Provider Deductibles will not exceed the maximum for Non-PPO Provider Deductible expense. The maximum family Deductible amounts are shown in the Schedule of Benefits. Once You have paid the applicable maximum family Deductible, no further Deductibles will be applied during that Calendar Year.

### Coinsurance

Covered Expenses in excess of any required Deductibles will be reimbursed at the coinsurance percentages shown in the Schedule of Benefits. There is a coinsurance percentage that will be applied to PPO Provider Covered Expenses, and a separate coinsurance percentage that will be applied to Non-PPO Provider Covered Expenses.

### Out-of-Pocket Limit

Except as noted below, when the combined Covered Expenses You must pay for Yourself and all of Your covered Dependents to satisfy the Plan's Deductible and coinsurance provisions equals the amount shown in the Schedule of Benefits, the Plan will reimburse additional Covered Expenses Incurred during the remainder of the Calendar Year at 100%. There is an individual out-of-pocket limit and a family maximum out-of-pocket limit that applies to Covered Expenses for PPO Providers, and limits for Non-PPO Providers. The out-of-pocket limits are shown in the Schedule of Benefits.

The following charges will not contribute toward satisfaction of the individual or family out-of-pocket limits: The copayment applicable to office calls, Emergency room charges or prescription Drugs; charges for services listed under the Limitations and Exclusions section; charges that are over the Customary, Usual and Reasonable amount for services received at non-Network providers; or the penalty for failure to comply with the Utilization Review Plan.

## LIFETIME BENEFIT MAXIMUM

The Maximum Lifetime payment of Covered Expenses under this Plan for each Covered Person shall not exceed the Lifetime Benefit Maximum specified on the Schedule of Benefits. The Lifetime Benefit Maximum includes payments under this and any other group health plan sponsored by the Employer since November 1, 2006 and applies to all Covered Expenses incurred by the Covered Person under this or any other Employer plan whether or not there is any interruption of coverage under this Plan or any other Plan.

Any sub-limits included for certain types of services in the Schedule of Benefits are to be included in the Lifetime Benefit Maximum.

## SUPPLEMENTAL CATASTROPHIC ACCIDENT AND EMERGENCY BENEFIT

Up to $25,000 of Covered Expenses in excess of the Lifetime Benefit Maximum are eligible for payment pursuant to the following supplemental catastrophic accident and emergency benefit.

Payment is limited to Covered Expenses that:

1. would have been paid under the Plan but for the Lifetime Benefit Maximum, and

2. were caused by an unanticipated catastrophic accident or emergency that prevented the Covered Person from completing or cause a third party to complete an application for other health coverage (including without limitation coverage under: a private health insurance policy; a group, association, governmental or religious health plan; or the Wisconsin Health Insurance Risk Sharing Plan) before such Covered Person incurs Covered Expenses in excess of the Lifetime Benefit Maximum.

Payment is further limited to Covered Expenses in excess of the Lifetime Benefit Maximum incurred before the earlier of:

1. the date an application for such other health coverage is completed by You or on Your behalf, and

2. the date You, Your spouse (if any) or, if You are a covered Dependent, Your parent or guardian could have through the exercise of reasonable diligence

    a. recognized You would incur Covered Expenses in excess of the Lifetime Benefit Maximum, and
    b. completed and application for other health coverage or requested such application to be completed by a third party, whether or not such application results in other health coverage.

# UTILIZATION REVIEW PLAN

Throughout this booklet the term "SHPS" will be referenced. SHPS is a Utilization Management, Cost Containment Program administered by HealthEOS and staffed by licensed professional nurses who have years of experience in health care. They understand the importance of minimizing the intrusion into the Qualified Practitioner/patient relationship and rely on their ability to promote health care alternatives that are acceptable to everyone: patients, Qualified Practitioners and Employers. SHPS was formerly known as AHC or Associates for Healthcare.

## HOW THE PROGRAM WORKS

When Your Qualified Practitioner recommends an inpatient Confinement for a Covered Person, SHPS must be called (toll-free 1-877-298-5659) at least 72 hours prior to the admission.

When You or Your Qualified Practitioner call SHPS for Pre-admission Certification, You will be asked for the following information:

1. Group name and number
2. Name of Employee
3. Employee's Social Security Number
4. Name of patient
5. Patient's birthday
6. Patient's address
7. Admitting Hospital
8. Phone number of admitting Hospital
9. Qualified Practitioner's name and phone number
10. Reason for admission
11. Admission date

**IMPORTANT: PRE-ADMISSION CERTIFICATION DOES NOT VERIFY OR GUARANTEE COVERAGE. BENEFITS ARE SUBJECT TO ALL PLAN PROVISIONS, LIMITATIONS AND EXCLUSIONS.**

## PRE-ADMISSION REQUIREMENTS

"Pre-admission Certification" means approval by SHPS of the Medical Necessity for a proposed Confinement in a Qualified Treatment Facility, and the appropriate length of stay.

You or Your Qualified Practitioner must contact SHPS at least 72 hours before admission in order to avoid incurring a penalty to benefits otherwise payable under the Plan (see "Pre-admission Certification Penalty" in this section). **Special rules apply to Emergency admissions, explained further in this section.** Your Qualified Practitioner, the Qualified Treatment Facility or any other person who can provide the necessary information may make contact; however You are responsible for making sure that SHPS has been contacted. Upon notification, SHPS will contact Your Qualified Practitioner for all pertinent details concerning the admission. This is only the first step in the certification procedure. In order to certify Your admission, SHPS will:

1. Review Your Qualified Practitioner's treatment plan;
2. Advise You and Your Qualified Practitioner if the proposed Confinement is certified as Medically Necessary; and
3. Advise You and Your Qualified Practitioner for how many days the Confinement is certified.

This Pre-admission Certification is valid for 30 days (excluding pregnancies) from the scheduled date of admission. If the patient does not enter the Qualified Treatment Facility within 30 days or enters for a different reason, another request for Pre-admission Certification must be made.

### Emergency Admissions

**Do not delay seeking medical care for any Covered Person who has a serious condition that may jeopardize his life or health because of the requirements of this program. You may contact SHPS after admission as described below and You will not incur a penalty.**

If You or a covered Dependent must be admitted on an emergency basis, follow the physician's instructions carefully and contact SHPS by telephone within 48 hours or the first business day after the admission date.

The Plan does not require You or a covered Dependent to obtain approval of a medical service prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. In an urgent care or emergency situation, You or a covered Dependent simply follow the Plan's procedures after receipt of treatment, and file the claim as a Post-service Claim.

"Emergency", for purposes of this program, means a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. An Emergency may or may not be life threatening. The Plan Administrator may, in its discretion, request satisfactory proof that an Emergency or acute condition did exist.

### Weekend Admissions

Weekend Qualified Treatment Facility admissions (Friday, Saturday, or Sunday) will not be certified as Medically Necessary unless You are admitted on an Emergency basis, or treatment or surgery is performed on the day You are admitted.

### Extension of a Certified Admission

Your attending Qualified Practitioner may, at any time, initiate by telephone a request for re-evaluation or extension from SHPS. Following a review, Your attending Qualified Practitioner has the right to appeal any decision. It is important to remember that, at no time, will the decision-making authority for treatment be taken out of Your Qualified Practitioner's hands. SHPS will not, under any circumstances, interfere with the Qualified Practitioner-patient relationship or the course of treatment.

IF AN EXTENSION IS NOT CERTIFIED, BENEFITS OTHERWISE PAYABLE FOR THE EXTENSION PERIOD WILL BE TREATED AS DESCRIBED UNDER "PRE-ADMISSION CERTIFICATION PENALTY".

### Maternity Admissions

SHPS encourages two calls for Maternity Pre-Certification. SHPS should be called during Your first trimester and provided with the estimated date of delivery. A second call is encouraged at actual delivery.

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

If Your maternity stay admission exceeds the periods stated above, SHPS must be contacted within 24 hours or the next business day, whichever is sooner, or benefits otherwise payable will be subject to the penalty described under "Pre-Admission Certification Penalty".

## PRE-ADMISSION CERTIFICATION PENALTY

If You fail to notify Your pre-certification company of a Confinement within the time limits specified, the benefits otherwise payable under this Plan will be reduced by **25% up to a Maximum of $1,000**. This penalty will be applied to Covered Expenses before application of any Deductibles and coinsurance, and will not contribute to out-of-pocket limits.

## CASE MANAGEMENT

If You or Your covered Dependent becomes seriously or chronically ill or Injured, this Plan provides for case management services to help You use Your benefits under the Plan in the most effective manner. This is accomplished by working with You and Your Qualified Practitioner in planning and implementing health care alternatives to meet Your needs. The case management staff will try to conserve Your benefit dollars by making sure that Your case is handled as efficiently as possible.

Case management services are provided by SHPS. The case management staff at SHPS consists of licensed, professional nurses who have many years of experience in health care. They understand the importance of minimizing intrusion into the Qualified

**Utilization Review Plan (continued)**

Practitioner-patient relationship. The case management staff relies on its ability to promote health care alternatives that are acceptable to everyone: patients, Qualified Practitioners and Plan Administrators.

By promoting health care alternatives that are acceptable to You, Your Qualified Practitioner and Your Plan Administrator, case management helps to control health care costs and helps You use Your benefits more efficiently.

# MEDICAL COVERED EXPENSES

Please remember that, although a Qualified Practitioner may prescribe, recommend or approve certain treatment, services or supplies, a Qualified Practitioner's recommendation does not necessarily mean that such treatment, services or supplies satisfy the Plan's criteria for coverage or make the expense a Covered Expense under the Plan.

## HOSPITAL BENEFITS

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for the following services by a Qualified Treatment Facility or Hospital.

**Room and Board**
Average daily semi-private, ward, intensive care, isolation or coronary care room charges and general nursing services for each day of Confinement. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the Hospital where You are confined. If the Hospital in which You are confined has private rooms only, the private room rate will be covered.

**Hospital Miscellaneous Charges**
Charges made by the Hospital on its own behalf for services and supplies furnished for Your treatment during Confinement, including the following charges made by a Qualified Practitioner, whether billed directly or separately by the Hospital:

1. Professional services of a radiologist or pathologist for diagnostic x-ray and laboratory tests;

2. Professional services of an anesthesiologist.

## PRE-ADMISSION TESTING

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for Pre-admission testing. Benefits are payable at 100% when pre-admission testing is performed in a Qualified Practitioner's office or the outpatient department of a Hospital, within seven days of a covered inpatient Confinement and accepted by the inpatient facility in lieu of like tests performed after Your admission.

## QUALIFIED PRACTITIONER BENEFITS

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for the following services by a Qualified Practitioner:

1. Home and office calls;

2. Administration of anesthesia:

3. A surgical procedure, including post-operative care;

4. Multiple or bilateral surgical procedures including post-operative care.

   If multiple surgical procedures are performed at one operative session, the amount eligible as a Covered Expense will be limited to the Customary, Usual and Reasonable fee for the primary surgical procedure, 50% of the Customary, Usual and Reasonable fee for the secondary procedure and 25% of the Customary, Usual and Reasonable fee for the third and subsequent procedures.

5. Second surgical opinions.

No benefits are payable for incidental procedures, such as an incidental appendectomy.

## ORAL SURGERY

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for the following services by a Qualified Practitioner for oral surgery:

1. Surgical removal of unerupted, impacted teeth;

2. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require pathological examination;

3. Repair of or initial replacement of natural teeth damage due to Injury. Services must be received within 24 months of the Injury. Damage resulting from biting or chewing will not be considered an Injury; and

4. X-rays and anesthesia in connection with the covered procedure.

## WELLNESS BENEFIT

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for the following services for Covered Persons aged 18 and over.

Check ups or routine examinations include the office visit and related charges for:

1. Routine x-ray and laboratory tests, including routine mammograms and pap smears for any covered female person;

2. Screening colonoscopies; and

3. Routine immunizations.

See the section, "Other Covered Expenses" for additional coverage for mammograms and pap smears. You must not be confined in a Hospital or Qualified Treatment Facility and such expenses must not be for the diagnosis or treatment of a specific Injury or Sickness.

No benefits are payable under this provision for:

1. Medical examinations for Injury or Sickness;

2. Medical examinations caused by or related to a pregnancy;

3. Third party requested physicals (unless substituted for routine physical);

4. Hearing tests; or

5. Any dental examinations.

## WELL CHILD CARE BENEFIT

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits, for the following services for Covered Dependents under age 18:

Check ups or routine examinations include the office visit and related charges for:

1. Routine x-ray and laboratory tests;

2. Routine immunizations; and

3. Routine vision exams and hearing tests (to age 1 year).

Benefits under this provision are limited to 5 visits from birth to age 12 months, 3 visits from ages 12 months to 24 months, and one visit per year for ages 24 months to 18 years.

The Child must not be confined in a Hospital or Qualified Treatment Facility and such expenses must not be for the diagnosis or treatment of a specific Injury or Sickness.

No benefits are payable for:

1. Medical examinations for Injury or Sickness; or

2. Any dental examinations.

## PRESCRIPTION DRUG BENEFIT

You will receive a RESTAT prescription drug card. It will show Your name, ID number and group number. Eligibility is on-line.

Charges for drugs and medicines required by law to be obtained on the written prescription of a Qualified Practitioner or dentist are payable as shown on the Schedule of Benefits. Investigational new drugs which have reached a Phase 3 clinical investigation for the treatment of HIV infection are included in this benefit.

Birth control biologicals, implants and devices are not a Covered Expense. Over-the-counter medicines, drugs, supplies and vitamins (with the exception of pre-natal vitamins) are not a Covered Expense.

## OUTPATIENT HOSPITAL BENEFIT

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for the following outpatient services by a Qualified Treatment Facility:

1. Hospital miscellaneous charges for services and supplies of a Hospital provided on an outpatient basis.

2. Regularly scheduled treatments, such as physical therapy, kidney dialysis, chemotherapy, inhalation therapy and radiation therapy, when ordered by Your attending Qualified Practitioner and rendered on an outpatient basis.

## EMERGENCY ROOM MEDICAL CARE

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits, for the following services by a Qualified Treatment Facility emergency room:

1. Emergency Accident treatment provided within 48 hours of the Accident;

2. A surgical procedure; or

3. Treatment of a Sickness which is a medical Emergency.

## AMBULATORY SURGICAL CENTER

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for charges made by an Ambulatory Surgical Center, on its own behalf, for services and supplies in connection with covered surgical procedures.

## X-RAY AND LABORATORY TESTS

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for diagnostic x-ray and laboratory tests when performed by a Qualified Practitioner and not covered under the Hospital benefits provision of this Plan. These Covered Expenses do not include dental x-rays, unless related to a covered Injury.

## AMBULANCE SERVICE BENEFIT

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for local professional ground ambulance service. If Your Injury or Sickness requires special treatment not available in a local Hospital, appropriate transportation to the nearest Hospital equipped to provide the necessary treatment is covered. (Only charges incurred for the first trip to and from a Hospital will be included.)

## PREGNANCY BENEFIT

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for services by Qualified Treatment Facilities and Qualified Practitioners on behalf of any female Covered Person on the same basis as a Sickness. Complications of Pregnancy for any female Covered Person are payable as any other covered Sickness at the point the complication sets in.

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

## NEWBORN BENEFITS

Note: The benefits described in this section are available only if You apply for coverage for Your newborn Dependent within 30 days of the birth. If You have other eligible Dependents and declined Dependent coverage when You originally enrolled in the Plan, such Dependents may be added as provided under "Special Enrollment". Refer to the "Eligibility" section of this booklet for more information.

**Well-Newborn**
Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for Hospital charges for nursery room and board, Hospital miscellaneous charges, the Qualified Practitioner's charges for circumcision of a male newborn Child, and the Qualified Practitioner's charges for routine examination of the newborn Child before release from the Hospital.

**Sick-Newborn**
Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for expenses Incurred for necessary care and treatment of Injury or Sickness. Covered Expenses do not include Expense incurred for plastic or Cosmetic Surgery, except surgery for:

1. Reconstruction due to Injury, infection or other disease of the involved part; or

2. Congenital disease or anomaly which resulted in a functional defect.

## BIRTHING CENTER BENEFIT

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for services and supplies provided for prenatal care, delivery of children and immediate post-partum care.

## SKILLED NURSING HOME BENEFIT

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for the following services by a Skilled Nursing Home which:

1. Begins within 14 days after discharge from a Hospital Confinement or prior Skilled Nursing Home Confinement of at least three consecutive days;

2. Is necessary for care or treatment of the same Injury or Sickness which caused the prior Confinement; and

3. Occurs while You or Your covered Dependent are under the regular care of the Qualified Practitioner who certified the required Skilled Nursing Home Confinement.

Covered Expenses will include semi-private daily room and board, including general nursing services and necessary miscellaneous services and supplies. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the facility where You are confined.

## HOME HEALTH CARE BENEFIT

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for Home Health Care, as described below:

The Maximum weekly benefit for such coverage will not exceed the Customary, Usual and Reasonable fee for weekly care in a Skilled Nursing Home facility.

Each visit by a person providing services under a home health care plan, or evaluating the need for, or developing a plan of home health care will be considered as one home health care visit.

Up to four consecutive hours of home health aide service in a 24-hour period is considered one home health care visit. A home health aide visit of four hours or more is considered one visit for every four hours or part thereof. Benefits are limited to 40 visits per Calendar Year.

Home Health Care will not be reimbursed unless the Qualified Practitioner certifies that:

1. Hospitalization or Confinement in a Skilled Nursing Home would be required if home care was not provided;

2. Necessary care and treatment are not available from members of Your immediate family or other persons residing with You, without causing undue hardship;

   Immediate family, for purposes of this section, means Your spouse, children, parents, grandparents, brothers and sisters and their spouses.

3. The home health care services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Care Agency or certified rehabilitation agency.

If You were hospitalized immediately prior to the commencement of home health care, the home health care plan must also be initially recommended by the Qualified Practitioner who was the primary provider of services during Your hospitalization.

The home health care plan may consist of:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse (RN);

2. Part-time or intermittent home health aide services which are necessary as part of the home health care plan, provided under the supervision of a registered nurse (RN) or medical social worker, and which consist solely of caring for the patient;

3. Physical, respiratory, occupational or speech therapy;

4. Medical supplies, Drugs and medications prescribed by a Qualified Practitioner and laboratory services by or on behalf of a Hospital, when necessary under the home care plan and to the extent such items would be covered under the Plan if You had been hospitalized.

5. Nutritional counseling provided under the supervision of a registered dietician, when such services are necessary as part of the home care plan; and

**Medical Covered Expenses (continued)**

6. The evaluation of the need for and the development of a plan of home health care by a registered nurse (RN), physician assistant or medical social worker, when home health care is recommended or requested by Your attending Qualified Practitioner.

## HOSPICE CARE BENEFIT

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for Hospice care when it is furnished in a Hospice Facility or by a Hospice Care Agency in Your home. A Qualified Practitioner must certify that You are terminally ill with a life expectancy of six months or less.

For hospice care only, Your immediate family is considered to be Your parent, spouse and Dependent Children.

When Hospice Care is in lieu of a covered Confinement in a Hospital or Skilled Nursing Home, Covered Expenses may include:

1. Room and board and other services and supplies;

2. Part-time nursing care by or supervised by a registered nurse (RN);

3. Counseling services by a licensed clinical social worker or pastoral counselor for the hospice patient and immediate family;

4. Medical social services provided to You or Your immediate family under the direction of a Qualified Practitioner. Services include:

    a. assessment of social, emotional and medical needs, and the home and family situation,

    b. identification of the community resources available and assisting in obtaining those resources;

5. Dietary counseling;

6. Consultation and case management services by a Qualified Practitioner;

7. Physical or occupational therapy;

8. Part-time home health aide service; and

9. Medical supplies, Drugs and medicines prescribed by a Qualified Practitioner.

**Special Limitations on Hospice Care Benefits**
Covered Expenses for Hospice Care do not include private or special nursing services, a Confinement not required for pain control or other acute chronic symptom management, funeral arrangements, or financial or legal counseling, including estate planning or drafting of a will.

Covered Expenses for Hospice Care do not include homemaker or caretaker services including a sitter or companion services, house cleaning or household maintenance, services of a social worker, other than a licensed clinical social worker, services by volunteers or persons who do not regularly charge for their services, or services by a licensed pastoral counselor to a member of his congregation.

## MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for the following expenses Incurred for treatment of a Mental and Nervous Condition or for Substance Abuse:

1. Charges made by a Qualified Practitioner;

2. Charges made by a Qualified Treatment Facility;

3. Charges for Drugs which may be obtained only on the written prescription of a Qualified Practitioner.

**Medical Covered Expenses (continued)**

**Inpatient Benefits**
Covered Expenses while confined as a registered bed patient in a Qualified Treatment Facility are payable subject to the Deductible and coinsurance as shown on the schedule of benefits. Inpatient Benefits include, but are not limited to, individual or group psychotherapy, psychological testing and convulsive therapy.

**Outpatient Benefits**
Covered Expenses for outpatient treatment received while not confined in a Hospital or Qualified Treatment Facility are payable subject to the Deductible and coinsurance as shown on the schedule of benefits. Outpatient benefits include related expenses for prescription Drugs, diagnostic laboratory exams and psychological testing.

**Transitional Benefits**
Covered Expenses for Transitional Treatment received while not confined as a registered bed patient in a Hospital or Qualified Treatment Facility are payable subject to the Deductible and coinsurance as shown on the schedule of benefits.

**Maximum Benefit**
Covered Expenses for Mental and Nervous Conditions, Substance Abuse and alcoholism are subject to the same lifetime Maximum benefit as for other medical services, shown in the Schedule of Benefits

**Limitations**
Covered Expenses do not include treatment of nicotine habit or addiction, treatment of being overweight or obese, marriage counseling, or court ordered examinations or counseling.

## ACCIDENT BENEFIT

Covered Expenses under the Accident Benefit are payable as shown on the Schedule of Benefits. The Injuries must be sustained subsequent to the Covered Person's effective date. Services and supplies must be ordered by a Qualified Practitioner and furnished within a 90-day period beginning with the date the Covered Person sustained those Injuries.

**Covered Charges**
The Plan will pay benefits for the following when furnished for medical care to the Covered Person for accidental injuries including, but not limited to:

1. Services and supplies (including room and board) furnished by a Hospital for medical care in that Hospital;

2. Doctors' services for surgical procedures and other medical care;

3. Surgical dressings, casts, splints, trusses, braces and crutches;

4. X-ray and laboratory examinations;

5. Private duty nursing services by a registered nurse (R.N.) or Licensed Practical Nurse (L.P.N.);

6. Drugs and medicines requiring the written prescription of a licensed physician; and

7. Ambulance services for local travel (not more than 25 miles per trip).

## OTHER COVERED EXPENSES

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits, for the following:

1. Services of a registered nurse (RN) or licensed practical nurse (LPN) for nursing care ordered by Your attending Qualified Practitioner while You are not Confined.

2. Blood and/or blood plasma that is not replaced by donation and administration of blood and blood products including blood extracts or derivatives.

**Medical Covered Expenses (continued)**

3. Oxygen and other gases, and rental of equipment for their administration.

4. Prosthetic appliances for the replacement of the loss of natural limbs and eyes. Replacement appliances will only be covered when necessary due to a pathological change. Repair and maintenance expenses are not a Covered Expense under this Plan.

5. Casts, splints, surgical dressings, trusses, braces and crutches.

6. Special supplies when prescribed by Your attending Qualified Practitioner, including:

   a. Catheters,
   b. Colostomy bags, belts and rings,
   c. Flotation pads,
   d. Needles and syringes,
   e. Initial contact lenses or eyeglasses following cataract surgery

7. Rental up to the total purchase price or, when approved by the Plan, purchase of a wheelchair, Hospital bed, respirator or other Durable Medical Equipment. Repair and maintenance expenses are not a Covered Expense under this Plan.

8. Mechanical medical devices implanted in a body cavity to aid the function of an internal body organ.

9. Chiropractic Care for the treatment of an Injury or Sickness. Routine or maintenance Chiropractic Care is not a Covered Expense. Chiropractic Care benefits are payable, at the Deductible and coinsurance shown on the Schedule of Benefits, and is limited to 25 visits per Calendar Year.

10. Installation and use of an insulin infusion pump, other equipment and supplies used in the treatment of diabetes, and diabetic self-management education programs. Coverage for an insulin infusion pump is limited to the purchase of one pump per year. The pump must be in use for 30 days before purchase.

11. Services and supplies in connection with elective sterilizations, vasectomies and tubal ligations, for covered Employees and Dependent spouses only. Reversals of such procedures is not a Covered Expense.

12. Treatment by a licensed physical, speech or occupational therapist to restore loss or to correct impairment due to an Injury or Sickness.

13. Radiation therapy and chemotherapy.

14. Acupuncture when used as an anesthetic in place of anesthesia services that would have been covered under the Plan.

15. The following human organ or tissue transplants, when the transplant is provided from a human donor to a living human transplant recipient:

    a. Artery or vein transplants and bone or skin grafts;
    b. Bone marrow transplants;
    c. Cornea transplants;
    d. Heart transplants;
    e. Heart-lung transplants (combined procedures);
    f. Liver transplants; and
    g. Kidney transplants.

    Covered Expenses for acquisition, storage and transportation of organs are limited to a Maximum benefit paid of $10,000 per transplant. Covered Expenses for private duty nursing care are limited to a Maximum benefit paid of $10,000 per transplant.

    When the recipient and donor are covered by this Plan, each is entitled to benefits under the Plan.

**Medical Covered Expenses (continued)**

When only the recipient is covered by the Plan, both the donor and the recipient are entitled to the benefits of the Plan. The donor's benefits are limited to only those not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any government program. Benefits for the donor are considered as though paid for the recipient, and will accumulate toward any Plan Maximums.

When only the donor is covered by the Plan, neither the donor or the recipient is entitled to the benefits of the Plan.

If any organ tissue is sold rather than donated to the covered recipient, no benefits are payable for the purchase price of such organ or tissue. However, other costs related to the evaluation and procurement are covered for a recipient who is covered under this Plan.

16. Treatment of kidney disease, including dialysis and donor and recipient costs for kidney transplants.

17. Three examinations by low-dose mammography while a female Covered Person is age 40-49, and one examination by low-dose mammography per Calendar Year for a female Covered Person age 50 and over.

18. Office visit and laboratory charges for one routine pap smear per Calendar Year for any female Covered Person.

19. Diagnostic testing for infertility. The plan will not cover any expenses or charges incurred by or for the treatment of infertility.

20. Services in connection with a mastectomy for which benefits are payable under the Plan and reconstructive surgery has been elected in a manner determined in consultation with the attending Physician and the patient:

    a. Reconstruction of the breast on which the mastectomy has been performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
    c. Prosthesis to replace the breast on which the mastectomy has been performed; and
    d. Physical complications resulting from all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes)

21. Covered Expenses incurred outside the United States, provided an itemized statement is submitted which includes a description of the services rendered, the diagnosis and the cost of each service. The cost of the services must be provided in U.S. currency, and any payments will be sent directly to the Employee.

*All special benefits described in this section are covered only if they are Covered Expenses, Medically Necessary, not Experimental, and You did not travel to such location for the purpose of obtaining medical services, Drugs or supplies. All Covered Expenses are subject to the Plan provisions specified on the Schedule of Benefits.*

## LIMITATIONS AND EXCLUSIONS

This Plan does not provide benefits for:

1. Services or supplies:

    a. Furnished while You are not under the regular care of a Qualified Practitioner,
    b. Not authorized or prescribed by a Qualified Practitioner,
    c. For which no charge is made, or for which You would not be legally obligated to pay if You did not have this coverage,
    d. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid), or
    e. Furnished in the treatment of any Uniformed Service-related Injury or Sickness (past or present) while You are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies.

2. Eye refractive disorders, vision therapy (orthoptics), radial keratotomy or keratoplasty to correct refractive disorders, eyeglasses, hearing aids or the fitting or repair of any hearing aid or eyeglasses unless specifically provided for under this Plan. The initial purchase of eyeglasses or contact lenses following cataract surgery is a Covered Expenses.

3. Exams directed or requested by a court of law; routine physical exams for occupation, sports participants, employment or the purchase of insurance (unless substituted for a routine physical).

4. Any charges for, relating to or resulting from sex change operations.

5. Any Injury or Sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain, for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, regardless of whether a claim was filed for such benefits.

6. Plastic or Cosmetic Surgery, including any services or supplies related to, resulting from complications of, or for reversal of Cosmetic Surgery, unless for reconstructive surgery due to Injury, infection or other disease of the involved part; or due to congenital disease or anomaly which resulted in a functional defect of a Dependent Child.

7. Dental care or treatment except as specifically described.

8. Any loss to a Covered Person who is not a member of the armed forces which was caused or contributed to by:

    a. War or any act of war, whether declared or not, or
    b. Any act of international armed conflict, or any conflict involving armed forces or any international authority.

9. The treatment of mental and nervous disorders, chemical dependence or alcoholism unless specifically provided for under this Plan.

10. Any drug or medicine which is not approved for marketing by United States Food and Drug Administration, by issuance of a New Drug Application or other form of formal approval; or any approved drug which is not used for the specific indication which led to its approval by the United States Food and Drug Administration. This does not include investigational new drugs which have reached a Phase 3 clinical investigation for the treatment of HIV infection.

11. Any medical equipment, supplies, prescribed drugs, procedures, or treatment which are Experimental or investigational in nature and have not been established as safe or effective, or are not in accordance with generally accepted professional standards, or which do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time the service is rendered.

12. Pre-Existing Conditions to the extent specified in the "Pre-existing Conditions Limitation" section.

13. Services provided by a person who ordinarily resides in Your home or who is a Family Member.

14. Custodial Care (in custodial or similar institutions, or rest cures).

**Limitations and Exclusions (continued)**

15. Charges in excess of the Customary, Usual and Reasonable fee for the service or supply.

16. Any medical Expense Incurred prior to Your effective date or after the date Your coverage under the Plan terminates, except as specifically described.

17. Any medical expense for a Sickness or Injury that occurred during the commission of, or attempt to commit, an illegal act, or participation in an illegal occupation, or participation in civil insurrection or riot, and any complication arising therefrom.

18. Services not Medically Necessary for diagnosis and treatment of an Injury or Sickness.

19. Private duty nursing while confined in a Hospital or other Qualified Treatment Facility.

20. Biologicals, implants and devices, except as specified in this document.

21. Any artificial means to achieve pregnancy including, but not limited to, in vitro fertilization, GIFT, artificial insemination and all related charges.

22. Any charges that would have been paid by Your primary plan, as determined by the Coordination of Benefit rules of this Plan, if You had complied with all of the requirements of that plan, including any penalties for failure to pre-certify the services.

23. Elective abortions, unless carrying the fetus to full term would endanger the life of the mother.

24. Dental implantology techniques, including prosthetic devices related to such techniques.

25. Charges incurred outside the United States, if You traveled to such location for the purpose of obtaining medical services, drugs or supplies.

26. Services or treatment for behavioral problems, learning disabilities, or developmental delays when not the result of an Injury or Sickness.

27. Any charges for weight control or reduction including, but not limited to, nutritional supplements, dietary or nutritional counseling, individual or behavior modification therapy, body composition or underwater weighing procedures, exercise therapy, weight control or reduction programs, or any obesity surgery including but not limited to stomach stapling, gastric bubble, intestinal or stomach bypass or suction lipectomy.

28. Educational testing or training, or recreational therapy.

29. Chelation (metallic ion therapy), except in the treatment of heavy metal poisoning.

30. Treatment programs, services or supplies having to do with the cessation of tobacco usage or nicotine addiction.

31. Phone consultations, completion of claim forms or forms necessary for Your return to work or school, or for an appointment You did not attend.

32. Any charge for holistic medicine or other programs with an objective to provide complete personal fulfillment.

33. Charges for a standby surgical team, unless surgery is actually performed.

34. Any charge for rolfing, colon therapy, homeopathy, reiki or visualization sessions.

35. Acupuncture therapy.

36. Treatment of a sexual dysfunction including, but not limited to, implants and hormonal therapy.

37. Genetic testing or counseling.

38. Reversal of any sterilization procedure.

**Limitations and Exclusions (continued)**

39. Services or supplies which are educational in nature.

40. Sales tax.

41. Medical supplies and equipment for personal comfort, personal hygiene or convenience, including, but not limited to: air conditioners; air cleaners; humidifiers; physical fitness equipment; physician's equipment; disposable supplies, other than colostomy supplies; or self-help devices not medical in nature.

42. Any human organ or tissue transplant not specifically listed, or any non-human or artificial organ or tissue transplant.

43. Pre-marital laboratory expense, fertility studies or related medical or surgical studies.

44. Treatment of temporomandibular joint disease (TMJ), except radical surgical procedures for which benefits are limited to $500.

45. Charges for services and supplies that are to treat Injuries for which a Covered Person is reimbursed or may be entitled to be reimbursed by another party or insurer; however the Plan may make payment on these claims if the terms of the Plan's Subrogation Provision have been satisfied.

46. Charges for services or supplies resulting from malpractice, malfeasance or misfeasance.

**With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).**

Remember that the foregoing list of Limitations and Exclusions is not exhaustive. Please contact the Plan's Administrative Service Manager if You have any questions regarding the Plan's coverage of a particular expense.

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# SECTION 2

# DEFINITIONS

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# DEFINITIONS

Certain words and phrases used in this Summary Plan Description are defined below as an explanation of how the terms are used. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this Summary Plan Description for that information.

### Accident:
Accident means a happening, definite as to time and place, by chance and without intention or design, which is unforeseen and unexpected.

### Actively at Work:
Actively at Work or Active Employment means performing on a regular full-time basis all customary occupational duties at the Employer's business establishment, or another location of business when required to travel on the job, and be scheduled to work at least 32 hours per week. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor. An Employee shall be deemed Actively at Work on any Employer-approved holiday or vacation provided that the Employee was Actively at Work on his last regularly scheduled working day before such vacation or holiday. In no event will an Employee be considered Actively at Work if he has effectively terminated employment.

### Administrative Service Manager:
Administrative Service Manager is the person or firm employed by the Plan Administrator to provide certain services in connection with the operation of the Plan including the processing of claims. In the event that no Administrative Service Manager is employed by the Plan Administrator at any particular point in time, Administrative Service Manager will mean the Employer.

### ADA:
ADA means the American Dental Association.

### AHA:
AHA means the American Hospital Association.

### AMA:
AMA means the American Medical Association.

### Amendment:
Amendment means a formal document, duly authorized by the person or persons designated by the Plan Administrator, that changes the plan provisions of the Plan.

### Ambulatory Surgical Center:
Ambulatory Surgical Center means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of Qualified Practitioners, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous Qualified Practitioner services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

### Annual Change Period:
The one-month period that occurs annually during the month of October when employees can change deductible elections. Coverage for those enrolling during the Annual Change Period will become effective on the Plan's anniversary date of November 1st.

### Birthing Center:
A Birthing Center is a licensed facility which:

1. Provides:

    a. Prenatal care,
    b. Delivery and immediate postpartum care, and
    c. Care of a child born at the birthing center;

2. Is directed by a Qualified Practitioner specializing in obstetrics and gynecology;

3. Has a Qualified Practitioner or certified nurse midwife present at all births and during the immediate postpartum period;

4. Extends staff privileges to Qualified Practitioners who practice obstetrics and gynecology in the area;

5. Has at least two beds or birthing rooms for use by patients during labor and delivery;

6. Provides full-time skilled nursing services (directed by a RN or certified nurse midwife) in the delivery and recovery rooms;

7. Provides diagnostic x-ray and laboratory services for the mother and newborn;

8. Has the capacity to administer a local anesthetic and perform minor surgery (including episiotomy and repair of perineal tear);

9. Is equipped and staffed to handle medical emergencies and provide immediate life support measures;

10. Accepts only patients with low risk pregnancies;

11. Has a written agreement with an area Hospital for Emergency transfer of patients and ensures its staff is aware of the procedure;

12. Provides an ongoing quality assurance program; and

13. Keeps a medical record for each patient.

### Calendar Year:
Calendar Year is the 12-month period of time beginning on January 1 and ending on December 31.

### Certificate of Coverage:
Certificate of Coverage means a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

### Child:
Child means, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, any stepchild, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the federal Omnibus Budget Reconciliation Act of 1993, or any other Child for whom the Employee or the Employee's spouse has obtained legal guardianship and who resides with and who is dependent upon the Employee in a regular parent-child relationship. If the Employee or Employee's spouse is required by court order or divorce decree to provide coverage for a Child not dependent on the Employee for support and maintenance, these provisions are waived for that Child.

### Chiropractic Care:
Chiropractic Care means office visits, x-rays, manipulations, supplies, heat treatment and cold treatment.

### COBRA:
COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

### Complications of Pregnancy
Complications of Pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy, but adversely affected by pregnancy or caused by pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;

2. A non-elective cesarean section surgical procedure;

3. A terminated ectopic pregnancy; or

4. A spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not mean:

1. False labor;

2. Occasional spotting;

3. Prescribed rest during the period of pregnancy; or

4. Similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct complication of pregnancy.

### Confinement:
Confinement means being a resident patient in a Hospital for at least 15 consecutive hours per day, or being a resident bed patient in a Skilled Nursing Home or other Qualified Treatment Facility 24 hours per day. Successive Confinements are considered one Confinement if:

1. Due to the same Injury or Sickness; and

2. Separated by fewer than 30 consecutive days when You are not confined.

### Cosmetic Surgery or Cosmetic:
Cosmetic Surgery or Cosmetic means any Surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

### Covered Expense:
A Covered Expense is a Medically Necessary service or supply listed for coverage under this Plan which is Customary, Usual and Reasonable and which is not limited or otherwise excluded.

### Covered Person:
A Covered Person is an eligible Employee or eligible Dependent who has met all of the conditions for coverage under the Plan.

### Creditable Coverage:
Creditable Coverage means prior medical coverage that an individual had from any of the following sources: a group health plan; group, individual or other form of health insurance coverage; Medicare (Part A, B or C); Medicaid; the Active Military Health Program or TRICARE (medical and dental care for members and former members of the Uniformed Services and their dependents); a medical care program of the Indian Health Service or a tribal organization; a state health benefits risk pool; the Federal Employees Health Plan; a Peace Corps Act Health Program; a public health plan that provides health coverage by insurance or other means including any plan established by the U.S. government, a state, a foreign country, or any political subdivision thereof; or a State Children's Health Insurance Program (CHIPS).

Solely for the purposes of illustration and not in limitation of the foregoing, 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 and excludes coverage for liability, limited scope dental or vision benefits, specified disease and/or other supplemental-type benefits.

### Custodial Care:
Custodial Care means care or Confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical

condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

### Customary, Usual and Reasonable:

Customary, Usual and Reasonable means fees for services and supplies which are reasonably necessary for the care and treatment of Sickness or Injury, but only to the extent that such fees are reasonable. Determination that a fee is reasonable will be made by the Plan Administrator, taking into consideration:

1. The fee which the Qualified Practitioner most frequently charges the majority of patients for the service or supply;

2. The prevailing range of fees charged in the same area by Qualified Practitioners of similar training and experience for the service or supply; and

3. Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular service or supply.

For purposes of this section, "Area" means a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of Qualified Practitioners rendering such services or furnishing such supplies.

### Deductible:

Deductible means the amount of Covered Expenses which must be paid by a Covered Person before the Plan will begin reimbursement of additional Covered Expenses.

### Dependent:

Dependent means one or more of the following person(s):

1. An Employee's lawfully wed spouse possessing a marriage license who is not divorced from the Employee;

2. An Employee's unmarried Child who is less than 19 years of age;

3. An Employee's unmarried Child who is at least 19 years of age but less than 25 years of age, who is dependent upon the Employee for a minimum of 50% support and who is a full-time student at an accredited high school, junior college, college, university, or licensed trade school. With respect to a junior college, college or university, full-time attendance requires enrollment for credit of at least twelve hours per semester or as determined by the school. With respect to a licensed trade school, full-time attendance requires enrollment in a course of instruction requiring at least six months to complete and attendance of at least twenty hours per week. If a Dependent whose eligibility is based on his continuous attendance in an accredited school as a full-time student becomes ineligible because of his failure to enroll as a full-time student, he will again become eligible to be a Covered Person on the date he begins classes as a full-time student.

   Dependent children who drop below full-time student status as a result of Injury or Sickness will be covered through the end of the current term (semester, quarter, trimester). Dependent children will be covered for up to four months following the close of a school term, provided they are enrolled as a full-time student for the next following school term.

4. An Employee's unmarried Child who was continuously covered prior to attaining the limiting age under (3) or (4) above, who is mentally or physically incapable of sustaining his own living and is still primarily dependent upon the Employee for support. Such Child must have been mentally or physically incapable of earning his own living prior to attaining the limiting age under (3) or (4) above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 30 days after the date the Child attains the limiting age of (3) or (4) above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year; or

5. A covered Employee's grandchild, as long as the Employee's covered Dependent child, who is the parent of the grandchild, is not yet 18 years old and unmarried.

For the purposes of this Plan, the definition of Dependent does not include any person who is a member of the armed forces of any country or who is a resident of a country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

### Diagnostic Service:
Diagnostic Service means a test or procedure performed for specified symptoms to detect or to monitor a Sickness or condition. It must be ordered by a Qualified Practitioner.

### Drug:
Drug means insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a state restricted drug (any medicinal substance which may be dispensed only by prescription, according to state law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed Physician.

### Durable Medical Equipment:
Durable Medical Equipment means equipment which:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;

3. Generally is not useful to a person in the absence of an Sickness or Injury; and

4. Is appropriate for use in the home.

### Emergency:
Emergency means a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan Administrator may, in its discretion, request satisfactory proof that an Emergency or acute condition did exist.

### Employee:
Employee means a person who is a regular full-time Employee of the Employer, regularly scheduled to work for the Employer in an employer-Employee relationship. Such person must be scheduled to work at least 32 hours per week in order to be considered "full-time." An Employee will not be a leased, seasonal or temporary employee, or an independent contractor.

### Employer:
Employer means Saelens Corporation, the sponsor of this Plan.

### ERISA:
ERISA means the Employee Retirement Income Security Act of 1974, as amended.

### Expense Incurred:
Expense Incurred means the fee charged for services and supplies needed to treat the Injury or Sickness. The date a supply or service is provided is the Expense Incurred date.

### Experimental:
Experimental means services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

All phases of clinical trials shall be considered experimental.

Drugs are considered Experimental if they are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

### Family Member:
Family Member means Your lawful spouse, Child, parent, grandparent, brother or sister, or any person related in the same way to Your covered Dependent.

### FMLA:
FMLA means the Family and Medical Leave Act of 1993, as amended.

### FMLA Leave:
FMLA Leave means a leave of absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

### Grievance:
Grievance means any dissatisfaction with the Plan's administration or claims practices, or provision of services, which is expressed in writing by You or someone authorized by You.

### HIPAA:
HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

### Home Health Care Agency:
Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

1. It is s primarily engaged in and duly licensed to provide skilled nursing services and other therapeutic services, if such licensing, is required by the appropriate authority where services are provided;

2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one registered nurse (RN) to govern the services provided and it must provide for full-time supervision of such services by a Qualified Practitioner or registered nurse;

3. It maintains a complete medical record on each patient;

4. It has a full-time administrator; and

5. It is approved by Medicare.

### Hospice Care Agency:
Hospice Care Agency means an agency which has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meet all of the following requirements: has obtained any required certificate of need; provides 24 hour a day, seven days a week service, supervised by a Qualified Practitioner; has a full-time coordinator; keeps written records of services provided to each patient; has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and has a licensed social service coordinator.

A Hospice Care Agency will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an on going quality assurance program, permit area medical personnel to use its services for their patients and use volunteers trained in care of and services for non-medical needs.

### Hospice Care Program:
Hospice Care Program means a written plan of hospice care which is established and reviewed by the Qualified Practitioner attending the person and the Hospice Care Agency, and provides palliative and supportive care to hospice patients. It offers supportive care to the families of the hospice patients, an assessment of the hospice patient's medical and social needs, and a description of the care necessary to meet those needs.

### Hospice Facility:
A Hospice Facility means a licensed facility, or part of a facility, which principally provides hospice care, has 24 hour a day nursing services provided under the direction of a registered nurse (RN), has a full-time administrator, keeps medical records of each patient, has an on going quality assurance program, and has a Qualified Practitioner on call at all times.

### Hospital:
Hospital means a Qualified Treatment Facility that meets all of the following requirements:

1. It provides medical and surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;

2. It is under the supervision of a staff of Physicians;

3. It provides 24-hour-a-day nursing service by registered nurses;

4. It is duly licensed as a hospital, except that this requirement will not apply in the case of a state tax-supported Qualified Treatment Facility;

5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a Custodial or training-type Qualified Treatment Facility, or a Qualified Treatment Facility which is supported in whole or in part by a federal government fund; and

6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Qualified Treatment Facility is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

### Injury:
Injury means physical damage to the body caused by an external force and due directly and independently of all other causes to an Accident which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit. Muscle tiredness or soreness resulting from overexertion in an athletic or physical activity is considered a Sickness under the Plan.

### Late Enrollee:
Late Enrollee means an individual who is enrolled for coverage after the expiration of the initial eligibility date described in Section 3. Note, however, a Special Enrollee shall not be considered a Late Enrollee.

### Lifetime:
When used in reference to benefit Maximums and limitations, Lifetime means the time a Covered Person is covered under this Plan. In no circumstances does Lifetime mean a Covered Person's life span.

### Maximum Amount or Maximum:
Maximum Amount or Maximum means the greatest benefit payable for a specific coverage item or benefit under the Plan.

### Mastectomy:
Mastectomy means the surgical removal of all or part of a breast.

### Medically Necessary:
Medically Necessary means services or supplies which are determined by the Plan to be:

1. Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical condition, Sickness, or Injury;

2. Provided for the diagnosis or direct care and treatment of the medical condition, Sickness, or Injury;

3. Within standards of good medical practice within the organized medical community;

4. Not primarily for the convenience of the Covered Person, the Covered Person's Qualified Practitioner or another provider of service; and

5. The most appropriate supply or level of service which can safely be provided.

For Hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The mere fact that the service is furnished, prescribed or approved by a Qualified Practitioner does not mean that it is Medically Necessary. In addition, the fact that certain services are excluded from coverage under this Plan because they are not Medically Necessary does not mean that any other services are deemed to be Medically Necessary.

### Medicare:
Medicare means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

### Mental or Nervous Condition:
Mental or Nervous Condition means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services; or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

### Named Fiduciary:
Named Fiduciary means Saelens Corporation, which has the authority to control and manage the operation of the Plan.

### Network or PPO Network:
Network or PPO Network means the medical provider network ("PPO") allowing discounted fees for services to Covered Persons. The PPO will be identified on the Covered Person's identification card.

### Physician:
Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), psychiatrist or midwife.

### Plan:
Plan means this Plan of benefits, established by the Plan Sponsor and administered by the Plan Administrator, including any schedules, attachments and Amendments to the Plan. The Plan is a legal entity. This Summary Plan Description provides a description of the Plan.

### Plan Administrator:
Plan Administrator means the Employer, who is responsible for the day-to-day functions and engagement of the Plan. The Plan Administrator may employ other persons or firms to process claims and perform other Plan connected services.

### Plan Year:
Plan Year means a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

### Pre-admission Tests:
Pre-admission Test means those Diagnostic Services done prior to scheduled surgery, provided that:

1. The tests are approved by both the Hospital and the Qualified Practitioner;

2. The tests are performed on an outpatient basis prior to Hospital admission; and

3. The tests are performed at the Hospital into which Confinement is scheduled, or at a Qualified Treatment Facility designated by the Qualified Practitioner who will perform the surgery.

## Pre-Existing Condition:

Pre-existing Condition means any Sickness or Injury (other than Pregnancy), regardless of cause, for which medical advice, diagnosis, care or treatment was received, by or from a health care provider or practitioner duly licensed to provide such care under applicable state law and operating within the scope of practice authorized by such state law, during the six months immediately prior to the date an Employee's Waiting Period commences (the "Enrollment Date"). In the case of a Late Enrollee or Special Enrollee, this period begins on Your Effective Date.

Coverage will be available for such condition on the day immediately following the expiration of 12 months.

Pre-Existing Condition Limitation will not apply for:

1. Pregnancy, under any circumstances.

2. Newborns, or a Dependent Child (under age 18) that is adopted if covered under Creditable Coverage within 30 days of adoption (or placement of adoption), if enrolled for coverage under the Plan within 30 days of birth, adoption or placement of adoption.

3. Any condition that has not been diagnosed by a Qualified Practitioner, but has been indicated by genetic testing.

A Pre-Existing Condition limitation may apply if there is a 63 consecutive day break in coverage.

## Pregnancy:

Pregnancy means carrying a child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

## PPO (Preferred Provider Organization):

PPO means the medical provider network ("PPO Network") allowing discounted fees for services to Covered Persons. The PPO will be identified on the Covered Person's identification card.

## Psychiatric Hospital:

Psychiatric Hospital means a Qualified Treatment Facility constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;

2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;

3. It is licensed as a psychiatric hospital;

4. It requires that every patient be under the care of a Physician; and

5. It provides 24-hour-a-day nursing service.

The term Psychiatric Hospital does not include a Qualified Treatment Facility, or that part of a Qualified Treatment Facility, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

## Qualified Practitioner:

Qualified Practitioner means a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

## Qualified Treatment Facility:

Qualified Treatment Facility means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community

mental health center, residential treatment facility, Psychiatric Treatment Facility, Substance Abuse Treatment Center, alternative Birthing Center, Home Health Care Center, or any other such facility that the Plan approves.

### Sickness:
Sickness means any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an employee under any worker's compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness.

### Significant Break in Coverage:
Significant Break in Coverage means a period of 63 consecutive days during all of which an individual did not have any Creditable Coverage, but does not include waiting periods and affiliation periods.

### Skilled Nursing Home:
A Skilled Nursing Home is an institution, or distinct part thereof, which is lawfully run in the jurisdiction where it is located and maintains and provides:

1. Permanent and full-time bed care facilities for resident patients;

2. A Qualified Practitioner's services available at all times;

3. A registered nurse (RN) or Qualified Practitioner in charge and on full-time duty and one or more registered nurses (RN's) or licensed vocational or practical nurses on full-time duty;

4. A daily record for each patient; and

5. Continuous skilled nursing care for persons during their convalescence from Sickness or Injury.

A Skilled Nursing Home is not, except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of drug addicts or alcoholics.

Skilled Nursing Home also includes any institution referring to itself as a convalescent nursing home or extended care facility.

### Special Enrollee:
A Special Enrollee is an eligible Employee or eligible Dependent who is entitled to and who requests Special Enrollment (as described in Section 3):

1. Within 30 days of losing other health coverage; or

2. For a newly acquired Dependent, within 30 days of the marriage, birth, adoption or placement for adoption.

### Substance Abuse:
Substance Abuse means any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

### Substance Abuse Treatment Center:
Substance Abuse Treatment Center means a Qualified Treatment Facility which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. The Qualified Treatment Facility must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;

2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or

3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a state agency having legal authority to do so.

### Total Disability or Totally Disabled:

For an Employee or an employed spouse covered under this Plan, Total Disability means that, during the first 12 months of disability, the Employee or the covered spouse of an Employee is prevented by Injury or Sickness from performing each and every material duty of his or her job or occupation.

After the first 12 months disability, Total Disability or Totally Disabled means that the Employee or the covered spouse of an Employee is at all times prevented by Injury or Sickness from engaging in any job or occupation for wage or profit for which he or she is reasonably qualified by education, training, or experience.

Total Disability of a non-employed spouse or Child means being house- or inpatient-facility confined due to an Injury or Sickness.

### Uniformed Services:

Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

### Waiting Period:

Waiting Period means the period of Active Employment before an eligible Employee or eligible Dependent may become covered under this Plan.

### You and Your:

You and Your refers to an eligible covered Employee and any of his eligible covered Dependents, where appropriate in context and unless otherwise indicated.

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# SECTION 3

# ELIGIBILITY

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# ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

These provisions apply to Employees who become eligible on or after the effective date of this Plan and to Dependents who become eligible on or after the effective date of this Plan.

Employees who were eligible and covered under any plan that this Plan replaces will be eligible on the Effective Date of this Plan. Any Waiting Period or portion thereof satisfied under the prior plan will be applied toward satisfaction of the Waiting Period of this Plan. Eligibility will include Dependents of such an Employee.

## EMPLOYEE COVERAGE

### Employee Eligibility

You are eligible for coverage under the Plan if the following conditions are met:

1. You are an Employee who is a regular full-time Employee of the Employer, regularly scheduled to work for the Employer in an employer-Employee relationship. You must be scheduled to work at least 32 hours per week in order to be considered "full-time." An Employee will not be a leased, seasonal or temporary employee, or an independent contractor; and

2. You satisfy a Waiting Period of full-time employment with the Employer as follows:

    a. Employees hired after November 1, 2006, 90 days of continuous employment;
    b. Part-time Employees moved to a regular full-time status, a combined total of 90 days of continuous employment as both a part-time Employee and a regular full-time Employee;
    c. Temporary employees hired to a permanent position with at least 60 days of temporary employment, 30 days of continuous employment as a regular full-time Employee; or
    d. Temporary employees hired to a permanent position with less than 60 days of temporary employment, a combined total of 90 days of continuous employment as both a temporary employee and a regular full-time Employee.

Your eligibility date is the date You satisfy the above conditions.

### Employee Effective Date

Your effective date will be the first day of the month following Your eligibility date. Your coverage under this Plan will commence on Your effective date provided that You have enrolled on forms furnished and accepted by the Plan Administrator within 30 days of Your effective date, and You are making any required contributions.

If Your completed enrollment forms are received by the Plan Administrator **more than 30 days after** Your effective date, You will be a **Late Enrollee** and You will not be covered under this Plan except as provided in the section for Special Enrollment.

An eligible Employee must begin active work with the Employer before coverage will be effective under the Plan. Employee coverage will begin at 12:01 AM on the Employee's effective date of coverage under the Plan. All Employees that do not provide certificates of Creditable Coverage from their previous health insurance carrier are subject to pre-existing condition limitations.

## NOTICE OF ENROLLMENT RIGHTS

If You are declining enrollment for Yourself and/or Your Dependents (including Your spouse) because of other health insurance coverage, You may in the future be able to enroll Yourself and/or Your Dependents in this Plan provided that You request enrollment within 30 days after Your other coverage ends. In addition, if You have a new Dependent as a result of marriage, birth, adoption or placement for adoption, You may be able to enroll Yourself and Your Dependents, provided that You request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

## CHANGES IN ELIGIBILITY

It is important that any change in eligibility for Yourself and/or any of Your eligible Dependents be reported to Your Employer, as soon as possible. Changes of eligibility include, but are not limited to:

1. Marriage or divorce

2. Death of any Dependent

3. Birth, adoption or placement for adoption of a Child

4. Dependent child reaching the limiting age

5. IRS ineligible Dependent child

6. Total Disability

7. Retirement

8. Medicare eligibility

## DEPENDENT COVERAGE

### Dependent Eligibility

A Dependent will be considered eligible for coverage in accordance with the following:

1. Newborn or newly adopted children of a covered Employee will be eligible from the moment of birth or placement for adoption provided the child is properly enrolled on a form furnished and accepted by the Plan Administrator as a Dependent of the Employee within 30 days of the child's date of birth or placement for adoption. The Pre-existing Condition limitation will be waived for an adopted child, under age 18, of a covered Employee, and for a child, under age 18, placed in the home of a covered Employee in anticipation of adoption, provided the adoption (or placement for adoption) occurs while the Employee is covered under the Plan and provided coverage for such child becomes effective within 30 days of the adoption (or placement for adoption).

2. A Spouse will be considered an eligible Dependent from the date of marriage, provided the Spouse is properly enrolled on a form furnished and accepted by the Plan Administrator as a Dependent of the Employee within 30 days of the date of marriage.

3. Spouses eligible for coverage under another group plan are not eligible for coverage under the Plan, except in the case of spouses presently eligible for coverage under the Plan who have a Pre-existing Condition which would be limited by the other group plan, or who must wait to enroll during an open or special enrollment period of the other group plan. Such spouses may continue their coverage under the Plan until the Pre-existing Condition limitation under the other group plan is satisfied, or until they are able to enroll in the other group plan at the time of an open or special enrollment period.

4. If a Dependent is acquired other than at the time of birth, due to a court order, decree or marriage, that 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 on a form furnished and accepted by the Plan Administrator as a Dependent of the Employee within 30 days of the court order, decree or marriage.

5. A Dependent acquired through a Qualified Medical Child Support Order, a National Medical Support Notice or a Medical Child Support Order will be subject to the eligibility and effective date provisions contained in the section "Qualified Medical Child Support Order".

An Employee may cover Dependents only if the Employee is also covered, except as follows: If the Employee was enrolled under the Plan as of November 1, 2006, the Employee at any time between November 1, 2006 and March 31, 2007 may elect to terminate the Employee medical, dental and vision (which must include a reason for the termination), but continue to pay for and cover any eligible Dependents insured under the Plan as of November 1, 2006. If this option is elected, the Employee will no longer be eligible for the insurance and would be considered a Late Enrollee if applying at a later date, except as otherwise provided under "Special Enrollment Period".

If both parents are eligible for coverage under this Plan, only one may enroll eligible Dependents for coverage.

An individual's eligibility for any state Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

### Dependent Effective Date

An Employee who makes written request for Dependent Coverage shall have such coverage as follows:

1. If You make such written request within 30 days of Your effective date, Your eligible Dependents shall become covered as of Your Effective date.

2. For newly acquired Dependents, if You make such written request within 30 days of the Dependents' eligibility date, coverage will become effective for those Dependents on their eligibility date or the first day of the month following the date of the application is received. Newborns, adopted children or children placed for adoption can only be added on the date of birth, adoption or placement for adoption.

3. Except as otherwise provided under "Special Enrollment Period", if You make such written request more than 30 days after the date on which a Dependent became eligible for Dependent coverage, such Dependent will be a Late Enrollee, and will not be covered under this Plan.

4. A Dependent acquired through a Qualified Medical Child Support Order, a National Medical Support Notice or a Medical Child Support Order will be subject to the eligibility and effective date provisions contained in the section "Qualified Medical Child Support Order".

If Your Dependent child becomes an eligible Employee of the Employer, he is no longer eligible as Your Dependent and must make application as an eligible Employee. See "Changes in Employee/Dependent Status" in this section.

Dependent coverage will begin at 12:01 AM on the Dependent's Effective Date of coverage under the Plan

## CHANGES IN EMPLOYEE/DEPENDENT STATUS

If both spouses are eligible Employees and each has enrolled for coverage as an Employee under this Plan, this Plan permits one spouse to change his or her status to that of a Dependent at any time.

In addition, if both spouses are Employees and eligible for coverage under this Plan, and one spouse previously waived coverage as an Employee in favor of coverage as a Dependent, this Plan permits the Dependent spouse to change his or her status to that of an Employee when:

1. Both Employees decide to transfer coverage under the Plan from one spouse to the other;

2. A spouse decides to take coverage as an Employee for any reason; or

3. One spouse terminates coverage under the Plan for any reason.

Other eligible Dependents may be transferred to the spouse with Employee coverage at the time of the change in status.

Each enrollment change must be made separately and in writing on a form furnished and accepted by the Plan Administrator within 30 days of the requested effective date. Failure to comply with this enrollment requirement by either spouse will cause that spouse to become a "Late Enrollee", and he or she will lose coverage under the Plan except as provided in "Special Enrollment".

If Your Dependent Child becomes an eligible Employee of the Employer, he or she is no longer eligible as Your Dependent and must make application as an eligible Employee. Such application must be made in accordance with the provisions contained in "Employee Coverage" in this section. Failure to comply with the required enrollment within 30 days of the former Dependent's eligibility date will cause the former Dependent to be a "Late Enrollee" and no coverage will be available under this Plan except as provided in "Special Enrollment".

## SPECIAL ENROLLMENT AND ANNUAL CHANGE PERIODS

If You have a special enrollment event, the Plan will provide a new enrollment date for You to enter the Plan as shown below. At that time, You will be able to enroll in the Plan without being subject to the Late Enrollee provisions of the Plan. If the Plan has more than one benefit option, You will be able to select from all options for which You are eligible.

## Special Enrollment for Individuals Losing Coverage

You and Your Dependents are entitled to enroll in the Plan during a Special Enrollment Period if You meet all of the following requirements:

1. You are eligible for coverage under the Plan but are not currently covered under the Plan;

2. You previously declined to enroll in the Plan and signed a written waiver of coverage, stating as the reason the existence of alternative group or other health coverage (including COBRA); and

3. You were covered under such alternative group or other health coverage at the time You signed the waiver, and such coverage is no longer available, for any of the reasons set forth below.

A loss of coverage occurs if the other coverage ends:

1. Due to Your exhaustion of the maximum COBRA period;

2. Due to Your loss of eligibility. "Loss of Eligibility" means loss of coverage resulting from:

   a. termination of employment, a reduction in the number of hours of employment, or any loss of eligibility after a period that is measured based on any of those events;
   b. legal separation or divorce;
   c. death;

   Loss of Eligibility shall not mean loss of coverage resulting from an individual's failure to pay premiums on a timely basis or any termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of fact in connection with such coverage.)

3. Benefits due to Your reaching the lifetime maximum for all benefits; or

4. Due to termination of employer contributions towards the cost of the other coverage.

A special enrollment event occurs when one of the above takes place. You **must** provide proof that the other coverage was lost due to one of the above shown reasons. At that time, an Employee or Dependent may be enrolled in this Plan as follows:

1. When the Employee has a loss of coverage, the Employee and any Dependent may enroll. The Dependent does not have to have had a loss of coverage at that time to be enrolled;

2. When a Dependent has a loss of coverage, only that Dependent and the Employee may enroll. The Employee does not have to have had a loss of coverage at that time to enroll. Other Dependents that did not have a loss of coverage will be considered Late Enrollees.

## Special Enrollment for Marriage

If You, as the Employee, are now getting married, a special enrollment event will occur on the date of Your marriage. At that time, You may enroll in this Plan. Any Dependents acquired on the date of Your marriage may also be enrolled at this time.

## Special Enrollment for Birth, Adoption or Placement for Adoption

If You experience the birth of a Dependent Child, or the adoption or placement for adoption of a Dependent Child, a special enrollment event will occur on that date. At that time, You may enroll in this Plan. Your Dependent spouse and the newborn or adopted Child may also be enrolled at this time.

## Special Enrollment Period (Time Frames for Enrollment)

"Special Enrollment Period" shall mean, with respect to "Special Enrollment for Individuals Losing Coverage", the period which ends 30 days after:

**Eligibility and Effective Date of Coverage (continued)**

1. The date on which the coverage is exhausted, if the coverage was COBRA continuation coverage; or

2. The date on which the coverage terminated because of Loss of Eligibility or termination of employer contributions toward the cost of such coverage, for other individual or group health coverage.

With respect to "Special Enrollment for Marriage" or "Special Enrollment for Birth, Adoption or Placement for Adoption", the period which ends 30 days after the date of one of the following, triggers the special enrollment rights:

1. Marriage;

2. Birth;

3. Adoption; or

4. Placement for adoption.

### Annual Change Period

The one-month period that occurs annually during the month of October when employees can change deductible elections. Coverage for those enrolling during the Annual Change Period will become effective on the Plan's anniversary date of November 1st.

### Effective Date of Coverage; Conditions

All conditions for effectiveness of coverage under the Plan which are set forth in "Employee Coverage" and "Dependent Coverage", will apply to persons enrolling during a Special Enrollment Period. Coverage for Employees or Dependents enrolling during a Special Enrollment Period will become effective at 12:01 AM as follows: on the date of marriage or the date following the loss of coverage or the first day of the month following the receipt by the Plan of the required enrollment forms; or on the date of birth, adoption or placement for adoption. Enrollment must be in writing in a form furnished and accepted by the Plan Administrator, and must be received by the Plan Administrator within 30 days of the eligibility date under "Special Enrollment Period". If You enroll for coverage more than 30 days after the date of qualifying event under the Special Enrollment Period, You (and/or any eligible Dependents) will be considered a Late Enrollee under the Plan.

## QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If a child is the subject of a "Qualified Medical Child Support Order" ("QMCSO"), the child must be considered an "Alternate Recipient" under the Plan. Upon the Plan Administrator's determination that an order is a QMCSO, coverage must immediately be provided to the child.

"**Alternate Recipient**" shall mean any child of a Covered Person who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as an eligible Dependent.

For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent. If an Employee does not enroll the child in the Plan, the Plan must recognize the child's right to be enrolled as an Alternate Recipient. The custodial parent or legal guardian of the child may also exercise this right. For purposes of reporting and disclosure under ERISA, an Alternate Recipient will be treated as an Employee under the Plan. The parent or legal guardian may have this right on behalf of the alternate recipient.

"**Medical Child Support Order**" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Covered Person's child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or

2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"**National Medical Support Notice**" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing state agency;

2. Name and mailing address (if any) of an employee who is a Covered Person under the Plan;

3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Person or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and

4. Identity of an underlying child support order.

"**Qualified Medical Child Support Order**" or "**QMCSO**" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Person is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Covered Person and the name and mailing address of each such Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

3. The period of coverage to which the order pertains; and

4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";

    a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;

    b. Informs the Plan Administrator that, if a group health plan has multiple options and the Employee is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

2. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events**.**

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Covered Persons without regard to this Section, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Covered Person and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Covered Person and each affected Alternate Recipient of such determination.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

Payment for benefits under this Plan will be made to the Alternate Recipient or the provider of service. Payment may also be made to the custodial parent or legal guardian.

## REINSTATEMENT OF COVERAGE FOLLOWING LAYOFF OR APPROVED LEAVE OF ABSENCE

If You are now an eligible Employee and Your coverage under the Plan was terminated after a period of layoff or approved leave of absence, and You are now returning to work within one year of such termination, You may resume coverage under this Plan effective the first day of the month following the day You return to work.

## PRE-EXISTING CONDITION LIMITATION

A Pre-existing Condition limitation will apply to You and Your eligible Dependents entering or reentering the Plan after the Effective Date, except as set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). No coverage is provided for expenses in connection with a Pre-existing Condition.

A "**Pre-existing Condition**" is any Sickness, illness, Disease or Injury (other than Pregnancy), regardless of cause, for which medical advice, diagnosis, care or treatment was received, by or from a health care provider or practitioner duly licensed to provide such care under applicable state law and operating within the scope of practice authorized by such state law, during the six months immediately prior to the date an Employee's Waiting Period commences (the "Enrollment Date"). In the case of a Late Enrollee or Special Enrollee, this period begins on Your Effective Date.

Coverage will be available for such condition on the day immediately following the expiration of 12 months.

You have the right to demonstrate any Creditable Coverage, and the applicable period shall be reduced by any Creditable Coverage unless that Creditable Coverage occurred before a Significant Break in Coverage.

A "**Late Enrollee**" is an eligible Employee or Dependent who enrolls in the Plan more than 30 days from the date he or she became eligible. A "Special Enrollee" is an eligible Employee or Dependent who enrolls in the Plan under the provisions for Special Enrollment.

Pre-Existing Condition Limitation will not apply for:

1. Pregnancy, under any circumstances.

2. Newborns, or a Dependent Child (under age 18) that is adopted if covered under Creditable Coverage within 30 days of adoption (or placement of adoption), if enrolled for coverage under the Plan within 30 days of birth, adoption or placement of adoption.

3. Any condition that has not been diagnosed by a Qualified Practitioner, but has been indicated by genetic testing.

**You may prove Creditable Coverage by either of two methods**:

1. For prior coverage effective on or after July 1, 1996, You may present a written Certificate of Coverage from the source or entity that provided the coverage showing:

    a. The date the Certificate was issued;
    b. The name of the group health plan that provided the coverage;
    c. The name of the Covered Person to whom the Certificate applies;
    d. The name, address, and telephone number of the plan administrator or issuer providing the Certificate;
    e. A telephone number for further information (if different);
    f. Either:

        (1) A statement that You or Your Dependent has at least 18 months of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage; or
        (2) The date any waiting period (and affiliation period, if applicable) began and the date Creditable Coverage began; and

    g. The date Creditable Coverage ended, unless the Certificate indicates that coverage is continuing as of the date of the Certificate; or

2. If the Covered Person for any reason is unable to obtain a Certificate from another plan (including because the prior coverage was effective prior to July 1, 1996), he may demonstrate Creditable Coverage by other evidence, including but not limited to documents, records, third-party statements, or telephone calls by this Plan to a third-party provider of medical services. This Plan will treat a Covered Person as having provided a Certificate if that individual:

    a. Attests to the period of Creditable Coverage;
    b. Presents relevant corroborating evidence of some Creditable Coverage during the period; and

**Eligibility and Effective Date of Coverage (continued)**

c. Cooperates with the Plan Administrator's efforts to verify his status.

If You did not receive or do not have a certification from the prior plan, federal law requires Your prior plan to provide You with one upon receiving Your written request within 24 months of the date Your coverage ended. If You are unable to obtain a certification after requesting one in writing, the Plan Administrator will assist You in obtaining the necessary information to demonstrate Creditable Coverage under the prior plan, or You may call Custom Benefit Administrators for assistance at 1-800-944-2188.

If, after review of the information about Creditable Coverage, it is determined that an exclusion for Pre-existing Conditions applies, You will be notified of that conclusion and the notice will specify the source of any information on which it was based in reaching the determination. The notice will also explain the Plan's appeals procedures and give You a reasonable opportunity to present additional evidence.

If the Plan Administrator later determines that an individual did not have the claimed Creditable Coverage, the Plan Administrator may modify its initial determination to the contrary. In that case, the individual will be notified of the reconsideration; however, until a final determination is reached, the Plan Administrator will act in accordance with its initial determination in favor of the Employee or Dependent for the purpose of approving medical services.

## TERMINATION OF COVERAGE

Coverage under this Plan for any Covered Person will terminate at 12:01 AM on the earliest of the following:

For an Employee:

1. The date of termination of the Plan;

2. The day of the month in, or with respect to which, he requests that such coverage be terminated, provided such request is made on or before such date;

3. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his failure to make, when due, any contribution for coverage for himself to which he has agreed in writing;

4. The last day of the month in which he ceases to be eligible for such coverage under the Plan;

5. The last day and time of the month in which the termination of employment occurs; or

6. Immediately after an Employee or his Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

For Dependents:

1. The date of termination of the Plan;

2. Upon the discontinuance of coverage for Dependents under the Plan;

3. When such Dependent becomes covered as an Employee under the Plan;

4. The date of termination of the Employee's coverage for himself under the Plan;

5. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his failure to make, when due, any contribution for coverage for Dependents to which he has agreed in writing;

6. In the case of a Child for whom coverage is being continued due to mental or physical inability to earn his own living, the earliest to occur of:

    a. Cessation of such inability;
    b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or

c. Upon the Child's no longer being dependent on the Employee for his support;

7. On the date a Dependent Child marries;

8. The date the Dependent enters full-time military, naval or air service of any country;

9. The last day of the month such person ceases to be a Dependent, as defined herein; or

10. Immediately after an Employee or his Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

## HOW TO REQUEST A CERTIFICATE OF CREDITABLE COVERAGE

Federal law provides you the right to obtain proof of Your coverage dates under this Plan. The Plan generally will automatically provide a Certificate of Coverage to any Covered Person after the individual loses coverage in the Plan. This loss of coverage may be due to:

1. Your coverage under the Plan ends;

2. You reach the Lifetime Maximum of the Plan; or

3. COBRA continuation coverage under the Plan ends. For the applicable time frames when the Covered Person has the right to elect continuation coverage, see the section "Continuation of Coverage".

In addition, a Certificate of Coverage will be provided upon request at any time You or Your covered Dependent are insured under this Plan or within 24 months after coverage for You or any Dependent ends. In that case, the Certificate of Coverage will be provided at the earliest time that the Plan, acting in a reasonable and prompt fashion, can furnish it.

The Plan will make reasonable efforts to collect information applicable to any Dependents and to include that information on the Certificate of Coverage, but the Plan will not issue an automatic Certificate of Coverage for Dependents until the Plan has reason to know that a Dependent has lost coverage under the Plan.

Requests for a Certificate of Coverage may be written or oral and should be made to the human resources department at Your Employer. The request should include the Employee's name, the Employee's social security number or identification number, the names of the insureds needing proof of coverage, and the address where the certificate should be sent.

## IMPORTANT NOTICE FOR ACTIVE EMPLOYEES AND SPOUSES AGE 65 AND OVER

If You are an active Employee age 65 and over, or the spouse age 65 and over of an active Employee, and are eligible for Medicare, You have the option of either:

1. Continuing coverage under this Plan, in which case Medicare benefits would be secondary to this Plan; or

2. Electing Medicare coverage as primary, in which case **no benefits** would be payable under this Plan.

Contact Your Plan Administrator for further information.

# FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act is a federal law that applies to Employers with 50 or more Employees, and provides that an Employee may elect to continue coverage under this Plan during a period of approved FMLA leave at the same cost to the Employee as it would have been had the FMLA leave not been taken.

If this Plan is established while You are on FMLA leave, Your coverage will be effective on the same date as it would have been had You not taken leave. If provisions under the Plan change while You are on FMLA leave, the changes will be effective for You on the same date as they would have been had You not taken leave.

## EMPLOYEE ELIGIBILITY

You are an eligible Employee under the Act if all of the following conditions are met:

1. You are an Employee who has been employed with the Employer for a total of at least 12 months;

2. You have worked at least 1,250 hours during the 12 consecutive months prior to the request for FMLA leave; and

3. You are employed at a worksite that employs at least 50 employees within a 75-mile radius.

## FAMILY AND MEDICAL LEAVES

Coverage under this Plan can be continued during a period of FMLA leave. Coverage under FMLA leave is limited to a total of 12 weeks during any 12-month period that follows:

1. The birth of an Employee's child;

2. The placement of a child with an Employee for adoption or foster care;

3. The Employee taking leave to care for an Employee's Spouse, Son, Daughter or Parent that has a Serious Health Condition; or

4. The Employee taking leave due to a Serious Health Condition which makes him unable to perform the functions of his position.

This leave may be paid (accrued vacation time, personal leave or sick leave) or unpaid. The Employer has the right to require that all paid leave, including earned vacation time and/or sick time, be used prior to providing any unpaid leave.

The Employee must continue to pay the Employee portion of the Plan contribution during the FMLA leave. Payment must be made within 30 days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

### Notice of Leave

You must provide at least 30 days notice to Your Employer prior to beginning any leave under the Act. If the nature of the leave does not permit such notice, You must provide notice of the leave as soon as possible. Your Employer has the right to require medical certification to support Your request for leave due to Your or Your family members' Serious Health Condition.

### Maximum Leave Period

During any one 12-month period, the maximum amount of FMLA leave may not exceed 12 weeks.

If You and Your spouse are both employed by the Employer, FMLA leave may be limited to a combined period of 12 weeks, for both spouses, when FMLA leave is due to:

1. The birth or placement of a Son or Daughter;

2. The need to care for a Parent.

### Termination Before the Maximum Leave Period

Coverage will continue until the end of 12 weeks from the date the FMLA leave began. Coverage may end prior to this under the following circumstances:

1. If You decide not to return to work, coverage under the Plan may end at that time; or

2. If the Plan contribution is not paid within 30 days of its due date, coverage under the Plan may end at that time.

Notice of termination must be provided at least 15 days prior to the termination.

If You do not return to work when coverage under the Act ends, You will be eligible for COBRA Continuation of Coverage at that time.

### Recovery of Plan Contributions

The Employer has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA leave if the Employee does not return to work at the end of the leave. This right will not apply if failure to return is due to circumstances beyond the Employee's control.

## REINSTATEMENT OF COVERAGE UPON RETURN TO WORK

The law requires that coverage be reinstated upon the Employee's return to work following an FMLA leave whether coverage under the Plan was maintained during the FMLA or not.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA leave had not been taken. The Waiting Period and the Pre-Existing Condition limitation will be credited as if You had been continually covered under the Plan.

## DEFINITIONS

For this provision only, the following terms are defined as stated.

**Serious Health Condition** is a Sickness, Injury, impairment or physical or mental condition that involves:

1. Inpatient care in a Hospital, Hospice or Qualified Treatment Facility, including any period of incapacity due to a serious health condition, or treatment of or recovery from a serious health condition;

2. Continuing treatment by a Qualified Practitioner, including any period of incapacity:

    a. For more than three consecutive calendar days, if a Qualified Practitioner is consulted two or more times during the period or if a Qualified Practitioner is consulted once and a continuing treatment program is provided;

    b. Due to pregnancy or prenatal treatment, even if treatment is not provided or it does not last for more than three days;

    c. Due to a chronic condition (i.e. a condition which required periodic treatments by a Qualified Practitioner and continues over an extended period of time, whether incapacity is continuous or periodic), even if treatment is not provided or it does not last for more than three days;

    d. Which is permanent or long term due to a condition which requires the supervision of a Qualified Practitioner, but for which treatment is ineffective; or

    e. To receive multiple treatments from a Qualified Practitioner for restorative surgery due to an Accident or Sickness or for a condition that would likely result in a period of incapacity of more than three days without such treatment.

**Spouse** is Your lawful husband or wife.

**Son or Daughter** is Your natural blood-related child, adopted child, step-child, foster child, a child placed in Your legal custody or a child for which You are acting as the parent in place of the child's natural blood related parent. The child must be:

1. Under the age of 18; or

2. Over the age of 18, but incapable of self-care due to a mental or physical disability.

**Parent** is Your natural blood related parent or someone who has acted as Your parent in place of Your natural blood related parent.

NOTE: For complete information recording Your rights under the Family and Medical Leave Act, contact Your Employer.

## UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") is a federal law, effective October 13, 1994, which provides that You may elect to continue coverage under the Plan for Yourself and Your Dependents, where:

1. They were Covered Persons in the Plan immediately prior to the Employee's leave of absence for Uniformed Service; and

2. The reason for the Employee's leave of absence is service in the Uniformed Service of coverage during military leave.

The law requires that an Employer continue to provide coverage under this Plan during a military leave that is covered by the Act for You and Your Dependents which is identical to coverage provided under the Employer's Plan to similarly situated, Employees and Dependents. This means that if the coverage for similarly situated Employees and Dependents is modified, coverage for the individual on USERRA leave will be modified. The cost of such coverage will be:

1. For leaves of 30 days or less, the same as the Employee contribution required for similarly situated Employees;

2. For leaves of 31 days or more, up to 102% of the full Plan contribution.

Continuation applies to medical, dental, prescription drug, vision and other health coverages as provided under this Plan. Short and long term disability and life insurance coverage will not be included in this continuation.

For Employers subject to COBRA, continued coverage provided under this provision will reduce the allowed maximum period of continuation provided under COBRA.

### Maximum Period of Coverage during USERRA Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date You fail to return to Employment with the Employer following completion of Your leave. Employees must return to employment within:

    a. The first full business day of completing Uniformed Service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such Uniformed Service,

    b. 14 days of completing Uniformed Service, for leaves of 31 to 180 days,

    c. 90 days of completing Uniformed Service, for leaves of more than 180 days; or

2. 24 months from the date Your leave began.

### REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

The law also requires, regardless of whether continuation as stated above was elected, that Your coverage and Your Dependents' coverage be reinstated immediately upon Your honorable discharge from Uniformed Service and return to employment, if You return within:

1. The first full business day of completing Your Uniformed Service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such Uniformed Service;

2. 14 days of completing Uniformed Service, for leaves of 31 to 180 days;

3. 90 days of completing Uniformed Service, for leaves of more than 180 days;

If, due to a Sickness or Injury caused or aggravated by Your Uniformed Service, You cannot return to work within the times stated above, You may take up to a period of two years, or as soon as reasonably possible if for reasons beyond Your control You cannot return within two years, to recover from such Sickness or Injury and return to employment within the times stated above.

**Uniformed Services Employment and Reemployment Rights Act (USERRA) (continued)**

Continued coverage through USERRA will not include coverage for any Sickness or Injury caused or aggravated by Your military service, as determined by the Secretary of Veteran Affairs.

NOTE: For complete information regarding Your rights under the Uniformed Services Employment and Reemployment Rights Act, contact Your Employer.

# CONTINUATION OF COVERAGE

## EMPLOYER CONTINUATION COVERAGE

If You and Your Employer continue to pay the required Plan contributions and the Plan is not terminated, Your coverage may, at the Employer's discretion, remain in force. Coverage will be continued for eligible Covered Persons should the following occur:

1. In the event of Total Disability, coverage will continue following termination of Active Employment; or

2. In the event of an approved leave of absence, coverage will continue. If this leave meets the requirements of FMLA, time under FMLA will run concurrently.

At the end of any period listed above, COBRA continuation will be offered. The end of the FMLA period will occur either when You do not return to work following a period of FMLA leave or when You indicate that You do not intend to return to work with the Employer.

If Your coverage under the Plan was terminated after a period of Total Disability or approved leave of absence and You are now returning to work within one year of such termination and are an eligible Employee, You may resume coverage under this Plan effective the first day of the month following the day You return to work.

### Continuation During FMLA Leave

Regardless of the established leave policies mentioned above, the Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

## THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

A federal law known as COBRA gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The entire cost (plus a reasonable administration fee) must be paid by the continuing person. Coverage will end in certain instances, including if the covered individual fails to make timely payment of premiums. Generally, COBRA applies to employers with 20 or more Employees. You should check with Your Employer to determine whether COBRA coverage is available for this Plan.

### Benefits Affected by COBRA

Any COBRA continuance option may include the benefits for which the “qualified beneficiary” (a person eligible for COBRA continuance) was covered just prior to the COBRA “qualifying event” (an event which qualifies a person for continued coverage under COBRA). Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of the Employer’s plan) are not eligible for continuance under COBRA.

### Employee Rights to COBRA

An Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work; or

2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part.

### Spouse Rights to COBRA

The spouse of an Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work;

2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part;

3. The death of the Employee;

4. The end of the spouse's marriage to the Employee. The marriage must end due to dissolution, annulment, divorce or legal separation; or

5. The Employee becoming entitled to Medicare.

## Dependent Child Rights to COBRA

The Dependent child of an Employee that is covered by this Plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the Employee's hours of work;

2. The termination of the Employee's employment. This will not apply if termination is due to gross misconduct on the Employee's part;

3. The death of the Employee;

4. The end of the Employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

5. The Employee becoming entitled to Medicare; or

6. The child ceasing to be considered a Dependent child as defined in this Plan.

## Maximum Time Periods

Continuation will be available for a qualified beneficiary up to the maximum time period shown in items 1, 2 or 3 below. Multiple qualifying events which may be combined under COBRA will not continue a beneficiary's coverage for more than 36 months beyond the date of the original qualifying event. When the qualifying event is "entitlement to Medicare," the 36-month continuation period is measured from the date of Medicare entitlement. For all other qualifying events, the continuation period is measured from the date of the qualifying event, not the date of loss of coverage.

1. Up to 18 months for an Employee and his covered Dependents when coverage terminates due to reduction of hours worked, or termination of employment for reasons other than gross misconduct. Note: an individual who is disabled on the date of the qualifying event may have COBRA coverage extended (and an extra fee may be charged) from 18 months to 29 months provided that:

    a. The individual is determined as being disabled for Social Security purposes before or during the first 60 days of COBRA coverage; and

    b. The individual notifies the Plan Administrator within 60 days of the Social Security Administration's determination of disability and within the original 18-month COBRA period which applies to the person.

2. Up to 36 months for:

    a. A Dependent child who is a Covered Person in the Plan and who ceases to be an eligible Dependent;
    b. A Dependent who is a Covered Person in the Plan and whose eligibility ceases due to the Employee's death;
    c. A spouse who is a Covered Person in the Plan and whose eligibility ceases due to divorce or legal separation; or
    d. A Dependent who is a Covered Person in the Plan, when the Employee's coverage ceases due to entitlement to Medicare. (NOTE: If COBRA is already in force due to loss of coverage because of termination or reduction of hours, Medicare entitlement is not a second qualifying event and only 18 months is applicable.)

3. Under COBRA's special bankruptcy rules for retirees and their Dependents who are Covered Persons, continuation coverage following the qualifying event of the Employer's filing for reorganization under the Bankruptcy Code must extend until:

    a. The date of death of the retired Employee or the surviving spouse of the retiree, if the retiree died before the filing and the spouse still had coverage under the Plan; or

**The Consolidated Omnibus Reconciliation Act (COBRA) (continued)**

b. 36 months after the date of death of the retired Employee, in the case of the surviving spouse or Dependent child of the retired Employee.

For this item 3, coverage does not terminate when the person becomes entitled to Medicare.

**Continued coverage may also cease before the end of the maximum period on the earliest to occur of the following dates:**

1. The date that the Employer ceases to provide a group health plan to any Employee;

2. The date on which coverage ceases by reason of the qualified beneficiary's failure to make timely payment of any required premium. This is retroactive to the last day for which payment was received;

3. The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated in item 3 above). However, a qualified beneficiary who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less; or

4. The first day of the month that begins more than 30 days after the date of the Social Security Administration's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

## Electing COBRA

Each person covered by this Plan has an independent right to elect COBRA for himself or herself. A covered Employee or spouse may elect COBRA for all family members. A parent or legal guardian may elect coverage for a minor child.

If coverage has been terminated in anticipation of a qualifying event, the right to COBRA will still apply at the time of the event. In this case, COBRA will be effective on the date of the event even though it is after the date coverage is lost or cost increased.

If the Employee's Dependent Child is born during the COBRA coverage period, that child may be added to the coverage. The Child will have all the rights that any other child would have under COBRA. If a Child is adopted by or placed for adoption with the Employee during the COBRA coverage period, that Child may be added to the coverage. The Child will have all the rights that any other child would have under COBRA.

## Notice and Election Requirements

When coverage terminates due to an Employee's death, termination or reduction of hours, entitlement to Medicare, bankruptcy or failure to return from FMLA Leave, the Employer has 30 days from the date of such event in which to notify the Plan Administrator or Administrative Services Manager of the qualifying event.

In the event of divorce, legal separation or change of Dependent status, the qualified beneficiary has 60 days from the qualifying event in which to notify the Plan Administrator that the qualifying event has occurred. With respect to qualified beneficiaries who are disabled, in the event the Social Security Administration issues a final determination that the qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator or Administrative Services Manager of this determination within 30 days of the date it is made.

Complete instructions on how to elect continuation coverage will be provided by the Plan Administrator or Administrative Services Manager within 14 days of receiving notice of the qualifying event. Qualified beneficiaries then have 60 days in which to elect continuation. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing instructions. If You elect COBRA within the 60-day period, COBRA will be effective on the date that You would lose coverage. If You do not elect COBRA within this 60-day period, COBRA will not be available. Your coverage under the Plan will terminate.

## Premium Requirements

Once coverage is elected, payment for the cost of the initial period of coverage must be made within 45 days. Thereafter, payments are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, coverage will be canceled and will not be reinstated. If the initial or subsequent premium payments are not made, coverage will be retroactively terminated back the last day for which payment was received.

The Plan may add a 2% administration charge to the premium cost. The Plan may charge an additional 50% during the 11-month extension for total disability if the disabled individual is covered.

### The Trade Act of 2002

If You did not elect COBRA during the election period described above, another 60-day period may be presented for You to elect COBRA. If Your loss of coverage was due to a Trade Adjustment Assistance (TAA) event and You are determined to be TAA eligible during the six month period following Your loss of coverage, You will have an additional period in which to elect COBRA. This election period will begin the first of the month in which You became TAA eligible. The period will end on the earlier of: 60 days from the date it began or the end of the six month period following Your loss of coverage due to a TAA event.

If You elect COBRA during this TAA election period, COBRA will be effective on the first of the month in which You became TAA eligible. COBRA will not be provided for the period of time between Your loss of coverage and the first of the month in which You became TAA eligible. However, that time will be not counted as a lapse in coverage for purposes of determining if the Plan's Pre-Existing Condition exclusion will apply. In this case, the maximum period of coverage will be counted from the date You lost coverage under the Plan, not the date COBRA is effective. If You do not elect COBRA within this period, COBRA will not be available again.

If You elect COBRA, it is Your duty to pay all of the monthly payments. The Trade Act of 2002 did create a tax credit for TAA eligible individuals. Under the Act up to 65% of the cost of COBRA can be taken as a tax credit. The Act also provides an option for an advance payment of the tax credit toward the cost of COBRA. If You have any questions about this tax credit, call the Health Care Tax Credit Customer Contact Center at 1-866-628-4282 (toll-free). Additional information about the Trade Act of 2002 can be found at www.doleta.gov/tradeact/2002act_index.asp.

### Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide notice to the Human Resource department of your employer of the disability within 60 days after the latest of: 1) The date of the SSA disability determination; 2) The date on which the qualifying event occurs; 3) The date on which the qualified beneficiary loses coverage; or 4) The date on which the qualified beneficiary is informed of the obligation to provide the disability notice.

### Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### Procedures for Providing Notice to the Plan

In order to maintain Your rights under COBRA, You are required to provide the Plan with notice of certain events, as described above. The Plan will consider Your obligation to provide notice satisfied if you provide written notice to the Plan Administrator that includes:

1. The Employee's name and social security number or identification number;

2. The name of the individual(s) to whom the notice applies;

3. The reason for which notice is being provided; and

4. The address and phone number where You can be contacted.

Notice should be addressed to the Human Resources Department, Attn: COBRA Administration. Notice should be mailed to the Plan Administrator's address shown in this Plan. Your notice will not satisfy Your obligation if it is not provided within the time frame stated above for that notice.

## Other Information

The Plan Administrator will answer any questions You may have on COBRA. You can also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) for answers to Your questions. Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at www.dol.gov/ebsa.

To protect Your rights under COBRA, You should notify the Plan Administrator of any changes that affect Your coverage. Such changes include a change for You or a family member in marital status, address, or other insurance coverage. When providing any notice to the Plan, a copy should be maintained for Your own records.

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# SECTION 4

# GENERAL PLAN INFORMATION

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# ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION made by Saelens Corporation, the "Plan Sponsor" as of November 1, 2007 hereby amends and restates the provisions of the Saelens Corporation Medical Benefit Plan (the "Plan"), which was originally adopted by the Company, effective November 1, 2006.

## Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the "Effective Date").

## Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by ERISA. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

**Saelens Corporation**

By: _____

Name: _____

Title: _____

Date: _____

# PLAN DESCRIPTION INFORMATION

## INTRODUCTION AND PURPOSE

The Plan Sponsor has established the Plan for the benefit of eligible Employees, on the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor or may be funded solely from the general assets of the Plan Sponsor. Covered Persons in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help to offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document and Summary Plan Description is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for hospital, medical or oral surgery charges. The Plan Document is maintained by the Plan Sponsor and may be inspected at any time during normal working hours by any Covered Person.

| | |
|---|---|
| **PLAN NAME** | Saelens Corporation Employee Medical Benefit Plan |
| **TYPE OF PLAN** | A self-funded welfare benefit plan providing certain medical and oral surgery benefits to covered Employees and Dependents.<br><br>This Plan is not financed or administered by an insurance company. The Plan's benefits are not guaranteed by a contract of insurance. |
| **PLAN EFFECTIVE DATE** | November 1, 2007 |
| **GROUP NUMBER** | 8302 |
| **PLAN YEAR FOR GOVERNMENT REPORTING** | November 1 to October 31 |
| **PLAN ADMINISTRATOR AND PLAN SPONSOR** | Saelens Corporation<br>100 Veterans Drive<br>Johnson Creek, WI 53038<br>(920) 699-8880 |
| **PLAN NUMBER** | 501 |
| **PLAN SPONSOR IDENTIFICATION NUMBER** | 39-1205830 |
| **ADMINISTRATIVE SERVICE MANAGER** | Custom Benefit Administrators<br>305 5th Avenue South, Suite 206<br>P.O. Box 1385<br>La Crosse, WI 54602-1385<br>(800) 944-2188 (Toll-free) or (608) 784-2442 |
| **AGENT FOR SERVICE OF LEGAL PROCESS** | Mr. Bryan Weiss<br>Saelens Corporation<br>100 Veterans Drive<br>Johnson Creek, WI 53038<br>(920) 699-8880 |

This Plan is a legal entity. Service for legal process may be filed with the Agent for Service of Legal Process.

# PLAN ADMINISTRATION

**Plan Administrator**
The Plan is administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator has retained the services of the Administrative Service Manager to provide certain claims processing and other technical services.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

## Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;

2. To determine all questions of eligibility, status and coverage under the Plan;

3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

4. To make factual findings;

5. To decide disputes which may arise relative to a Covered Person's rights;

6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

7. To keep and maintain the Plan documents and all other records pertaining to the Plan;

8. To appoint and supervise a third party administrator to pay claims;

9. To perform all necessary reporting as required by ERISA;

10. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;

11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

12. To perform each and every function necessary for or related to the Plan's administration.

# STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, You are entitled to certain rights and protections under ERISA. ERISA provides that all Covered Persons are entitled to:

### Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

### Continue Group Health Plan Coverage

Continue health care coverage for Yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or Your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

A reduction or elimination of exclusionary periods of coverage for Pre-existing Conditions under Your group health plan, if You have Creditable Coverage from another plan. You should be provided a Certificate of Coverage, free of charge, from Your group health plan or health insurance issuer when You lose coverage under the plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, You may be subject to a Pre-existing Condition exclusion for 12 months (18 months for Late Enrollees) after Your Enrollment Date in Your coverage.

### Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the 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 Covered Persons and beneficiaries. No one, including Your Employer, Your union (if any), or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

### Enforce Your Rights

If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, You may file suit in 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 would pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

### Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administration, You should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration,

**Statement of ERISA Rights (continued)**

U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA).

# COORDINATION OF BENEFITS

## Benefits Subject to This Provision

Benefits described in this Plan are coordinated with benefits provided by other plans under which You are also covered. This is to prevent the problem of over insurance and a resulting increase in the cost of coverage.

## Effect on Benefits

Benefits will be reduced under certain circumstances when You are covered both under this Plan and any other plan defined below which also provide coverage for Covered Expenses. Reimbursement under this Plan and any other plans included under this provision will not exceed 100% of the total Allowable Expenses Incurred under this Plan.

Benefits under this Plan will be coordinated with benefits paid or payable under another plan, as defined, whether or not a claim is filed with such other plan.

## Definition of other plans

For the purposes of this provision, this Plan will coordinate benefits with other plans providing any coverage which includes reimbursement of medical or dental expenses, or provides benefits or services by:

1. Group or franchise insurance coverage, whether insured or self-insured;

2. Hospital or medical service organizations on a group basis and other group pre-payment plans;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage sponsored or provided by or through an educational institution;

5. Any governmental program or a program mandated by state statute;

6. Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of injuries arising out of a motor vehicle Accident, and any other medical and liability benefits received under any automobile policy;

7. Any coverage sponsored or provided by or through an Employer, trustee, union, Employee benefit, or other association.

This includes group-type contracts not available to the central public, obtained and maintained only because of the Covered Person's membership in or connection with a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion.

## How Coordination of Benefits Works

One of the plans involved will pay benefits first, without considering the benefits available under the other plans. This is called the primary plan. The other plans will then make up the difference, up to the total Allowable Expense. These plans are called secondary plans.

When a plan provides benefits in the form of services rather than cash payments, the Customary, Usual and Reasonable cash value of each service will be deemed to be both a Covered Expense and a benefit paid. This Plan will not pay more than it would have paid without this provision.

## "Allowable Expenses"

"Allowable Expenses" means any Medically Necessary, Customary, Usual and Reasonable item of expense, at least a portion of which is covered under this Plan. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made therefor.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

## Order of Benefit Determination

A plan will be considered the primary plan and pay benefits first if it meets one of the following conditions:

1. The plan has no coordination provision;

2. The plan covers the person as an Employee;

3. For a Child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the Calendar year pays before the plan covering the other parent. If both parents have the same birthday, the plan covering the parent for the longer period of time will pay first;

4. In the case of Dependent Children covered under the plans of divorced or separated parents (whether or not legally married):

    a. The plan of a parent who has custody will pay the benefits first,

    b. The plan of a stepparent who has custody will pay the benefits next,

    c. The plan of a parent who does not have custody will pay benefits next, and

    d. The plan of a stepparent who does not have custody will pay benefits next;

    e. If there is a court decree which gives one parent financial responsibility for the medical expenses of the Dependent children, the rules stated above will not apply if they conflict with the court decree. Instead, the plan of the parent with financial responsibility, as ordered by the court, will pay benefits first.

5. The plan covering a laid off or retired person, or a person on COBRA or any other form of continuation, or covering the Dependent of such a person, will pay benefits after the plan covering such persons as an active Employee or the Dependent of an active Employee.

6. The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons as an active Employee or the Dependent of an active Employee.

If the above rules do not apply or cannot be determined, then the Plan that covered the person for the longer period of time will be primary.

If a plan other than this Plan does not include provisions 3. or 5., then those provisions will be ignored in order to determine benefits with the other plan.

## Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any other plan, this Plan may release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information or instruments as may be necessary to implement this provision.

## Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

## Right of Recovery

**Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the Maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative,**

**any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Covered Person or his Dependents.**

## Coordination of Benefits with Medicare

In all cases, coordination of benefits with Medicare will conform with Federal Statutes and Regulations. In the case of Medicare, each individual who is eligible for Medicare will be assumed to have full Medicare coverage (i.e. Part A Hospital insurance and Part B voluntary medical insurance) whether or not the individual has enrolled for full coverage. Your benefits under this Plan will be coordinated to the extent allowed by Federal Statutes and Regulations.

If any Covered Person is eligible for Medicare benefits because of End Stage Renal Disease ("ESRD"), the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement (with respect to charges Incurred on or after February 1, 1991 and before August 5, 1997), and for the first 30 months of Medicare entitlement (with respect to charges Incurred on or after August 5, 1997), unless applicable federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

# RECOVERY RIGHTS – GENERAL RECOVERY RIGHTS PROVISIONS

## Applicable to Right of Subrogation, Right of Reimbursement, Right of Recovery Provision, and Workers' Compensation

You may incur medical or other charges related to Injuries or Sicknesses caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the Injury or Sickness. If so, You may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights You may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or payable and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supercedes any right that You may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery that You procure or may be entitled to procure regardless of whether You have received compensation for any of Your damages or expenses, including any of Your attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, You agree that acceptance of benefits is constructive notice of this provision.

You must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;

2. Authorize the Plan to sue, compromise and settle in Your name to the extent of the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan Your rights to Recovery when this provision applies;

3. Immediately Reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

**By accepting any benefits paid by this Plan, You agree that such benefits are an advancement of Plan assets.**

**When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Sicknesses or Injuries), You will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, <u>before</u> any medical or other benefits will be paid by the Plan for the Injuries or Sickness.** If the Plan pays any medical or other benefits for the Injuries or Sickness before these papers are signed and things are done, the Plan still will be entitled to Subrogation and Reimbursement. In addition, You will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and You acknowledge that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

## Amount Subject to Subrogation or Reimbursement

**Any amounts recovered will be subject to Subrogation or Reimbursement.** In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise, even if You do not receive full compensation for all of Your charges and expenses.

### "Another Party"
"Another Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Sickness.

"Another Party" shall include the party or parties who caused the Injuries or Sickness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Sickness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Sickness.

### "Recovery"
"Recovery" shall mean any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Sickness. Any Recovery shall be deemed to apply, first, for Reimbursement.

### "Subrogation"
"Subrogation" shall mean the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

### "Reimbursement"
"Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Sickness and for the expenses incurred by the Plan in collecting this benefit amount.

### When You Retain an Attorney
If You retain an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Sicknesses or Injuries. Additionally, Your attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay Your attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of Your attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

You or Your attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. You or Your attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because You or Your attorney are not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

### When the Covered Person is a Minor or is Deceased
These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

### When a Covered Person Does Not Comply
**When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Sicknesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Sicknesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.**

### When Recovery Includes the Cost of Past or Future Expenses
In certain circumstances, a Covered Person may receive a Recovery that includes amounts intended to be compensation for past and future expenses for treatment of the Sickness or Injury which is the cause of the Recovery. This Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the Covered Person to inform the Plan Administrator when expenses are incurred related to a Sickness or Injury for which a Recovery has been made. Acceptance of benefits under this Plan for which the Covered Person has received a Recovery will be considered fraud, and the Covered Person will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Covered Person is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

## Workers' Compensation

This Plan excludes coverage for any Injury or Sickness that is eligible for coverage under any Workers' Compensation policy or law regardless of the date of onset of such Injury or Sickness. However, if benefits are paid by the Plan and it is later determined that You received or are eligible to receive Workers' Compensation coverage for the same Injury or Sickness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Sickness regardless of the amount or terms of any settlement You receive from Workers' Compensation. The Plan will exercise its right to recover against You. The Plan reserves its right to exercise the Recovery Rights provision even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that the Injury or Sickness was sustained in the course of or resulted from Your employment;

3. The amount of Workers' Compensation benefits due specifically to health care expense is not agreed upon or defined by You or the Workers' Compensation carrier; or

4. The health care expense is specifically excluded from the Workers' Compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when You file a claim for coverage under Workers' Compensation if a claim for the same Injury or Sickness is or has been filed with this Plan. Failure to do so, or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers' Compensation, will be considered a fraudulent claim and You will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

# GENERAL PROVISIONS

## AMENDMENTS TO OR TERMINATION OF THE PLAN

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any).

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Plan assets will be allocated and disposed of for the exclusive benefit of Covered Persons, except that any taxes and administration expenses may be paid from the Plan's assets.

## APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Covered Person is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Administrative Service Manager. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as his authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

## AUTOPSY

The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

## CLERICAL ERROR/DELAY

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

## CONFORMITY WITH APPLICABLE LAWS

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated Maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable law.

## FAILURE TO ENFORCE PLAN PROVISIONS

The Plan's failure to enforce any provision of the Plan will not affect the right, thereafter, to enforce such provision nor affect the right to enforce any other provision of the Plan.

## FREE CHOICE OF PROVIDER

Any Covered Person may select any provider of service for care, treatment, services or supplies he wishes. This Plan does not dictate the choice of provider nor will it interfere in the provider/patient relationship or the course of treatment. The benefits available under this Plan will be provided, however, only to those providers and services defined and listed for coverage in the Summary Plan Description.

## HEADINGS

The headings used in this Plan Document are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

## LIMITATION ON ACTIONS

No action at law or in equity shall be instituted to recover under this Plan prior to the expiration of 90 days after a claim for benefits has been filed in accordance with the requirements of this Plan. Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within one year after the expenses due to Injury or Sickness are incurred or are alleged to have been incurred. Any limitation on actions regarding claims for benefits shall be as provided in Section, "General Provisions", "Claims Procedures; Payment of Claims", heading "Decision on Review to be Final".

## MEDICAID COVERAGE

A Covered Person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the state Medicaid program; and the Plan will honor any Subrogation rights the state may have with respect to benefits which are payable under the Plan.

## NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

## NON-U.S. PROVIDERS

Medical expenses for care, supplies, or services which are rendered by a Qualified Practitioner whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, Maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non-U.S. Provider;

2. The Covered Person is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;

3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;

4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and

5. Claims for benefits must be submitted to the Plan in English.

## NOT A CONTRACT

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

## PHYSICAL EXAMINATION

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

## PLAN CONTRIBUTIONS

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) by each Covered Person.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Covered Person's contribution (if any) will be determined from time to time by the Plan Administrator.

## PRONOUNS

All personal pronouns used in the Plan shall include either gender unless the context clearly indicates otherwise.

## PROTECTION AGAINST CREDITORS

Benefit payments under the Plan are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind. Any attempt to accomplish these will not be recognized. The Plan Administrator may, at its sole discretion, terminate Your interest in the benefits payable under this Plan, in which event the Plan will then apply the amount of the payment to the benefit of an adult child, guardian of a minor child, brother or sister, or other relative of the Covered Person. Such payment will fully discharge the Plan's liability to the extent of the payment.

## RIGHT OF RECOVERY PROVISION

Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Covered Person on whose behalf the payment was made.

A Covered Person, Provider, another benefit plan, insurer, or any other person or entity who receives a payment for expenses exceeding the amount of benefits available under the terms of the Plan or on whose behalf such payment to the Plan was made, shall return the amount of such erroneous payment to the Plan Sponsor within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan Sponsor for an erroneous payment and such payment shall be reimbursed in lump sum or deducted from future claims presented for processing.

Health care providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan

Administrator. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the Plan shall be entitled to recover its litigation cost and actual attorney's fees incurred.

## RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

## SECURITY

The Employer, who is the sponsor of this Plan, will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Employer certifies to the Plan that it agrees to:

1. Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity, and availability of the information it creates, receives, maintains or transmits;

2. Require that any agent or subcontractor of the Employer agrees to the same requirements that apply to the Employer under this provision;

3. Report to the Plan any security incident that the Employer becomes aware of; and

4. Apply reasonable and appropriate security measures to maintain adequate separation between the Plan and itself.

## STATEMENTS

In the absence of fraud, all statements made by a Covered Person will be deemed representations and not warranties. A statement will not be used to contest coverage under the Plan unless a signed copy of the statement is provided to the Covered Person or, if deceased, to his beneficiary.

## WRITTEN NOTICE

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

# CLAIM PROCEDURES; PAYMENT OF CLAIMS

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service. However, as noted below, because of this Plan's design, there are no Pre-service Urgent Care Claims which may be filed with the Plan.

1. Pre-service Claims. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. However, if the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

   A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

   **It is important to remember that, if You need medical care for a condition which could seriously jeopardize Your life, there is no need to contact the Plan for prior approval. You should obtain such care without delay.**

   The Plan does not require the Covered Person to obtain approval of any urgent care or Emergency medical services or admissions prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

   Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants inpatient Confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Covered Person has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

   a. The Plan determines that the course of treatment should be reduced or terminated; or

   b. The Covered Person requests extension of the course of treatment beyond that which the Plan has approved.

   If the Plan does not require You to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. You simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

## WHEN HEALTH CLAIMS MUST BE FILED

Health claims must be filed with the Administrative Service Manager within 365 days of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Administrative Service Manager in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Administrative Service Manager, together with a Form HCFA or Form UB92:

1. The date of service;

2. The name, address, telephone number and tax identification number of the provider of the services or supplies;

3. The place where the services were rendered;

4. The diagnosis and procedure codes;

5. The amount of charges, which reflect any applicable PPO repricing;

6. The name of the Plan;

7. The name of the covered employee; and

8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Administrative Service Manager will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Administrative Service Manager within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the Covered Person of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

## TIME OF CLAIM DETERMINATION

You will be notified, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Non-urgent Care Claims:

    a. If You have provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

    b. If You have not provided all of the information needed to process the claim, then You will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. You will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and You (if additional information was requested during the extension period).

2. Concurrent Claims:

    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying You of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. You will be notified sufficiently in advance of the reduction or termination to allow an appeal and to obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

    b. Request by a Covered Person Involving Urgent Care. If the Plan Administrator receives a request from a Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Covered Person makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Covered Person submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.

    c. Request by a Covered Person Involving Non-urgent Care. If the Plan Administrator receives a request from the Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

**Claim Procedures; Payment of Claims (continued)**

3. Post-service Claims:

   a. If You have provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

   b. If You have not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then You will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then You will be notified of the determination by a date agreed to by the Plan Administrator and You.

4. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies You, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

5. Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies You, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

## NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION

The Plan Administrator shall provide You with a notice, either in writing or electronically, containing the following information:

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based;

2. Specific reason(s) for a denial;

3. A description of any additional information necessary for You to perfect the claim and an explanation of why such information is necessary;

4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of Your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;

5. A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to Your claim for benefits;

6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to You, free of charge, upon request); and

8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided to You, free of charge, upon request.

## APPEAL OF ADVERSE BENEFIT DETERMINATIONS

### Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and You believe the claim has been denied wrongly, You may appeal the denial and review pertinent documents. The claims procedures of this Plan provide You with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. You at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;

2. You the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

4. For a review that takes into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;

5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

7. That You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for benefits in possession of the Plan Administrator or the Administrative Services Manager; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances.

### Requirements for Appeal

You must file an appeal of a post-service claim in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, Your appeal must be addressed as follows:

For Pre-service and Post-service Claims:

Custom Benefit Administrators
Attn: Claim Appeal Department
P.O. Box 1385
La Crosse, WI 54602-1385

It shall be Your responsibility to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Dependent;

2. The Employee/Dependent's social security number;

3. The group name or identification number;

4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, You will lose the right to raise factual arguments and theories which support this claim if You fail to include them in the appeal**;

5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

6. Any material or information that You have which indicates that You are entitled to benefits under the Plan.

If You provide all of the required information, it may be that the expenses will be eligible for payment under the Plan.

### Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify You of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

2. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.

3. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

4. Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

### Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide You with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;

2. Reference to the specific portion(s) of the Plan Document on which the denial is based;

3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;

4. A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for benefits;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to You upon request;

6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, will be provided free of charge upon request;

7. A statement of Your right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and

8. The following statement: "You and Your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your state insurance regulatory agency."

### Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

## Decision on Review to be Final

If, for any reason, You do not receive a written response to the appeal within the appropriate time period set forth above, You may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.**

# PRIVACY

## NOTICE OF PRIVACY PRACTICES

This Notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully. The privacy of your health information is important to us.

### Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2004, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

### Uses And Disclosures Of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

### Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

2. Modifying, amending or terminating the Plan.

"Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

### Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

4. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

5. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

**Privacy (continued)**

6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

7. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

10. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    a. The Plan Sponsor will appoint specified individuals to have access to PHI and will make them known to the Plan Administrator. Internal procedures for secure handling of PHI will be established.

    b. The access to and use of PHI by the individuals shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

    c. In the event any of the individuals do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

    "Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

1. The Plan Documents have been amended to incorporate the above provisions; and

2. The Plan Sponsor agrees to comply with such provisions.

### Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

### Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

### Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.