PLAN DOCUMENT
THE INSURANCE TRUST
GROUP HEALTH BENEFIT

January 1, 2011

DISCLOSURE STATEMENT

The Plan is a self-insured plan, and benefits are not guaranteed by a licensed insurer.

The Plan is not covered by the Georgia Life and Health Guaranty Association.

Certain other major protections offered to Georgia residents under the Georgia Insurance Code and Rules and Regulations, such as conversion rights and certain mandated or required benefits, may not be available through the Plan.

HOW TO SUBMIT A CLAIM

Benefits under this plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a claim to submit for payment that person must:

1) Obtain a Claim Form from his or her employer or the Plan Administrator;
2) Complete the Employee section portion of the form. ALL QUESTIONS MUST BE ANSWERED;
3) Have the Physician complete the Provider's portion of the form;
4) For plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
    - Name of Plan
    - Employee's name
    - Name of patient
    - Name, address, telephone number of the provider of care
    - Diagnosis (Nature of illness or injury)
    - Type of service rendered, with diagnosis and/or procedure code
    - Date(s) of service
    - Charges for each service

5) Send the above to the Claims Administrator at this address:
    CORE ADMINISTRATIVE SERVICES, INC.
    PO Box 90
    Macon, GA 31202-0090
    (478) 741-3521

WHEN CLAIMS SHOULD BE FILED

Claims must be filed with the Claims Administrator within 90 days of the date charges for the service was rendered. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date will be declined or reduced unless:

(a) it is not reasonably possible to submit the claim in that time; and
(b) the claim is submitted within one year from the date incurred and is accepted by the Claims Administrator in its sole discretion. The one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information will be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Also, Section XIV entitled "CLAIMS REVIEW AND APPEAL PROCEDURE".

PRE-CERTIFICATION AND UTILIZATION REVIEW SERVICES

Pre-certification is required before all admissions to a Hospital or Out-patient Surgical Center (or within two working days of an emergency admission). The phone number for pre-authorization is 1-888-741-2673. Failure to pre-certify may result in a $500 penalty.

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The Insurance Trust
PLAN "A"
Effective January 1, 2011
SCHEDULE OF BENEFITS

The personal coverage benefits and the dependent coverage benefits for which an employee is covered under this plan shall be those shown in the following Schedule:

MAJOR MEDICAL EXPENSE BENEFITS	**PPO (In-Network)**	**NON-PPO (Out-of-Network)**
Penalty for Non-Compliance with Pre-Certification Requirements	$500	$500
Hospital Emergency Room Co-pay per Visit	$150 co-pay	$150 co-pay
Hospital 'Per admission' Deductible	None	$200
Cash Deductible (all-inclusive) (applies to all covered expenses unless otherwise specified)	$500	$500
Family Deductible (cumulative)	X3	X3
Doctor's Office Visit charge (includes allergy injections billed alone)	$25 co-pay, then 80%	Deductible, then coinsurance
X-Ray/Lab Tests Performed in Doctor's Office	80%, Deductible waived	Deductible/60%
X-Ray/Lab Tests at Hospital or Free-standing Chemical Dependency Facility	Deductible/80%	Deductible/60%
Hospital-based Physicians charges (Anesthesiologists, Radiologists & Pathologists)	Deductible/80%	Deductible/60%
Co-Insurance Percentage	80%	60%
Maximum Out-of-Pocket (Not including Deductible)		
Individual	$5,000	$10,000
Family	X3	X3

Note: PPO and Non-PPO Out of Pocket amounts are NOT integrated

Benefit Period	Calendar Year
Maximum Annual Benefit per Covered Person	$750,000
Maximum Lifetime Benefit per Covered Person	Unlimited

In-Patient Room & Board Rate Limits:

Semi-Private Room	Usual and Customary Charge
Private Room[1]	Most common semi-private
ICU or CCU	Usual and Customary Charge
Miscellaneous Services	Usual and Customary Charge

The Doctor's Office Visit co-payment and benefit penalties do not apply to the deductible or out-of-pocket limit, and continue after the deductible and out-of-pocket limits are met.

[1] In the event a hospital does not contain semi-private rooms, the private room limit is 90% of the hospitals lowest priced private room. If a private room or isolation room is medically necessary due to contagious disease, the hospital's Usual and Customary Charge for such room will be a covered expense.

SCHEDULE OF BENEFITS (cont'd)

MATERNITY EXPENSES [2]	SAME AS ANY OTHER ILLNESS
Routine Nursery Care	Included as an expense of the baby
SKILLED NURSING FACILITY	Maximum $3,480 per calendar year
HOSPICE CARE	Maximum $10,000 per calendar year
HOME HEALTH CARE	Maximum $2,500 per calendar year
SUPPLEMENTAL ACCIDENT BENEFIT	1st $500 per accident payable at 100%, with regular benefits thereafter

	PPO (In-Network)	**NON-PPO (Out-of-Network)**
CHIROPRACTIC CARE		
Benefit	$25 co-pay	Deductible/coinsurance
Maximum Benefit payable per Year	$1,200	
MENTAL OR NERVOUS DISORDER; SUBSTANCE ABUSE	No Coverage	No Coverage
WELLNESS BENEFIT – Adult & Child (Eye Exams are included up to $100)	Covered at 100%	N/A
PRE-ADMISSION TESTING	100%	Deductible, then 100%
AIR AMBULANCE	Deductible/60%	Deductible/60%

PRESCRIPTION DRUGS	Preferred Independent	Retail Chain	CVS
Tier I – Generic	$10/30% cost of drug after $150	$17/40% cost of drug after $150	$20/50% cost of drug after $150
Tier II – Specified Brand / Non-Generic	$30/30% cost of drug after $150	$50/40% cost of drug after $150	$55/50% cost of drug after $150
Tier III – Brand (Non-Preferred) and Compound Drugs	30% + $50 cost of drug after $150	40% + $70 cost of drug after $150	40% + $75 cost of drug after $150

$100 Deductible on first dollar for all prescriptions in Tier II and/or Tier III

WAITING PERIOD	90 Days
ELIGIBILITY DATE	1ST of the month following or coincident with the waiting period

NOTE—MANDATORY PRE-ADMISSION CERTIFICATION PROGRAM – NON-EMERGENCY, ELECTIVE HOSPITALIZATION OR OUT-PATIENT SURGERY MUST BE CERTIFIED BEFORE A COVERED PERSON ENTERS THE HOSPITAL. Refer to page 2 of this booklet for details.

[2] No maternity coverage for dependent children.

SCHEDULE OF BENEFITS (CON'T)

"OPTIONAL" DENTAL EXPENSE BENEFITS
See Section VI for further information

Calendar Year Deductible: $50 per insured ($150 maximum per Family Unit)
Deductibles are waived for Preventive/Diagnostic treatments.

Percentage Payable:

Class I - Diagnostic and Preventative Procedures	100%
Class II - Basic Procedures	80%
Class III - Major Procedures	80%
Class IV - Orthodontic Services	Coverage available, call for details.
Dental Calendar Year Maximum Benefit	$1,000

SECTION II

DEFINITIONS

As used throughout this Plan Document, the following words and phrases have the meaning specified below when used with initial capital letters:

1. **Active Work or Actively-At-Work** - An Employee's continuous, full-time performance of all customary duties of his or her occupation at the Employer's usual place of business, or other business locations to which the Employer requires the Employee to travel throughout the year. The standard work week is defined as 30 hours per week for the purposes of this Plan.

2. **Benefit Period** - A period of one year (12 consecutive months). The Benefit Year for this Plan is shown in the Schedule of Benefits.

3. **Chiropractic Care** - Charges for professional services for treatment which involves manual manipulation (with or without the application of treatment modalities such as, but not limited to, diathermy, ultrasound, heat and cold) of the spinal skeletal system and/or surrounding tissue to restore proper articulation of joints, alignment of bones or nerve functions.

4. **Claims Administrator** - Core Administrative Services, Inc.

5. **Cosmetic Procedures** - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Plan Administrator.

6. **Covered Employee** - An Employee for whom coverage under this Plan is effective.

7. **Covered Person** - A Covered Employee or a Dependent for whom coverage under this Plan is effective. A Covered Person may be covered under this Plan as either an Employee or Dependent, but not both.

8. **Custodial Care** - That type of care or service that does not require special skills or training which is designed primarily to assist a Covered Person, whether or not Totally Disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking, getting in and out of bed and supervision over medication which can normally be self-administered.

9. **Dependent** - The term "Dependent" means:
   A. The Participant's legal spouse who is a resident of the same country in which the participant resides. Such spouse must have met all requirements of a valid marriage contract in the state of marriage of such parties.

   B. The Participant's child who is under the age of 26.

C. The Participant's unmarried child of any age who is or becomes disabled and dependent upon the Participant. Proof of incapacity must be furnished to the Claims Administrator, and additional proof may be requested from time to time.

Those situations specifically excluded from the definition of a Dependent are:

A. A spouse who is legally separated or divorced from the Participant, unless coverage is required due to court order or decree. Such spouse must have met all requirements of a valid separation or divorce contract in the State granting such separation or divorce; or
B. Any person on active military duty; or
C. Any person eligible for coverage under this Plan as an individual Participant; or
D. Any person who is covered as a Dependent by more than one Participant of the same Company.

10. Durable Medical Equipment - medical equipment which is:

A. Durable enough to withstand repeated use;
B. Primarily and customarily used to serve a medical purpose; and
C. Not generally useful to a person in the absence of illness or injury.

11. Effective Date - The date which is referred to as the Effective Date on the Plan enrollment form for this Plan Document.

12. Employee - A person directly employed as a full-time employee in the regular business of, and compensated for services by the Employer.

13. Employer - The Employer is the party that employs an Employee who is covered by the Plan.

14. ERISA - The Employee Retirement Income Security Act of 1974, as amended from time to time.

15. Experimental or Investigational Service – Medical, surgical, diagnostic, psychiatric, technologies, supplies, treatments, procedures, health care services, drug therapies, medications or devices that, at the time the Plan or the Plan Administrator makes a determination in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by an institutional review board for the proposed use (devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial as set forth in FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exception:

- If a Covered Person has a life threatening Illness or condition (i.e., one that is

likely to cause death within one year of the request for treatment), the Plan Administrator may, in his discretion, consider an otherwise Experimental or Investigational Service to be covered by the Plan. Before making such determination, the Plan or the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Illness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

16. **Family Unit** - A Covered Employee and those covered under this Plan as Dependents.

17. **Free-Standing Chemical Dependency Treatment Center** (or Residential Treatment Facility). A place which meets all of these requirements:

A. It is accredited by the Joint Commission on Accreditation of Hospitals or is licensed by the appropriate state licensing authority as a chemical dependency treatment center;
B. It is operated chiefly for the treatment of chemical dependency;
C. It provides only treatment which is directly under the supervision of a Physician; and
D. It provides 24-hour nursing service by graduate nurses (R.N.).

18. **Home Health Care Provider** - A home health agency or a visiting nurse's association which meets all the following requirements:

A. It is licensed by the state in which it is located;
B. It qualifies as a home health agency under Medicare;
C. It meets the standards of the applicable area-wide health care planning agency;
D. It provides skilled nursing services and other services on a visiting basis in the patient's home;
E. It is responsible for administering a Home Health Care program; and
F. It supervises the delivery of a Home Health Care program where the services are prescribed and approved in writing by the patient's attending Physician.

19. **Hospice** - A public agency or private organization which meets all of these requirements:

A. It primarily provides care to terminally ill persons;
B. It provides 24-hour care to control symptoms associated with terminal Illness;
C. It has on its staff an interdisciplinary team which includes at least one Physician, one registered professional nurse (RN), one social worker, and at least one pastoral or similar counselor, and volunteers;
D. It is a licensed organization with standards of care which meets those of the National Hospice Organization;
E. It maintains central clinical records on all patients;
F. It provides appropriate methods of dispensing drugs and medicines; and
G. It offers a coordinated program of home care and In-patient care for a terminally-ill patient and his or her family.

"Hospice" does not include an organization or section which mainly provides Custodial Care, care for drug addicts and alcoholics, domestic services, or is a place of rest, a home for the aged or a hotel or similar institution.

20. **Hospital** - A place which meets all the following conditions:

A. It is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals;
B. It is operated on a 24-hour per day basis;
C. It is operated mainly for the treatment of sick or injured persons on an In-patient basis;
D. It has a staff of one or more Physicians available at all times;
E. It provides 24-hour nursing service by graduate registered nurses (R.N.); and
F. It includes areas designed for diagnosis and major surgical procedures. If it is mainly a place for the treatment of mentally ill or mentally disabled persons, it has an agreement, by contract or otherwise, with an accredited Hospital to perform surgery if necessary.

"Hospital" does not include a convalescent, nursing, rest, rehabilitation or Skilled Nursing Facility; or a facility mainly operated for treatment of the aged, drug addicts or alcoholics.

21. **Illness** - A disorder of the body or mind, a disease, or a pregnancy. Illnesses which are due to the same cause or to a related cause(s) are considered one Illness.

22. **Injury** - Bodily Injury caused by an accident and which results directly from the accident, independent of all other causes. An accident is an external event that is sudden in occurrence, direct and unforeseeable and is exact as to time and place.

23. **In-patient** – Uninterrupted confinement for 23 or more hours as a registered bed patient in a Hospital, Skilled Nursing Facility, Hospice or Free-Standing Chemical Dependency Treatment Center.

24. **Medically Necessary** - "Medically Necessary" means that a service, medicine, supply or equipment, incurred on the advice of a physician, is necessary and appropriate for the diagnosis or treatment of an Illness or Injury based on generally accepted current medical practice. A service, medicine, supply, or equipment will not be considered Medically Necessary if:

A. It is provided only for a convenience to the Covered Person or Provider;
B. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
C. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;
D. It is part of a plan of treatment that is considered to be Investigational, Experimental or for research purposes in the diagnosis or treatment of an Illness or Injury; and
E. It involves the use of a drug or substance not formally approved by the United States Food and Drug Administration, even if the approval is not required.

The fact that any particular doctor may prescribe, order, recommend, or approve a service, medicine, supply or equipment does not of itself, make the service or supply Medically Necessary.

25. **Medicare** - Medical benefits provided by Title XVIII of the Social Security Act, as amended.

26. **Mental or Nervous Disorder** - An emotional or mental condition characterized by abnormal functioning of the mind or emotions, and in which psychological, intellectual, emotional or behavioral disturbances are the dominating factor. For the purpose of determining benefits, "Mental or Nervous Disorder" also includes drug addiction and alcoholism.

27. **Non-surgical Doctor's Office Call or Visit -** A visit to a Physician's office where the participating Physician charges a separate fee for each "office call". The "office call" codes are determined by the American Medical Association's "Current Procedural Terminology" (CPT) coding guide. An office call also includes any non-surgical service for which a Physician or Surgeon bills IN ADDITION TO his fee for the office call AT THE SAME TIME AND AT THE SAME SITE as the office call. Services performed in a doctor's office are not, by themselves, eligible as an office call. These types of services include, but are not limited to, physical therapy, office surgery of any type, injections, x-rays, laboratory charges or any other service not billed as an "office call". Office surgery does not qualify as an "office call".

28. **Out-patient -** Receiving medical services while not confined as a registered bed patient in Hospital, Skilled Nursing Facility, or Hospice.

29. **Out-patient Surgical Center -** Any public or private establishment which:

A. has an organized medical staff of Physicians;
B. has permanent facilities that are equipped and operated mainly for performing surgical procedures;
C. provides continuous Physician services and registered professional nursing services while patients are in the facility; and
D. which does not provide services or other accommodations for patients to stay overnight.

30. **Physician or Surgeon -** Any professional practitioner who holds a lawful license authorizing the person to practice medicine or surgery in the locale in which the service is rendered, limited to a Doctor of Medicine (MD), a Doctor of Osteopathy (DO), a Doctor of Podiatric Medicine (DPM), a Doctor of Dental Surgery (DDS), a Doctor of Chiropractic (DC), a Doctor of Optometry (OD) or a Psychologist. As used herein, the term Psychologist shall include only a practitioner who is duly licensed or certified in the state where the service is rendered, has a doctorate degree in psychology, and has had a least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology or has a state license in psychology. For psychiatric care, the term "Physician" shall include the services of a licensed social worker practicing within the scope of his or her license.

"Physician" does not include a person who is the Covered Person receiving treatment or who is a Relative of the Covered Person receiving treatment.

31. **Plan -** The group medical Plan as described herein which was originally effective and was last restated (if restated) on the date indicated on the Plan enrollment form.

32. **Plan Administrator -** The person responsible for the day-to-day functions and

management of the Plan. The Plan Administrator is listed in Section XII. The Plan Administrator may employ persons or firms to process claims and perform other related services.

33. Pre-admission Testing - X-ray and laboratory exams which are performed on an out-patient basis within seven days prior to hospital admission provided that the following conditions are met:

A. such tests are related to the performance of the scheduled surgery or treatment;

B. such tests have been ordered by a Physician after a condition requiring such surgery or treatment has been diagnosed and Hospital admission has been requested by the physician and confirmed by the Hospital;

C. such covered person is subsequently admitted to the Hospital, or confinement is canceled or postponed because a Hospital bed is unavailable or, if after the tests are reviewed, the Physician determines that the confinement is unnecessary; and

D. such tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

34. Pre-existing Condition - Illness or Injury of a Covered Person who is not under age 19, that has been diagnosed or treated, or which prescription medication was taken or prescribed within the six (6) months which immediately precede the Enrollment date under which the Covered Person becomes covered under this Plan.

35. Relative - The spouse, parent, brother, sister or child of the Covered Person, or the spouse of the Covered Person's parent, brother, sister or child.

36. Routine Nursery Care - Hospital charges for room and board, supplies and services including circumcision, if applicable, for a newborn child while the mother is Hospital-confined due to delivery.

37. Routine Physical Exams - Routine, non-symptomatic physical exams for adults, including related lab work and x-rays.

38. Second Surgical Opinion - An assessment of the need for surgery by a second Physician (or third Physician, if the opinions of the first and second Physician are in conflict). This assessment includes the Physician's examination of the Covered Person as well as diagnostic testing. Physicians providing Second (or third) Surgical Opinions for a specific medical condition cannot be professionally or financially associated with the Physician who initially recommended surgery. Second (and third) opinions must be secured from a specialist (preferably a board certified specialist) in the field for which the patient is contemplating surgery, and must not be part of the same medical or surgical group as the first opinion physician.

39. Skilled Nursing Facility - A facility or separate part of a facility which meets all the following requirements:

A. It is licensed according to the laws of the state in which it is located;

B. Its main purpose is to provide Skilled Nursing treatment to a Covered Person who is recovering from an Illness or Injury;

C. It includes areas for medical treatment;

D. It provides 24-hour per day nursing service under the full-time supervision of a

Physician or graduate registered nurse (R.N.);

E. It maintains daily health records for each patient;
F. It has an agreement which provides for the services of a Physician;
G. It has an arrangement with one or more Hospitals for the transfer of patients;
H. It has a suitable method for providing drugs and medicines to patients;
I. It has an effective utilization review plan;
J. Its functions are developed with the advice and review of a skilled group which includes at least one Physician; and
K. It is not mainly a place for rest, rehabilitation or Custodial Care, the aged, drug addicts, alcoholics, mentally disabled persons or mentally disturbed persons.

40. Special Enrollment Period - An opportunity to enroll in the Plan after the initial enrollment period has passed. Requirements are explained in Section IV, Eligibility.

41. Totally Disabled - An Injury or Illness which prevents a Covered Employee from performing each of the main duties of his or her occupation with the Employer, or performing the duties of any occupation for wage or profit, or which prevents a covered Dependent from performing the normal activities of a healthy person of the same age.

42. Usual and Customary Charge - The ordinary charge made by a person or group which provides services, treatments or materials. "Usual and Customary Charge" does not include any charge which the Employer finds to be greater than the general level of charges made:

A. By others who provide the same or similar services, treatments or materials;
B. For an Illness or Injury of comparable severity and nature to the Illness or Injury being treated; or
C. To persons of similar income or net worth in the area where the Covered Person usually resides. The term "area" means a county or a greater area which provides a typical cross-section of others who provide similar services, treatments, or materials to persons of similar income or net worth.

43. Visit - Each instance of treatment, consultation, therapy or related session given by a health care provider. For the purpose of defining one Home Health Care Visit, each four-hour instance is considered one Home Health Care Visit, although one Visit may be less than four hours duration.

44. Waiting Period - The period of time which begins with an Employee's most recent date of employment with the Employer, and ends on the day prior to the day the Employee is eligible for coverage under the Plan. The Waiting Period is shown in the Schedule of Benefits.

45. Wellness - Those in-network preventative health services required to be provided by 29 U.S.C. § 1185d, 29 C.F.R. § 2590.715-2713 or other applicable law.

SECTION III

PRE-EXISTING CONDITION PROVISION

Claims resulting from Pre-Existing Condition(s), as defined in the Plan, are excluded from coverage under the Plan except as specified below:

> If the Covered Person is covered under the Plan for a period of twelve (12) consecutive months, eighteen (18) months for late applicants, the pre-existing condition limitations will no longer apply and all charges incurred thereafter will be considered eligible.

EXCEPTION TO THE PRE-EXISTING CONDITION PROVISION

A portion or all of the above mentioned time periods may be waived under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) if the patient provides proof of prior “Creditable Coverage”. Please refer to Section XIII of this document.

SECTION IV

EFFECTIVE DATES OF A COVERED PERSON'S COVERAGE

1. EMPLOYEE COVERAGE - Except as affected by paragraphs 2, 4, and 5 below, coverage for an Employee is effective at 12:01 a.m. on the latest of:

A. The date an Employee becomes eligible for coverage;
B. The date an Employee signs a payroll deduction order, if any part of the cost for this Plan is contributory; or
C. The date the Employee makes written application for coverage.

2. DELAYED EFFECTIVE DATE FOR EMPLOYEE COVERAGE - The Effective Date of an Employee's coverage will be delayed if he or she is not Actively-at-Work on the date coverage would otherwise take effect until such time as he or she returns to active work. Absence due to any health factor is not considered an absence for purposes of measuring continuous service.

3. DEPENDENT COVERAGE - Except as affected by paragraphs 4 and 5, an Employee's Dependent coverage will take effect at 12:01 a.m. on the latest of:

A. The date the Employee becomes eligible for Dependent coverage;
B. The date the Employee makes written application for Dependent coverage and signs a payroll deduction order.

If an Employee acquires a new Dependent while covered for Dependent coverage, coverage for the new Dependent is effective on the date the Dependent is acquired.

A newborn or newly-acquired Dependent will be automatically covered if the Employee already has Dependent coverage or if the Employee applies for Dependent coverage within 31 days of the date the Dependent becomes eligible.

4. EFFECTIVE DATE FOR SPECIAL ENROLLMENTS - You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- the birth, adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by your Employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by your Employer);

- benefits are no longer offered by the Plan to a class of individuals that include you or an eligible Dependent;
- you or an eligible Dependent incurs a claim that would exceed a lifetime limit on all benefits under the Plan;
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

If you wish to change your elections, you must contact the Plan Administrator within 31 days of the change in family status.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

5. EFFECTIVE DATE FOR LATE APPLICANTS - A Late Applicant is a person, including yourself, for whom you do not elect the coverage offered by this Plan within 31 days of the date the person becomes eligible for such coverage. Unless affected by another provision of this Plan, coverage for an Employee and/or his or her otherwise qualifying Dependent(s) for whom the Employee makes application after the initial enrollment period shall take effect on the later of the date (1) the Employee makes written application for coverage and agrees to pay any applicable required premium, and (2) meets all pertinent Actively-At-Work requirements of the Plan. The Pre-existing Condition provisions of the Plan shall apply to a late enrollee.

SECTION V

MAJOR MEDICAL BENEFITS

1. **DEDUCTIBLE** - The deductible is an amount of eligible charges a Covered Person must incur before major medical benefits are payable. The deductible will be satisfied when eligible charges equal the individual deductible amount shown in the Schedule of Benefits. PPO and Non-PPO deductibles are integrated and not separate.

The Covered Person must meet a new deductible amount each Benefit Year, (refer to the Schedule of Benefits).

The deductible amount is applied separately to each Covered Person's eligible charges, except when the family deductible (refer to the Schedule of Benefits) has been satisfied by the Family Unit with eligible charges used toward any individual deductible amounts.

If the family deductible amount is satisfied, all members of the Family Unit will be included in a Benefit Year, and no further deductible requirement applies, except for any applicable In-patient Hospital deductible.

2. **MAJOR MEDICAL BENEFITS** - The Employer will pay major medical benefits on behalf of a Covered Person who is a Covered Employee of the Employer or a Dependent of that Covered Employee if, during a Benefit Year, that Covered Person incurs charges which: (a) are not excluded by the terms of this Plan, and (b) are not paid under any other terms of this Plan. The amount of the benefit to be paid will be equal to:

A. The benefit percentage shown in the Schedule of Benefits, multiplied by:

B. The total eligible charges which are in excess of the deductible amount, and incurred during the Benefit Year.

3. **MAXIMUM BENEFITS** - Benefits paid for a Covered Person's Illnesses and Injuries will not exceed the maximum benefits per Covered Person shown on the Schedule of Benefits.

4. **ELIGIBLE CHARGES** - Only those charges incurred by a Covered Person while covered under this Plan are considered eligible charges. A charge is considered to be "incurred" on the date a service is performed or a purchase is made. If a charge is not specifically included below, it is considered an excluded charge. Eligible charges are the actual charges, not more than the Usual and Customary Charge, incurred for an Illness or Injury for one or more of the following:

A. **Room and Board** - Room and board and routine nursing services for each day of confinement in a Hospital or Free-Standing Chemical Dependency Treatment Center;

B. **ICU & CCU** - Intensive or Cardiac Care room and board, if Medically Necessary;

C. **Hospital Expenses** - Medical services and supplies furnished by a Hospital;

D. **Anesthesia** - Anesthesia and its administration by a licensed anesthesiologist or registered nurse anesthetist (R.N.A.);

E. **Physicians & Surgeons** - Fees of Physicians for medical treatment including fees for surgical procedures. In the case of multiple surgical procedures performed through the same or separate incision(s) during the same operative session the covered expense for only the Reasonable and Customary Charge for the major procedure will be allowed at 100%. 50% of the Reasonable and Customary Charge will be allowed for the secondary procedure and 25% of the Reasonable and Customary Charge for any additional procedure(s) will be allowed except that no benefits will be allowed for procedures that are considered incidental (i.e.: appendectomy, excision of scar tissue, lysis of adhesions, etc.). Bilateral procedures will be eligible at 100% for one side and 50% for the other side.

F. **Nurses** - Services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for private duty nursing when Medically Necessary;

G. **Therapists** - Services of a licensed physical or occupational therapist when such services are prescribed by a physician;

H. **X-Rays** - X-rays other than dental x-rays, laboratory tests, and other diagnostic services which 1) are performed as the result of definite symptoms of an Illness or Injury; or 2) reveal the need for medical treatment.

I. **Therapy** - X-ray and radiation therapy.

J. **Ambulance** - Professional ambulance service as follows:
   (1) ground transportation when Medically Necessary and used locally to or from the nearest Hospital qualified to render treatment;
   (2) air ambulance where air transportation is medically indicated to transport a covered person to the nearest facility qualified to render treatment; and
   (3) "CARE" and "LIFE" flights in a life-threatening situation;

K. **Drugs** - Drugs and medicines which are approved by the Food and Drug Administration (FDA), require the written prescription of a Physician, and which must be dispensed by a licensed pharmacist or Physician. Such drugs must be necessary for the direct therapeutic treatment of an illness or injury. If there is a separate prescription drug card program, benefits will be paid in accordance with the provisions of the drug card contract, less co-payments outlined therein. Benefits will not be paid under the major medical portion of this plan for drug card co-payments, co-insurance, or charges paid under the drug card plan;

L. **Blood** - Charges for the processing and administration of blood or blood components, but not for these charges if blood/blood components are replaced;

M. **Prosthetic Appliances** - Initial supply of artificial limbs, eyes, or larynx, and the Medically Necessary repair and adjustment of these appliances. Replacement

of such is only covered when due to change in medical condition or due to growth;

N. **Lenses** - The first pair of eyeglasses or contact lenses prescribed as part of postoperative treatment for intraocular surgery or due to accidental injury;

O. **Mastectomy Supplies** - Medically Necessary external breast prostheses and post-surgical brassieres following a mastectomy;

P. **Medical Supplies** - Medical supplies, which include:

(1) Casts, splints, braces, crutches, surgical dressings, and trusses, but not to include dental braces, dental appliances or orthopedic shoes;

(2) Ostomy supplies, catheters, oxygen, syringes, and needles necessary for the treatment of diabetes or allergies;

(3) Rental of (or purchase of, if the rental cost exceeds the purchase price) hospital equipment, which includes a wheelchair, hospital bed, oxygen equipment or similar such Durable Medical Equipment;

Q. **Out-Patient Services** - Charges for services performed in an Out-patient Surgical Center;

R. **Skilled Nursing Facility** - Room and board charges for each day of confinement in a Skilled Nursing Facility if the confinement:

(1) Follows Hospital-confinement of at least three consecutive days of Hospital room and board charges which are eligible charges under this Plan;

(2) Begins within fourteen days after the Covered Person is released from the Hospital;

(3) Is for treatment of the same Illness or Injury which resulted in the Hospital confinement; and

(4) Is a confinement during which a Physician is present and consulting with the Covered Person at least once every seven days.

No payment will be made for Skilled Nursing Facility confinement:

(1) For charges which are excluded from coverage by the terms of this Plan; or

(2) To the extent that the charges are paid under any other terms of this Plan.

Room and board charges mean charges made by a Skilled Nursing Facility for the cost of room, meals, and services such as general nursing services provided to all In-patients on a routine basis;

S. **Speech Therapy** - Services of a licensed speech therapist, but only for the restoration of speech when loss is due to accidental bodily injury, cerebral vascular accident (stroke), cerebral tumor or laryngectomy;

T. **Routine Newborn Care** - Routine Newborn Care for a newborn child who is a Covered Person at the time of birth. Routine Newborn Care includes Hospital charges for room and board, services and supplies up to a maximum of four

days, but only while the mother is confined for delivery. Routine Newborn Care does not include coverage for your children's children. Routine Newborn Care also includes charges for circumcision and routine pediatric care;

U. **Dental** - Charges for certain dental/oral surgical expenses as follows:
(1) Surgical removal of impacted teeth (no allowance for other extractions);
(2) Treatment required due to accidental injury to natural teeth occurring while covered under this Plan. Such expenses must be incurred within six months of the date of the accident, and shall not in any event be deemed to include charges for repair/replacement of a denture.
(3) When patient's health condition dictates that patient must be confined as a bed patient in the hospital for other dental work to be performed, only the charges made by the hospital may be covered (no physician's fees). Medical necessity must be documented.

Except as described above, covered items under this benefit do not include charges for the diagnosis or treatment of teeth or gums (including the restoration and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes), orthodontics, surgical orthodontics, implantology or orthopedic appliances for the jaw.

V. **Hospice** - Hospice care for a Covered Person who is terminally ill and related services for the Covered Person's family who are covered under this Plan. A terminally ill person is a person who has a life expectancy of six months or less as certified in writing by the Physician in charge of the person's care and treatment. Eligible Hospice care expenses for a Covered Person are limited to the following:
(1) Hospice care in a free-standing Hospice facility, a Hospital-based Hospice, extended care Hospice facility or nursing home Hospice;
(2) Care received from an interdisciplinary team of Hospice professionals for Hospice and home care; and
(3) Pre-bereavement counseling;
(4) Post-bereavement counseling during the twelve months following the death of the terminally ill person, up to a maximum of six counseling sessions.

W. **Home Health Care** - Home Health Care provided by a Home Health Care Provider for medical care, if:
(1) The Covered Person requires nursing services, therapy, or other services on an intermittent basis, provided by a Home Health Care Provider.
(2) The Covered Person is Totally Disabled and is essentially confined to the home;
(3) The Covered Person would otherwise have been confined as an In-patient in a Hospital or a Skilled Nursing Facility;
(4) The Covered Person is examined by the attending Physician at least once every 30 days; and
(5) The plan of treatment including Home Health Care is in writing by the attending Physician prior to the beginning of treatment and certified by the attending Physician at least once every month.

Eligible Home Health Care services do not include:

(1) Custodial Care, meals, nutritional services, or housekeeping services;
(2) Services or supplies not outlined in the Home Health Care plan;
(3) Services of a Relative of the Covered Person, or the services of a social worker;
(4) Transportation services;
(5) Care for tuberculosis, alcoholism, drug addiction, mental or nervous disorders, or care for the deaf or blind; or
(6) Care for senility, mental deficiency or disability.

X. **Supplemental Accident Benefits** - Supplemental Accident Benefits, if included in the Schedule of Benefits. This benefit is designed to supplement the major medical benefit and, therefore, is not subject to any deductible. All charges incurred by a Covered Person in connection with injuries sustained in or resulting from one accident and covered under this provision will be paid as outlined in the Schedule of Benefits. Any portion of the charges exceeding such maximum allowable amount will be considered under the major medical benefit portion of the Plan, subject to all Plan conditions, exclusions and limitations. The injuries must be sustained while the covered person is covered for medical benefits under the Plan, and services must be rendered within 90 days of the accident date in order to be eligible for this special benefit;

Y. **Sterilization** - Charges for voluntary sterilization on the same basis as any other illness for employees and dependent spouses;

Z. **Transplant** – **Human Organ & Tissue Transplant Benefits** - Services and supplies in connection with transplant procedures, subject to the following conditions:

This Plan Document includes a special attachment regarding human organ and tissue benefits, as explained in full in the Organ & Tissue Transplant Policy. All eligible Employees and their Dependents requiring human organ and tissue transplant services will have transplant-related charges covered under this separate policy, according to its terms and conditions, from the time of their evaluation through 365 days post transplant operation. After this specified benefit period has elapsed, all transplant-related medical benefits revert to the terms and conditions of health coverage under this Plan.

Benefits available for Human Organ Tissue Transplants are subject to the following:

(1) The Employee and Dependent(s) are eligible for medical benefits under the Plan;
(2) The Employee and Dependent(s) meet all the terms and conditions outlined in the Organ and Tissue Policy / Certificate; and
(3) The Employee or Dependent(s) do not have a pre-existing condition as defined in the Organ and Tissue Policy / Certificate.

Those Employees and their Dependents who are initially excluded from human organ and tissue transplant coverage under the Organ & Tissue Transplant Policy (due to a pre-existing condition) will continue to receive health care

benefits as related to transplantation according to the terms and conditions of the Plan until eligible for benefits under the separate policy.

AA. **Wellness** - The following items and services are covered at the levels listed in the Schedule of Benefits:

(1) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

(2) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) With respect to women, to the extent not described above, evidence informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

We will apply reasonable medical management techniques to determine the frequency, method, treatment, or setting for a wellness benefit described above to the extent such utilization is not specified in the recommendation or guideline.

BB. **Coverage by Operation of Law** - this Plan includes coverage for any statutorily mandated coverages that are not otherwise enumerated herein. Including coverages mandated after the beginning of the Plan's Benefit Year.

SECTION VI

DENTAL BENEFITS

Dental benefits will be paid for a covered Employee or a Dependent. They can be paid when covered expenses incurred during a Benefit Period equal or exceed the deductible. The benefits are described in the Schedule of Benefits and below:

1. CLASS I - DIAGNOSTIC AND PREVENTIVE PROCEDURES

A. EXAMINATIONS - Oral Examination - Only one oral examination (other than emergency examination) will be covered in each six month period.

B. RADIOGRAPHS

Intraoral X-Rays

Complete Series - Covered once each three year period

Bitewing - Only two will be covered in one calendar year

Occlusal

Periapical

Extraoral X-Rays

Panoramic

Sialography

TMJ

Cephalometric film

Posteroanterior and lateral skull and facial bone survey

Other extraoral - Only one of the listed extraoral procedures will be covered twice in one calendar year

Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Class I covered charges

C. PREVENTIVE SERVICES

Prophylaxis (Cleaning of teeth, including scaling and polishing) - Covered twice in one calendar year

Topical application of fluoride (including prophylaxis) - Applicable only to Dependent Children. Only one application will be covered each calendar year

Space maintainers - Applicable only to children under age 14

Topical application of sealers - Applicable only to children under age 14 - Covered once each quadrant in each four year period

D. OTHER SERVICES

Biopsy of oral tissue

Palliative treatment - Covered as a separate procedure only if no other service (except x-rays) is provided during the visit

Bacteriologic culture

Histopathologic examination

Pulp vitality test

Diagnostic test - Covered once each two year period

2. CLASS II - BASIC PROCEDURES

A. RESTORATIONS

Fillings (Amalgam, silicate, plastic or composite, including pin retention when necessary)

Stainless steel crown

B. ORAL SURGERY

Extraction of non-impacted teeth

Alveoplasty

Removal of dental cysts and tumors

Surgical incision and drainage of dental abscesses

Other surgical procedures

Tooth replantation

Surgical exposure to aid eruption

Surgical repositioning of teeth

Excision of hyperplastic teeth

C. PERIODONTIC SERVICES

Surgical procedures - Only one of the listed surgical procedures is covered for each quadrant per calendar year

Gingivectomy

Gingival curettage

Osseous surgery

Osseous graft

Scaling and root planting (full mouth) - Twice each quadrant in one calendar year

Periodontal appliance - One appliance each three year period

Periodontal prophylaxis

D. ENDODONTIC SERVICES

Pulp cap

Vital pulpotomy

Root canal therapy, including treatment plan, diagnostic x-rays, clinical procedures and follow-up care

Apexification

Apicoectomy

Retrograde filling

Apicoectomy and retrograde filling covered as a separate procedure only if performed more than one year after root canal therapy is complete

Apical curettage

Root resection

Hemisection

E. ANESTHESIA

General Anesthesia - Covered as a separate procedure only when required for complex oral surgical procedures covered under the Plan (and only when not performed in Hospital)

F. OTHER SERVICES

Repairs to bridges and full or partial dentures

Adding tooth to partial denture

Relining full or partial dentures (upper or lower) - Covered only if relining is done more than one year after the initial installation, and then not more than once each two year period

Recementing inlay, crown, bridge, or space maintainer
Consultation with specialist
Antibiotic drug injection

3. **CLASS III** - MAJOR PROCEDURES

A. RESTORATIONS

Gold foil
Gold inlays and onlays
Gold restorations - Covered only if the tooth cannot be restored by a silver filling and, for replacements, at least five years have elapsed since the date of the last placement
Porcelain inlay
Crowns (single restoration only)
Plastic (acrylic)
Plastic, prefabricated
Plastic with non-precious metal
Plastic with semi-precious metal
Plastic with gold
Porcelain with non-precious metal
Porcelain with semi-precious metal
Porcelain with gold
Gold (3/4 cast)
Gold (full cast)
Non-Precious metal (full cast)
Semi-Precious metal (full cast)
Crowns are covered only if the tooth cannot be restored by a filling and, for replacements, at least five years have elapsed since the last placement. Crowns for the primary purpose of periodontal splinting, altering vertical dimensions or restoring occlusion are not covered.
Cast post and core - Covered only for teeth that have had root canal therapy. Steel post and composite or amalgam

B. PROSTHODONTICS, FIXED

Fixed bridges - Initial or replacement
Initial placement of fixed bridges to replaced teeth which were missing prior to the effective date of the individual's coverage will be covered only after the individual has been covered under this Plan for 24 consecutive months, unless the fixed bridgework also included replacement of a natural tooth extracted while covered. Replacement of fixed bridges is covered only if the original bridge cannot be made serviceable and (a) the individual has been covered under this Plan for at least 12 consecutive months, and (b) five years have elapsed since the last placement.

C. PROSTHODONTICS, REMOVABLE -

Full or partial dentures - Initial placement of full or partial removable dentures to replace teeth which were missing prior to the effective date of the individual's coverage will be covered only after the individual has been covered under this Plan for 24 consecutive months, unless the denture also includes replacement of a natural tooth extracted while covered. Replacement of a full or partial removable denture will be covered only if the existing denture cannot be made serviceable and (a) the individual

has been covered under this Plan for at least 12 consecutive months (not applicable if replacement is made necessary by the initial placement of an opposing full denture), and (b) five years have elapsed since the last placement. Covered charges do not include any additional charges for overdentures or for precision or semi-precision attachments.

4. **CLASS IV** - ORTHODONTIC SERVICES (If Applicable)

If shown in the Schedule of Benefits, eligible expenses under Orthodontic Services are those incurred for diagnosis, surgical therapy, and appliance therapy. This includes related oral exams, surgery and extractions. But these will be an eligible expense only if the insured Dependent child is under the age of 19 and the treatment is for:

A. Overbite or overjet of at least four millimeters;
B. Maxillary and mandibular arches in either protrusive or retrusive relation of at least one cusp;
C. Cross-bite;
D. An arch length difference of more than four millimeters in either the maxillary or mandibular arch; or
E. Bimaxillary protrusion of 10 millimeters or more.

5. **COVERED CHARGES** - Covered charges will be the actual cost charged to you or your Dependent for treatment or service, but not more than the prevailing charge. Also:

A. If it is determined that more than one procedure could be performed to correct a dental condition, covered charges will be limited to the maximum allowance for the least expensive of the procedures that would provide professionally acceptable results
B. Covered charges will include only those charges for treatment or services that begin (as defined in the following provision) while you and your Dependents are covered under this Plan.
C. Covered charges will include only those charges for treatment or service that is completed while you and your Dependents are covered under the Plan.

6. **BEGINNING DATE OF TREATMENT**

Treatment or service will be considered to begin:

A. For root canal therapy, on the date pulp chamber is opened and the pulp canal explored to the apex;
B. For crowns, fixed bridgework, inlays or onlays restoration, on the date the tooth or teeth are fully prepared;
C. For full or partial dentures, on the date the master impression is made; and
D. For all other, on the date the treatment or service is performed.

7. **LIMITATIONS**

Dental benefits will not be paid for:

A. Any part of a charges for treatment or service that exceeds prevailing charges; or
B. The services of any person who is not a Dentist or Dental Hygienist, and the services of any person in your immediate family or any person in your Dependent's immediate family; or
C. Personalization of dentures or crowns (or any other treatment that is primarily cosmetic) and any procedure that does not have uniform professional

endorsement; or

D. Drugs and medicine (except for antibiotic injection); or
E. Instructions for plaque control, oral hygiene or diet; or
F. Treatment or service to alter vertical dimensions, restore occulsion or to duplicate lost or stolen prosthetic device; or
G. Treatment for which you or your Dependent have no financial liability or that would be provided at no charge in the absence of coverage, or that is paid for or furnished by the United States Government or one of its agencies (except Medicaid); or
H. Treatment or service that results from war or act of war, or from voluntary participation in criminal activities; or
I. Treatment or service that is covered by a Workers Compensation Act or similar law.
J. Dental services covered under the Medical plan are excluded from coverage under the Dental plan; these services will be considered under the Medical plan.
K. Implants/Implantology.

8. PRE-TREATMENT DETERMINATION

It is required that a Dental Treatment Plan be filed before treatment begins when charges for a period of dental treatment (other than emergency treatment) are expected to exceed $200. The phone number for pre-authorization is 1-888-741-2673.

SECTION VII

EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for charges in excess of the Usual and Customary Charge as determined by the Employer, and amounts over and above the benefit maximums shown in the Schedule of Benefits.

Unless specifically included as eligible charges elsewhere in this Plan Document, benefits will not be paid for:

1. Charges incurred prior to the effective date of coverage under the Plan, or after coverage is terminated;

2. Charges incurred as a result of revolt, riot, civil disturbance, war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country;

3. Charges arising out of or in the course of any employment for wage or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law.

4. Charges for Illness or Injury caused by or contributed to by engaging in an illegal occupation or by committing or attempting to commit a felony.

5. Charges incurred by a Covered Person who is not under the direct care of a Physician.

6. Charges resulting from care or treatment which is not Medically Necessary for the care and treatment of Illness or Injury, including but not limited to housekeeping and Custodial Care.

7. Charges incurred for treatment or care by a Physician, R.N., L.P.N., licensed or certified practitioner if he or she is a Relative; or treatment or care provided by any person who ordinarily resides with the Covered Person.

8. Charges incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage. This Plan will not create such an obligation to pay;

9. Charges for services which are provided due to a court order.

10. Charges for services, supplies, medicines or treatments, including surgery which are considered experimental or research by nature, and not recognized by the American Medical Association or Food and Drug Administration as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active illness or injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value;

11. Charges for military service-related Injury or Illness (past or present) furnished by a Hospital or facility operated by any foreign government agency or the United States

Government or any authorized agency of the United States Government or furnished at the expense of such government or agency.

12. Charges for health "check-ups", routine physical exams and well-baby care, which includes office visits, tests and immunizations, unless specifically included elsewhere.

13. Charges incurred in connection with the care or treatment of, or surgery performed for, a Cosmetic Procedure, including that portion of breast surgery which involves the implanting or injecting of any substance into the body for restoring breast shape, except for charges which result from an Illness or Injury which occurs while the Covered Person is covered under this Plan. Also, this exclusion shall not apply when such treatment is rendered to correct a condition resulting from an accidental injury sustained while covered under this Plan, or when rendered to correct a congenital anomaly, i.e., a congenital birth defect, for a Covered Dependent;

14. Charges incurred for treatment on or to the teeth, gums the nerves or roots of the teeth, gingival tissue or alveolar processes or supplies used in such treatment or for dental appliances, unless specifically included elsewhere in this plan.

15. Charges for:

A. Treatment of infertility or inducement of pregnancy, including fertility studies or testing;
B. In vitro fertilization;
C. Artificial insemination;
D. G.I.F.T. (Gameti Intrafallopian Transfer);
E. Surgical reversal of elective sterilization;
F. Fertility drugs;
G. Birth control devices, or their insertion or removal;

16. Charges for eye refractions or eye examinations for the correction of vision or fitting of glasses or contact lenses, furnishing or replacing glasses or contact lenses, radial keratotomy**,** lasik or any surgery of the eye specifically designed for improving vision that can be corrected through the use of corrective eye wear, or for hearing exams or hearing aids. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following intraocular surgery, nor does it apply to the initial purchase of a hearing aid if the loss of hearing is a result of surgical procedure performed while coverage is in effect.

17. Routine foot care, including but not limited to removal or treatment of corns, calluses, nail trimming (except in the case of certain diabetic and vascular conditions).

18. Charges for purchase of orthopedic shoes or other device for support of the feet, except for initial casting and insertion of orthomechanical device following major surgery to bones of the foot.

19. Charges for treatment of obesity or underweight conditions, dietary control or weight loss or weight gain, including but not limited to plans, dietary supplements, prescription medicines, enteral feeding, behavior modification, education, weight monitoring or enrollment in a health, athletic or similar club except for surgical treatment of morbid obesity, when determined to Medically Necessary and not contraindicated as

determined by the plan.

20. Charges for the purchase or rental of supplies of common use such as: exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows, mattresses and waterbeds, motorized transportation equipment, escalators or elevators, saunas, steam baths, swimming pools or blood pressure kits. This exclusion applies even if supplies of common use are obtained upon the recommendation of a Physician.

21. Charges for treatment of temporomandibular joint dysfunction and other jaw disorders and services directly attributable to the TMJ dysfunction will not be covered unless otherwise specifically provided for in the Schedule of Benefits.

22. Charges for non-prescription, non-legend medicines, vitamins (except pre-natal vitamins prescribed for an existing pregnancy), nutrients and food supplements, even if prescribed or administered by a Physician.

23. Charges for services or supplies that are for personal comfort or convenience, health or beauty aids including but not limited to television or other entertainment, telephone use, or personal care kits such as those sometimes provided during a hospital confinement or at any other treatment facility, education or training, or expenses actually incurred by other persons (i.e. guest trays from the cafeteria).

24. Charges for maternity for Dependent children.

25. Charges for the treatment, surgery or services to modify sex/gender (transsexualism).

26. Charges for the treatment of impotence (except for penile implant in cases of organic erectile dysfunction related to illness or injury), or any other sexual dysfunction or inadequacies.

27. Charges for testing of any kind for the sole purpose of determining the sex of an unborn child.

28. Marital, cultural, or societal counseling.

29. Charges for treatment of illness or injury as result of participation in a hazardous hobby including but not limited to skydiving, bungee jumping, professional sports or organized motorized sport racing.

30. Charges for travel, except by ambulance or air ambulance when Medically Necessary.

31. Charges for telephone consultations, missed appointments, completing forms, or providing written reports.

32. Charges for routine examinations or immunizations required for travel or to become a citizen of the United States.

33. Charges to improve general health conditions including cardiac and pulmonary rehabilitation unless otherwise determined by the Plan to be Medically Necessary.

34. Charges for biofeedback therapy.

35. Charges for non-emergency services received outside the United States.

36. Self-inflicted illness/injury except as Federal regulations prohibit such exclusion.

37. Charges for voluntary abortion (except when the mother's life is medically documented to be in danger).

Experimental or Investigational Services

The Plan through the Plan Administrator reserves the right to determine what is Experimental or Investigational. Any health care treatments, procedures, equipment, drugs, devices, and supplies that are, in the Plan Administrator's sole judgment, Experimental or Investigational for the specific Illness or Injury of the Covered Person receiving such services are excluded. Services that support or are performed in connection with the Experimental or Investigational Services are also excluded.

This exclusion applies even if Experimental or Investigational Services are the only available treatment option for your condition, unless the Plan Administrator has agreed to cover them as defined in Section 2, *Definitions.*

SECTION VIII

COORDINATION OF BENEFITS

1. COORDINATION OF BENEFITS - This provision coordinates benefit payments between this Plan and similar benefits payable under any other medical Plan so that the total benefits paid under all Plans involved does not exceed 100% of eligible charges. In this section, the term "Plan" means any health coverage which provides medical or dental care benefits. The Plan may be insured or uninsured, and includes the following:

A. Group, blanket or individual insurance;
B. Hospital or medical service pre-payment Plans;
C. Any coverage under Labor-Management-Trustee Plans, union welfare Plans, Employer organization Plans, or Employee benefit organization Plans;
D. Any government programs;
E. Any coverage required or provided by law;
F. "No fault" auto insurance; and
G. Third-party liability insurance.

Each policy, contract or Plan of benefits will be considered to be a separate Plan. A Plan may include a Coordination of Benefits provision, or similar provision, on some or all of its benefit provisions. Benefits or services subject to this provision are considered a separate Plan from those benefits and services which are not subject to this provision. "Allowable expense" means any Usual and Customary Charge covered in full or partially under more than one Plan. When this Plan pays after the benefits of another Plan are paid, "allowable expense" includes any deductible or co-insurance amounts not paid by the other Plan. In no case will benefits greater than 100% of allowable expenses be paid by all Plans together. No expenses are allowable if they are incurred while coverage is not effective under this Plan. If a Plan provides benefits in the form of services rather than cash payments, the usual cash value of the services are considered a benefit paid.

2. COORDINATION PROCEDURES - If a Covered Person is covered under more than one Plan, the Coordination of Benefits section applies. This section will be used to determine the amount of benefits payable under this Plan. One Plan is considered primary; all other Plans are secondary, as described below. Primary Plans pay benefits first without considering benefits available under other Plans. Secondary Plans then pay benefits up to the extent of their liability, taking other Plans into consideration.

A. If another Plan has no Coordination of Benefits provision, it is declared the primary Plan.
B. If all Plans have Coordination of Benefits provisions, a Plan is primary if it covers the person as an Employee, and secondary if it covers the person as a Dependent.
C. If a person is covered as a Dependent child under more than one Plan:
   (1) The Plan of the parent whose birthday falls earlier in the year is the primary Plan;
   (2) If the father and mother share the same birth date, the Plan covering the parent longer is the primary Plan;
   (3) If the other Plan coordinates benefits according to the sex of the parents, then the Plan that covers the person as a Dependent of a male is the

Primary plan;

(4) If parents are separated or divorced, the following applies: The Plan which covers a child as a Dependent of the parent with legal custody of the child is the primary Plan, unless a court decree outlines the obligation for medical expenses for the child. The Plan which covers the child as a Dependent of the parent with obligation for medical expenses is then primary.

D. If a Plan is "no-fault" auto insurance or third party liability coverage, it is considered the primary Plan.

E. If the foregoing rules do not establish which Plan is primary, then the Plan which has covered the person for the longest continuous period of time is considered primary.

3. COORDINATION WITH MEDICARE - If applicable, and to the greatest extent allowable under applicable Federal law, coverage under the Plan for a Covered Person who is covered under Medicare shall be secondary to coverage of such Covered Person under Medicare. If a Covered Person's coverage under this Plan is secondary to his coverage under Medicare, the benefits payable under this Plan shall be reduced in the manner described in the Coordination Procedures in paragraph 2 above. If a Covered Person's coverage under this Plan is not permitted to be secondary to his coverage under Medicare, the Covered Person shall be reimbursed for Covered Expenses in accordance with this Plan without regard to that Covered Person's coverage under Medicare. Notwithstanding any provision in this section to the contrary, if a Covered Person is covered by Medicare and chooses not to be covered under this Plan, coverage under this Plan shall terminate. A Covered Person is considered covered under Medicare for purposes of the Plan during any period such Covered Person has actual coverage through Medicare or, while otherwise qualifying for actual coverage under Medicare, does not have such coverage solely because he has refused or failed to make any necessary application for Medicare coverage.

4. RIGHT TO EXCHANGE INFORMATION - The Employer has the right to exchange benefit information with any insurance company, organization, or person to determine benefits payable under Coordination of Benefits. Information may be exchanged without the consent of or notice to any person. A person who claims benefits under this Plan must provide the Employer with information requested to determine benefit payments.

5. RIGHT TO RECOVERY - If payments have been made under any other Plan which should have been made under this Plan, the Employer has the right to reimburse to the extent necessary to satisfy the intent of this provision. If the Employer pays benefits in good faith to an organization, it is not required to pay the same benefits again. The Employer also has the right to recover any overpayments made due to coverage under another Plan. The Employer may recover overpayments from any insurance company, organization or person to whom or on whose behalf, the Employer paid benefits under this Plan.

6. SUBROGATION - Subrogation is this Plan's limited right to be substituted for a Covered Person in a claim for damages for willfully or negligently caused Injury. If payment is made for services on behalf of a Covered Person under this Plan, the Plan will be subrogated to all rights of recovery which the Covered Person, or his or her

representative, may have against any other party or liability insurer, but only to the extent of such payments. The Covered Person must do whatever is reasonably necessary to secure the Plan's rights and will do nothing to damage the Plan's rights.

7. THIRD PARTY LIABILITY - If a Covered Person has medical charges:

A. Incurred as the result of an accident, negligence or intentional acts of a third party; or

B. Incurred as the result of medical malpractice; and

C. For which the Covered Person makes a claim for benefits under this Plan;

the Covered Person or legal representative of a minor or person declared to be legally incompetent, must agree in writing to repay the Plan from any amount of money received by the Covered Person from the third party or its insurer. Repayment will be only to the extent of benefits paid by the Plan, but not more than the amount of the payment received by the Covered Person from the third party or its insurer.

Reasonable expenses such as attorneys' fees and related court costs, incurred in obtaining payment from the third party, may be deducted from the repayment amount to the Plan. The repayment agreement will be binding upon the Covered Person or the legal representative of a minor, or person who is declared legally incompetent, whether or not payment received from the third party or its insurer is the result of:

A. A legal judgment;

B. An arbitration award;

C. A compromise settlement; or

D. Any other arrangement.

The repayment agreement is equally binding upon the Covered Person regardless of whether or not the third party or its insurer has admitted liability or the medical charges are itemized in the third party payment.

SECTION IX

TERMINATION OF COVERAGE

1. TERMINATION OF COVERAGE FOR EMPLOYEES - An Employee's coverage will terminate on the earliest of:

A. The date this Plan is terminated;
B. The end of the period for which the last required Employee contribution has been paid;
C. The date a Covered Employee ceases to be in an Employee class eligible for coverage; and
D. The date on which a Covered Employee's employment with the Employer terminates.

Ceasing continuous, full-time Active Work is deemed termination of employment unless:

A. The Covered Employee is disabled due to Illness or Injury. In this case, coverage may be continued during the disability, for a maximum of 3 months, provided that the required Employee contributions are made by the Covered Employee; or
B. Cessation of work is due to a temporary lay-off or approved leave of absence. In this case, coverage may be continued two months after the lay-off or leave began, provided that any required Employee contributions are made by the covered employee.

The Employer cannot discriminate unfairly among Employees in similar situations. A Covered Employee's coverage for any specific benefit will terminate on the earlier of:

A. The date coverage for a benefit ends; or
B. The date the Covered Employee is no longer eligible for the benefit.

2. TERMINATION OF COVERAGE FOR DEPENDENTS - Dependent coverage will end for all of a Covered Employee's Dependents on the earliest of:

A. The date the Covered Employee's coverage terminates;
B. The date this Plan is terminated;
C. The date all Dependent coverage is discontinued under this Plan;
D. The date the Covered Employee is no longer in an Employee class which is eligible for Dependent coverage;
E. The end of the period for which the last required Employee contribution for his or her Dependent coverage has been paid; and
F. The date the Covered Employee no longer has any eligible Dependents.

Dependent coverage for any specific Dependent will end as of the date he or she is no longer a Dependent, as defined by this Plan (refer to the Definitions section).

HEALTH CARE CONTINUATION COVERAGE
VERY IMPORTANT NOTICE

A Federal law enacted on April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), requires that most employers providing group health plans offer employees and their families (if applicable) the opportunity to elect to purchase a temporary extension of health coverage (referred to as "COBRA Continuation Coverage" in this law) at group rates in certain instances where coverage under the plan would otherwise end. COBRA was subsequently amended by legislation enacted in December, 1989. This notice is intended to inform you in a summary fashion of your rights and obligations under COBRA. BOTH YOU (AND YOUR SPOUSE IF YOUR SPOUSE IS ELIGIBLE FOR COVERAGE) SHOULD TAKE THE TIME TO READ THIS NOTICE CAREFULLY.

1. ELECTION RIGHTS AND QUALIFYING EVENTS - If you are an employee of the Employer or its affiliates (the "Company") covered by the Company's group health plan (the "Plan"), you have a right to choose COBRA Continuation Coverage under the Plan if your health care coverage stops or will stop as a result of one of the following "qualifying events":

A. Termination of your employment (other than for reasons of gross misconduct). "Termination of employment" for purposes of COBRA Continuation Coverage means you are no longer an active employee because of such reasons as resignation, discharge, personal illness, layoff, location closing, work transfer/automation, retirement, or leave of absence; or

B. Reduction in your hours of employment (e.g., change to part-time status) to such an extent that you no longer have coverage.

If you are the spouse of an employee covered by the Plan, you have the right to choose COBRA Continuation Coverage under the Plan if your Company health care coverage stops or will stop as a result of one of the following "qualifying events":

A. The death of your spouse;

B. The "termination" of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment;

C. Divorce or legal separation from your spouse; or

D. Your spouse becomes entitled to Medicare benefits.

A Dependent child of an employee covered by the Plan has the right to COBRA Continuation Coverage under the Plan if the Dependent's Company health care coverage stops or will stop as a result of one of the following "qualifying events":

A. The death of a parent employed by the Company;

B. The "termination" of a parent's employment with the Company (for reasons other than gross misconduct) or a reduction in a parent's hours of employment with the Company;

C. The parent's divorce or legal separation;

D. The parent becomes entitled to Medicare benefits; or

E. The Dependent ceases to be a "Dependent" under the Plan.

2. NOTIFICATION REQUIRED - Under COBRA, the employee or a family member must notify the Plan Administrator, in writing, of a divorce or legal separation or a child's losing dependent status under the Plan within 60 days of the date of the qualifying event. This notification should be sent to the Plan Administrator. The Company has

the responsibility to notify the Plan Administrator of an employee's death, "termination of employment", reduction in hours, or Medicare eligibility.

When the Plan Administrator is notified that one or more of the qualifying events has occurred, the Plan Administrator will in turn notify you of your right to choose COBRA Continuation Coverage under the Plan. If you choose COBRA Continuation Coverage, you must file an election form with the Plan Administrator within 60 days or the later of:

A. The date of notification of your election rights, or
B. The date of the qualifying event.

If you do not choose COBRA Continuation Coverage, your coverage under the Plan will end in accordance with the terms of the Plan.

3. DURATION OF COBRA CONTINUATION COVERAGE - If you choose COBRA Continuation Coverage, it will be identical to the coverage provided under the Plan to similarly situated beneficiaries who have not had a qualifying event. COBRA requires that you be given the opportunity to elect COBRA Continuation Coverage for:

A. 18 months in the event of a "termination of employment" or reduction in hours. However, COBRA Continuation Coverage may be extended for up to a total of 36 months from the date of the original event if other events, such as divorce, legal separation or death occur during that 18-month period;
B. 36 months in the event of the death of the employee, divorce or legal separation of the employee, an employee becomes entitled to Medicare benefits, or a child ceases to satisfy the definition of "Dependent" under the terms of the Plan; or
C. Up to 29 months in the event of a "termination of employment" or a reduction in hours followed by a determination by the Social Security Administration that you were disabled on the date of the qualifying event, and you can provide notice of such determination to the Plan Administrator during the initial 18-month period and within 60 days of the determination.

The law also provided that your COBRA Continuation Coverage may be discontinued for any of the following reasons:

A. You do not pay for your COBRA Continuation Coverage on time;
B. You return to work at the Company and become covered under the Plan or another group health plan maintained by the Company;
C. You become covered under another group health plan as an Employee or as a Dependent, and the coverage does not contain a pre-existing condition exclusion or limitation that affects you;
D. You become entitled to Medicare benefits; or
E. The Company no longer provides group health coverage to any of its employees.

4. YOUR COST FOR COBRA CONTINUATION COVERAGE - You do not have to provide proof of good health to choose COBRA Continuation Coverage. However, COBRA requires that you pay for your COBRA Continuation Coverage each month for a long as you have COBRA Continuation Coverage. This means you will pay monthly for 18, 29 or 36 months (depending on the event qualifying you for eligibility) for COBRA Continuation Coverage. The cost of the coverage is 102% of the applicable premium (or 150% for additional months of coverage beyond the first 18 months in the case of a Social Security Administration determination of disability). The election of COBRA Continuation Coverage is in lieu of coverage continuation under the Plan that

must be paid fully or partially by the Company. In addition, at the end of the 18, 29 or 36 months COBRA Continuation Coverage period, you may have the opportunity to convert the coverage to an individual policy if provided by the Plan.

5. CONTINUATION OF COVERAGE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

An employee who qualifies and is approved for family or medical leave, without pay, will be eligible to continue group health insurance coverage under the same conditions as would have been provided if the employee had not taken leave.

The employee will be responsible for continuing to make health insurance premium payments for employee coverage, and the Dependent coverage, if applicable. The employer will continue to make any contributions made on behalf of the employee, prior to the leave. However, if an employee voluntarily does not return to work at the end of an approved leave, the employer may recover all premiums paid on the employee's behalf.

Premium payments must be made by the first of the month for which coverage is being sought. Failure to make payment within 30 days of the due date will terminate coverage.

SECTION XI

GENERAL PROVISIONS

1. EXCLUSIVE BENEFIT OF EMPLOYEES - This Plan is maintained for the exclusive benefit of Employees of the Employer. The plan will comply with all applicable technical regulations of the Internal Revenue Code, as published by the Federal Government.

2. SUMMARY PLAN DESCRIPTION - Each Covered Person will be given a Summary Plan Description by the Employer. The Summary Plan Description will outline benefits provided under this Plan, to whom benefits will be paid and any limitations or Plan requirements which may apply to the Covered Person. The Summary Plan Description is not a part of the Plan Document. If there is a conflict between the Plan and this Plan Document, the Plan Document will control.

3. STATEMENTS - In the absence of fraud, all statements made by a Covered Person are representations, not warranties. No statement will be used to contest the coverage provided by this Plan unless it is in writing, and a copy of the statement(s) is provided to the Covered Person or to his or her beneficiary, if any.

4. PLAN AMENDMENTS, FUTURE OF PLAN - The right is reserved in this Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan, covering any active or covered former employee or current or future retiree, in whole or in part, at any time. Any such change or termination in benefits:

A. Will be based solely on the decision of the Plan Sponsor; and

B. May apply to all active or covered former employees, current retirees, or future retirees, as either separate groups or as one group as determined by the Plan Sponsor.

5. CLAIM FORMS - When notice of claim is received, the Claims Administrator will send forms to the Covered Person for use in filing the required proof of loss. If he or she does not receive these forms within 15 days, the proof of loss requirement may be met by giving the Claims Administrator a written statement of the nature and extent of the loss within the time limit stated in the following Proof of Loss provision.

6. PROOF OF LOSS - The Claims Administrator must be given written proof of loss within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason if proof is filed as soon as reasonably possible. Proof of loss must be given no later than one year from the date of loss unless the person making the claim was legally incapacitated. The Plan may require, as part of the proof, authorization to obtain medical and non-medical information.

7. LEGAL ACTIONS - No legal action to recover any benefits may be brought before sixty days after the required written proof of loss has been given. No legal action may be brought more than three years after written proof of loss is required to be given.

8. PHYSICAL EXAMINATIONS - The Plan (at its own expense) may have a Covered Person examined as often as reasonably necessary while any claim is pending.

9. **IF YOU HAVE A CLAIM -** Claim forms are available from the Plan Administrator. The Claims Administrator who handles all claims for this plan is:

CORE ADMINISTRATIVE SERVICES, INC.
PO Box 90
Macon, GA 31202-0090
(478) 741-3521

SECTION XII

EMPLOYEE INCOME SECURITY ACT OF 1974 (ERISA)
SUMMARY PLAN DESCRIPTION

1. **ERISA -** This Plan is a funded Plan. The Employer and Employee are the sole sources of contributions to the Plan. This Plan is intended to comply with the Welfare Benefit Provisions of ERISA and with all other applicable Federal legislation whether or not such legislation is included by name in this Plan Document. Where indicated, this Plan shall automatically be amended to comply with such legislation even though no formal Amendment may be executed. The name of this Plan is The Insurance Trust Group Health Plan. The name, address and zip code of the Plan Sponsor is:

The Insurance Trust Group Health Plan
50 Lenox Pointe, NE
Atlanta, GA 30347

Employer Identification Number (EIN): 58-1440532
Plan Number: 501
Contract Number: 900
Plan Effective Date: September 1, 2001
Plan Anniversaries: September 1

The name, address and zip code of the Plan Administrator is:

Trevor Miller
The Insurance Trust Group Health Plan
50 Lenox Pointe, NE
Atlanta, GA 30324

The Plan Administrator is responsible for the administration of this Plan. Functions handled by the Plan Administrator include the receipt and deposit of contributions, maintenance of records of the Plan participants, authorization and payment of Plan administrative expenses, selection of consultants, selection of the Claims Administrator and determining of the eligibility of individual claimants for receipt of benefits. The designated agent for service of legal process is:

Plan Sponsor
The Insurance Trust Group Health Plan
50 Lenox Pointe, NE
Atlanta, GA 30324

The Plan is administered by the Plan Administrator with Core Administrative Services, Inc., a Third Party Administrator, acting as Claims Administrator.

Plan Contributions:

Personal Coverage is: Contributory
Dependent Coverage is: Contributory

2. LOSS OF BENEFITS - The Plan Administrator shall have the sole and exclusive discretionary authority to control, interpret and manage the operation and administration of the Plan. The Plan Administrator, in its discretionary authority, shall determine eligibility for benefits, construe the terms of the Plan and resolve any disputes which may arise with regard to the rights of any persons under the terms of the Plan, including but not limited to, eligibility for participation and claims for benefits.

SECTION XIII

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Effective with plan renewals on July 1, 1997, and later, the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 limits health plan Pre-Existing Condition limitations. With some qualifications, Pre-Existing Conditions are:

1. Permissible only if the limitation relates to a physical or mental condition for which medical advice, diagnosis, treatment or care was recommended or received within the six (6) month period before the Enrollment Date. Genetic status alone cannot be treated as a preexisting condition in the absence of diagnosis of a condition related to the genetic information.
2. Limited to 12 months (18 months for late enrollees) less the period of Creditable Coverage.
3. Pregnancy cannot be excluded under any circumstance.
4. Pre-Existing Condition limitations cannot apply to Newborns or adoptees (under age 18) if application for coverage is made within 30 days following the birth or placement and the child does not incur a subsequent 63-day break in coverage.

Any Pre-Existing Condition limitation is reduced by the period of other 'Creditable Coverage' subject to the following criteria:

1. Creditable Coverage includes coverage under most individual and group health insurance plans (including Medicare, Medicaid, TRICARE, the Indian Health Service, a state health risk benefit pool, the Federal Employee Health Benefit Program, a public health plan, Peace Corps Act health benefits, State Children's Health Insurance Program or governmental and church plans). Creditable Coverage does NOT include liability, dental, vision, specified disease and/or other supplemental types of benefits
2. Employers may count Creditable Coverage without regard to specific plan benefits.
3. Breaks in coverage of less than 63 consecutive days are ignored.
4. Waiting Periods and HMO affiliation periods are not considered a break in coverage.

For additional information concerning HIPAA, please see the Plan Administrator.

SECTION XIV

CLAIMS REVIEW AND APPEAL PROCEDURE

1. RIGHTS OF REVIEW AND APPEAL - If a claim is partly or totally denied for any reason, the Covered Employee will be given written notice of denial. Written denial will include:

A. Specific reasons for denial with reference to the Plan Document provision(s); and

B. A description and need for any other material pertinent to the claim.

If a claim is not processed within 90 days of receipt by the Claims Administrator, a Covered Employee may proceed to the review procedure, as if the claim had been denied.

2. REVIEW PROCEDURES - A Covered Employee, or the Covered Employee's representative, may request a review of the claim denial by making written request to the Claims Administrator within 180 days of receipt of the notice of denial. Written notice for review should:

A. State the reasons the Covered Person feels the claim should not have been denied;

B. Include any additional documentation which the Covered Person believes supports the claim. A Covered Employee may review pertinent documents and submit additional questions or information for consideration, including by presenting evidence and testimony as part of the review/appeals process.

3. DECISION ON REVIEW - The Claims Administrator or the Plan Administrator will make a full, fair review of the claim and give final written notice of its decision within 24 hours for urgent care claims, 15 days for pre-service claims, and 30 days for post-service claims after the request is received. The written notice on the review will include specific reasons for the decision and include reference to Plan Document provisions on which the decision was based.

4. EXTERNAL REVIEW PROCEDURE - A Covered Employee, or the Covered Employee's representative, may request an external review of the claim denial or coverage rescission. Any request for an external review must be filed with the Plan within four (4) months from the date of receipt of a notice of an adverse benefit determination or a final internal adverse benefit decision. Subject to federal law, claimants must generally exhaust their rights under the internal appeals process before an external review is permitted.

5. EXPEDITED EXTERNAL REVIEW PROCEDURE - A Covered Employee, or the Covered Employee's representative, may request an expedited external review of the claim denial or coverage rescission if:

(a) the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function;

(b) the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

6. STATEMENT OF ERISA RIGHTS - As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

A. Examine, without charge, at the Plan Administrator's office and upon written request at other specified locations, such as work establishments, all Plan Documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as details annual reports and Plan Descriptions.

B. Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

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

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Employee Benefit Plan. Those who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer 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.

If your claim is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if it finds, for example, that your claim is frivolous.

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

The right is reserved in this Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan, covering any active or covered former employee or current or future retiree, in whole or in part, at any time. Any such change or termination in benefits:

A. Will be based solely on the decision of the Plan Sponsor; and

B. May apply to all active or covered former employees, current retirees, or future retirees, as either separate groups or as one group as determined by the Plan Sponsor.

SECTION XV

NEWBORN'S and MOTHER'S HEALTH PROTECTION ACT (NMHPA)

NMHPA provides that the health plan which provides hospital coverage for childbirth cannot limit a mother's and newborn's confinement in the hospital to less than 48 hours in case of a vaginal delivery or 96 hours after a cesarean delivery.

The NMHPA minimum stay provisions may be less than stated, in instances when an attending physician or other provider, after consulting with the mother, may discharge a mother and her newborn earlier than the minimum NMHPA maternity stay. Additionally, the Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay.

SECTION XVI

WOMEN'S HEALTH and CANCER RIGHTS ACT

This Notice is required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) to inform you, as a member of the Plan, of your rights relating to coverage provided through the Plan in connection with a mastectomy. As a Plan Member, you have rights to coverage provided in a manner determined in consultation with your attending Physician for:

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

This coverage may be subject to deductible and co-payment provisions, if your Plan includes such provisions. Additional details regarding this coverage are provided in the Plan. Keep this notice for your records and call your Plan Administrator for more information.

SECTION XVII

NATIONAL MEDICAL SUPPORT NOTICE

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

SECTION XVIII

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how protected health information may be used or disclosed by the Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your protected health information, and describes your rights to access and control your protected health information.

Protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your Employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact: Georgia Pharmacy Association and The Georgia Pharmacy Association Insurance Trust, 50 Lenox Pointe, N.E., Atlanta, GA 30324, (404) 231-5074.

EFFECTIVE DATE

This Notice of Privacy Practices becomes effective on April 14, 2003.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your protected health information. We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to protected health information and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all protected health information that we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the contract holder for your member contract.

Primary Uses and Disclosures of Protected Health Information

The following is a description of how we are most likely to use and/or disclose your protected health information.

- **Payment and Health Care Operations**

  We have the right to use and disclose your protected health information for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

- **Payment**

  We will use or disclose your protected health information to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your protected health information when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was Medically Necessary.

- **Health Care Operations**

  We will use or disclose your protected health information to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your protected health information: (i) to provide you with information about one of our disease management programs; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

- **Business Associates**

  We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose protected health information, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Claims Administrator, Core Management Resources Group, Inc., which will be handling many of the functions in connection with the operation of our Group Health Plan; a retail pharmacy; and other necessary pharmacy providers.

- **Other Covered Entities**

  We may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your protected health information with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

- **Plan Sponsor**

  We may disclose your protected health information to the Plan Sponsor for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state

privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

Other Possible Uses and Disclosures of Protected Health Information

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your protected health information.

- **Required by Law**

  We may use or disclose your protected health information to the extent that federal law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

- **Public Health Activities**

  We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose protected health information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Health Oversight Activities**

  We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

- **Abuse or Neglect**

  We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your information if we believe that you have been a victim of abuse, neglect, or domestic violence.

- **Legal Proceedings**

  We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose

your protected health information in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

- **Law Enforcement**

  Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (3) it is necessary to provide evidence of a crime that occurred on our premises.

- **Coroners, Medical Examiners, Funeral Directors, and Organ Donation**

  We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

- **Research**

  We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

- **To Prevent a Serious Threat to Health or Safety**

  Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **Military Activity and National Security, Protective Services**

  Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

- **Inmates**

  If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

- **Workers' Compensation**

  We may disclose your protected health information to comply with workers'

compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- **Others Involved in Your Health Care**

  Using our best judgment, we may make your protected health information known to a family member, other Relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

  We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

  If you are not present or able to agree to these disclosures of your protected health information, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make.

- **Disclosures to the Secretary of the U.S. Department of Health and Human Services**

  We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

- **Disclosures to You**

  We are required to disclose to you most of your protected health information in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your protected health information that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

  We will disclose your protected health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose protected health information to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

  Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

YOUR RIGHTS

The following is a description of your rights with respect to your protected health information.

- **Right to Request a Restriction**

  You have the right to request a restriction on the protected health information we use or disclose about you for payment or health care operations.
  We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

  You may request a restriction by contacting us at Georgia Pharmacy Association and The Georgia Pharmacy Association Insurance Trust, 50 Lenox Pointe, N.E., Atlanta, GA 30324, (404) 231-5074.

  It is important that you direct your request for restriction to this number/address so that we can begin to process your request. Requests sent to persons or offices other than the number/address indicated might delay processing the request.

  We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

- **Right to Request Confidential Communications**

  If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

  You may request a restriction by calling/writing us at the number listed in the summary page of this Notice. It is important that you direct your request for confidential communications to this number/address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

  We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your protected health information with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger.

  We will accommodate a request for confidential communications that is reasonable and

that states that the disclosure of all or part of your protected health information could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.,* an EOB). *Unless* you have made other payment arrangements, the EOB (in which your protected health information might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within two business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, protected health information may be disclosed (such as through an Explanation of Benefits, "EOB"). Therefore, it is extremely important that you contact us at the number listed in the summary page of this Notice *as soon as* you determine that you need to restrict disclosures of your protected health information.

If you terminate your request for confidential communications, the restriction will be removed for *all* your protected health information that we hold, including protected health information that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your protected health information will endanger you.

- **Right to Inspect and Copy**

  You have the right to inspect and copy your protected health information that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

  To inspect and copy your protected health information that is contained in a designated record set, you must submit your request by calling us at the number listed in the summary page of this Notice. It is important that you call this number to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the one indicated might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

  We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact us at the number provided in this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be

reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

- **Right to Amend**

  If you believe that your protected health information is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by calling/writing. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to this number/address so that we can begin to process your request. Requests sent to persons or offices, other than the one indicated might delay processing the request.

  In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

- **Right of an Accounting**

  You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of protected health information will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

  An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

  You may request an accounting by submitting your request in writing to the Plan Administrator. It is important that you direct your request for an accounting to this address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

  Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

- **Right to a Paper Copy of This Notice**

  You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the number listed in this Notice. A copy of a complaint

form is available from this contact office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or any other ways retaliate against you for filing a complaint with the Secretary or with us.