DIXON FISHERIES
HEALTH AND WELFARE BENEFIT PLAN

Document and Summary Description

Effective: March 1, 2012

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ESTABLISHMENT OF THE PLAN
ADOPTION OF THE PLAN DOCUMENT AND SUMMARY DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Dixon Fisheries (the " Sponsor") as of March 1, 2012 hereby sets forth the provisions of the Dixon Fisheries Health and Welfare Benefit Plan (the "Plan").

Effective Date

The Plan Document is effective as of the date first set forth above, and any amendment is effective as of the date set forth in the amendment.

Adoption of the Plan Document

Dixon Fisheries, as the settler of the Plan, hereby adopts this Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA").

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

Dixon Fisheries

By: Debra Reardon

Name: DEBRA REARDON

Date: 5/22/12 Title: Office Manager

INTRODUCTION AND PURPOSE and GENERAL PLAN INFORMATION

Introduction and Purpose

Dixon Fisheries has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Participants in the Plan may be required to contribute toward their benefits.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for hospital and medical benefits. The Plan Document is maintained by Dixon Fisheries and may be inspected at any time during normal working hours by any Participant.

General Information

Name of Plan :	**Dixon Fisheries Health and Welfare Benefit Plan**
Plan Sponsor:	**Dixon Fisheries** **1807 N Main Street** **East Peoria, IL 61611** **Phone: 309-694-1457** **Fax: 309-694-0539**
Plan Administrator: **(Named Fiduciary)**	**Dixon Fisheries** **1807 N Main Street** **East Peoria, IL 61611** **Phone: 309-694-1457** **Fax: 309-694-0539**
Plan Sponsor ID No.	**37-0985018**
Source of Funding:	**Self-Funded**
Plan Status:	**Non-Grandfathered**
Applicable Law:	**ERISA**
Plan Year:	**March 1 through February 28(29)**
Plan Number:	**501**
Plan Type:	**Medical** **Prescription Drug**

Third Party Administrator:	**Group Plan Solutions Benefit Administration, a Division of Pekin Insurance** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-301-0747** **Fax: 309-478-2912** **Email: inquiry@groupplansolutions.com** **Website: www.groupplansolutions.com**
Participating Employer:	**Dixon Fisheries**
Agent for Service of Process:	**Dixon Fisheries** **Plan Administrator** **1807 N Main Street** **East Peoria, IL 61611** **Phone: 309-694-1457** **Fax: 309-694-0539**
COBRA & HIPAA Certificates:	**Group Plan Solutions Benefit Administration, a Division of Pekin Insurance** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-301-0747** **Fax: 309-478-2912** **Email: inquiry@groupplansolutions.com** **Website: www.groupplansolutions.com**
Utilization Review Agency:	**Medical Cost Management** **c/o Group Plan Solutions Benefit Administration, a Division of Pekin Insurance** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-641-5304** **Fax: 312-236-8549**
Preferred Provider Contact For Healthlink, Sagamore, And Healthy Directions (only for use when traveling)	**Group Plan Solutions Benefit Administration, a Division of Pekin Insurance** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-301-0747, ext. 2758** **Fax: 309-478-2912** **Email: inquiry@groupplansolutions.com** **Website: www.groupplansolutions.com**

Pharmacy Benefit Manager:	**Partners RX** **c/o Group Plan Solutions Benefit Administration, a Division of Pekin Insurance** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-301-0747** **Fax: 309-478-2912** **Email: inquiry@groupplansolutions.com** **Website: www.groupplansolutions.com**

Legal Entity and Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time.

Mental Health Parity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations.

Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with employee and/or employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right:

- to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents
- to make determinations in regards to issues relating to eligibility for benefits
- to decide disputes that may arise relative to a Plan Participant's rights, and
- to determine all questions of fact and law arising under the Plan.

SCHEDULE OF BENEFITS

In-Network Benefits	
Plan Year Deductible (March 1 to February 28/29)	
In-Network Individual Plan Year Deductible Amount	$ 3,000
In-Network Family Plan Year Deductible Amount	$ 9,000
In-Network Coinsurance Percentage	80%
In-Network Maximum Coinsurance Share	
Individual Maximum In-Network Coinsurance Share Amount	$ 2,000
Family Maximum In-network Coinsurance Share Amount	$ 6,000
Primary Care Evaluation & Management Copay	$ 35
Specialist Evaluation & Management Copay	$ 45
Emergency Room Copay for Charges by Hospital for Emergency Room Treatment and Emergency Room Physician for Evaluation And Management	$ 200
Preventive Care	100%
Out of Network Benefits	
Plan Year Deductible (March 1 to February 28/29)	
Out of Network Individual Plan Year Deductible Amount	$ 6,000
Out of Network Family Plan Year Deductible Amount	$18,000
Out of Network Coinsurance Percentage	60%
Out of Network Maximum Coinsurance Share	
Individual Maximum Out of Network Coinsurance Share Amount	$ 5,000
Family Maximum Out of Network Coinsurance Share Amount	$15,000
Inpatient Hospital Access Fee	$ 500
Preventive Care	Subject to Deductible and Coinsurance
Self-Injected Medication Copay (for each 30 Day Supply)	75% of cost up to $150 out of pocket for Participant , then 100%
Prescription Benefits	
Retail Pharmacy	
Generic Prescription Copay	$ 15

Preferred Brand Copay	$	30
Non-Preferred Brand Copay	$	60
Mail Order Pharmacy		
Generic Mail Order Prescription Copay	$	45
Preferred Brand Mail Order Copay	$	90
Non-Preferred Brand Mail Order Copay	$	180
Home Health Care Visit Maximum per Plan Year		60
Skilled Nursing Facility Maximum Days per Plan Year		90

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses. Please refer to the appropriate sections of the Plan Document for that information.** There are also definitions located in other sections of this Plan Document.

ADVERSE BENEFIT DETERMINATION

Means a determination by Us or our designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

APPEAL

Means a review of an adverse benefit determination by us, as required under this policy's claims and internal appeals procedures.

Once an authorized representative is appointed, we will direct all information and notification regarding the claim to the authorized representative. You will be copied on all notifications regarding decisions, unless you provide specific written direction otherwise.

AUTHORIZED REPRESENTATIVE

Means:

- a person to whom you have given express written consent to represent you in an external review, and includes your health care provider, or
- a person authorized by law to provide substituted consent for you, or
- your health care provider when you are unable to provide consent.

An Appointment of Authorized Representative form may be obtained from us. The completed form must be submitted to our third party administrator at:

Group Plan Solutions
2505 Court Street
Pekin, IL 61558
FAX # 309-478-2912
Email Address: healthclaimappeal@groupplansolutions.com

An assignment for purposes of payment does not constitute appointment of an authorized representative under these claim procedures.

BENEFIT PERIOD

The 12 month period during which deductible and coinsurance amounts apply. It begins on March 1 of a year and ends on February 28 (29) of the following year.

BEST EVIDENCE

Means evidence based on:

- randomized clinical trials; or
- if randomized clinical trials are not available, then cohort studies or case-control studies; or
- if the above-listed items are not available, then case-series; or
- if none of the above-listed items are available, then expert opinion.

CHILD, CHILDREN

Means the covered employee or covered employee's spouse's:

- natural born child
- legally adopted child who in the custody of the Participant pursuant to an interim court order of adoption vesting temporary care of the child to the covered employee or covered employee's spouse
- step child,or
- any other child that has been declared the legal responsibility of the covered employee or covered employee's spouse.

The child must be under 26 years of age.

It also means the covered employee or covered employee's spouse's child who is 26 years of age or older, if the child is incapable of self-sustaining support because of a handicapped condition. The child must have become incapable before he/she became 26 years of age.

CLAIM

Means any request for a Plan benefit or benefits made in accordance with the claim procedures. A communication regarding benefits that is not made in accordance with the claim procedures will not be treated as a claim.

CLAIMANT

Means a Participant person who makes a request for a Plan benefit or benefits in accordance with the claim and appeals procedures. Any reference to claimant in the section titled CLAIM AND APPEAL PROCEDURES also refers to an authorized representative of the Participant person.

COINSURANCE

Means the designated percentage that we will pay per Participant per benefit period in excess of any applicable deductible for covered expense. The percentages are shown on your Schedule of Benefits. The In-network coinsurance amount applies to covered services provided by a Preferred Provider. The Out of Network coinsurance amount applies to covered services provided by a Non-preferred Provider.

CONCURRENT CARE CLAIM

Means a claim where we approve an ongoing course of treatment that will be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims:

a. Where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; or
b. Where an extension is requested beyond the initially approved period of time or number of treatments.

COVERED EXPENSE

The medically necessary, regular, reasonable & customary charges for medical services and supplies that are incurred:

- By a Participant while this coverage is in force; and
- Before this coverage ends; and
- For the treatment of an illness or injury.

In determining whether an expense is a covered expense we will consider:

- The definitions, provisions, limitations and exclusions in the plan document; and
- Clinical coverage guidelines and medical policies as posted on the public website of the third party administrator; and
- Medical peer reviews and recommendations provided by nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

CUSTODIAL CARE

Care which is primarily for the purpose of meeting personal needs. It can be provided by persons without professional skills or training. Examples are help in walking, getting in and out of bed, bathing, eating, dressing, and taking medicine. Custodial care also includes supervision of the patient for safety reasons. It also includes durable medical equipment that does not treat a condition, but is used to facilitate activities of daily living, such as but not limited to hoyer lifts, electric wheelchairs, bath chairs, and raised toilet seats.

DEEMED EXHAUSTED

Means a claimant can initiate an external review because we failed to strictly adhere to the internal appeal procedure. The claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable.

DENTAL

Any care or treatment or surgery relating to the teeth or gums, including but not limited to preventative dental care, extractions, restorations, endodontics, periodontics, prosthodontics, oral surgery for any condition which is caused by or related to a problem of the teeth, medications, or any appliances which rest upon or are attached to the teeth. For the purposes of this Plan, all care, surgery, or treatment of this type will be considered dental treatment or surgery, regardless of the origin of the condition which caused the treatment or surgery.

DEPENDENT

Means the spouse and the child or children of the employee, who are not themselves covered as employees under this plan.

DOSAGE LIMIT

Means guidelines established by the RX Company restricting the dosage quantity of certain medications. Guidelines are based upon FED guidelines, plan limitations, and other industry standards. Dosage Limit guidelines are posted on the websites of the RX Company and the Third Party Administrator.

DURABLE MEDICAL EQUIPMENT

Durable medical equipment is medical equipment:

- Which is preauthorized by us;
- Is used repeatedly;
- Serves a medical purpose;
- Would not be useful to a person without an injury or illness;
- Is appropriate for treating an illness or injury in the home; and
- Is the standard model equipment that meets the patient's needs.

It includes blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, lancets, and lancing devices.

The following items are not considered durable medical equipment, and are not covered under this plan:

- Air purifiers or cleaners, air conditioners, humidifiers, dehumidifiers, vaporizers, or heaters
- Any equipment which provides comfort or convenience
- Structure or vehicle alterations, ramps, or elevators
- Whirlpools, exercise machines of any type, swimming pools, hot tubs
- Computers or communication devices
- Heating pads, heat lamps, ice bags, or coldpack pumps
- Raised toilet seats, translift chairs, tub chairs used in a tub or shower
- Duplicate equipment
- Similar types of items or equipment, or
- Expense in excess of the cost for the standard model of equipment that is attributable to purchasing a more advanced model of equipment than what is covered under this plan.

EFFECTIVE DATE

The date coverage is put in force or the date the Participant is added to this Plan.

EMERGENCY CARE

Means covered expense for services for treatment of an injury or emergency medical condition that reasonably requires the Participant to seek immediate medical care under

circumstances, or at locations which preclude the Participant from obtaining needed medical care from a Preferred Provider.

It does not mean covered expense for services provided by a non-preferred provider once a referral can be made to safely transfer the patient to the care of a preferred provider.

EMERGENCY SERVICES

Means those medical and health services provided to treat a medical condition, manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Means with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as is required to stabilize the patient.

ENROLLMENT DATE

Means the earlier of the date of enrollment of the individual in the Plan, or the first day of the waiting period of enrollment.

EQUIVALENT GENERIC DRUG

Means a drug that the RX Company has classified as safe, equivalent to, and as effective as the brand name drug that would otherwise have been prescribed.

EVALUATION AND MANAGEMENT SERVICES

Means those services properly assigned a CPT (American Medical Association Current Procedural Terminology) evaluation and management services code.

EXPERIMENTAL/INVESTIGATIONAL

Means any drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation, or treatment of an injury or illness if one or more of the following criteria apply. The drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use; or

- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
- Is subject to review and approval of an Institutional Review Board or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

It also means any service, supply, or treatment that is not commonly and customarily recognized by the physician's profession and within the United States as appropriate treatment of the patient's diagnosed illness or injury and determined to be of proven effectiveness by the appropriate National Scientific Organization related to the diagnosed illness or injury.

It also means any procedures, drugs, or devices with unproven efficacy. Unproven efficacy means that the procedures, drugs, or devices have not been used with sufficient frequency or have not achieved the requisite success rates to establish their safety and efficacy in the medical community. A procedure, drug, or device may be considered experimental/investigational for certain diagnoses and conditions, and considered established therapies for other diagnoses and conditions.

A medical treatment, procedure, drug or device that is approved through clinical trials will be considered experimental or investigational if reliable evidence shows it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its safety, efficacy, or its efficacy as compared with the standard means of treatment or diagnosis, and reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis, and/or approval has not been given by the United States Food and Drug Administration at the time it is furnished.

The fact that a procedure, drug, or device is the only available treatment for a condition will not make it eligible for coverage if it is Experimental/Investigational according to this definition.

EXTERNAL REVIEW

Means a review of an adverse benefit determination, including a final internal adverse benefit determination, under applicable federal external review procedures.

FAMILY STATUS CHANGE

A marriage, a birth, an adoption, or a child being place for adoption.

FINAL EXTERNAL REVIEW DECISION

Means a determination by an independent review organization at the conclusion of an external review.

FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

Means:

- An adverse benefit determination that has been upheld by us at completion of the Internal Appeal Procedures; or
- An adverse benefit determination for which the internal appeals procedures have been exhausted under the "deemed exhausted" rule in the Appeals procedure.

This policy provides for two levels of appeal. Completion of the second level appeal with an adverse benefit determination will result in a final internal adverse benefit determination, and will trigger the right to an external review.

FULL-TIME EMPLOYEE

Means a person employed by Dixon Fisheries on a permanent full-time basis. The person must work at least 30 hours per week.

HEALTH INSURANCE COVERAGE

Benefits consisting of medical care under any hospital or medical service Plan or certificate, hospital or medical service contract, or health maintenance organization contract offered by a health insurance issuer.

HOME HEALTH CARE

Care and treatment of a Participant under a plan of care established by his/her physician. The plan must be submitted to us in writing, and be preapproved by us. The plan of care must be reviewed at least every two months by your physician.

It consists of the medically necessary services for:

- Part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.);
- Part-time or intermittent home health aide services, which solely consist of caring for the patient, and which are provided under the supervision of a R.N. or medical social worker;
- Physical, respiratory, occupational or speech therapy;
- Nutrition counseling provided by or under the supervision of a registered dietician;
- Evaluation and development of a home health plan by a R.N., physician extender or medical social worker, when approved or requested by the primary care physician.

The home health care services must be provided or coordinated by a state-licensed or Medicare-certified home health agency or rehabilitation agency.

Up to 4 consecutive hours of care will be considered one home health care visit.

HOSPICE

An agency that provides a coordinated program of home and inpatient care for the special physical, psychological, and social needs of terminally ill persons and their families. The hospice agency must:

- Be certified or licensed as a hospice by the state in which they are operating;
- Operate under the direct supervision of a physician;
- Provide services 24 hours a day, seven days a week; and
- Maintain medical records on each patient.

HOSPICE CARE

Care and treatment provided by a hospice for a terminally ill person and the immediate family members of the person if they are covered under this Plan.

HOSPITAL

Means a place which:
- Is legally operated for the inpatient care and treatment of ill or injured persons;
- Is mainly engaged in providing medical and diagnostic services;
- Has continuous 24 hour nursing services; and
- Has a staff of one or more physicians available at all times.

It does not mean:
- A rest, nursing, or convalescent home;
- A facility or institution mainly for the treatment of alcoholics or drug addicts;
- A facility primarily affording custodial or educational care for persons suffering from mental diseases or disorders; or
- A freestanding ambulatory surgical facility that arranges for overnight stays within the facility.

ILLNESS

Any condition, disease, or sickness which causes loss and affects normal bodily function, other than a condition caused by injury.

It also means:
- A pregnancy or complication of pregnancy;
- A congenital defect or birth abnormality for a child.

IMMEDIATE FAMILY

The Participant's spouse, children, parents, brothers and sisters.

INDEPENDENT REVIEW ORGANIZATION

Means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations.

INJURY

Bodily injury caused by an accident.

IN-NETWORK

Means covered expense provided by a preferred provider.

IN-NETWORK COINSURANCE SHARE

The amount of covered expense that a participant must pay for services provided by a preferred provider in a plan year, after we have paid the coinsurance amount. In-network coinsurance share does not include:

- Any copay or deductible amounts
- Any amount the participant had to pay under the prescription medication benefit
- Any penalty for noncompliance with plan requirements
- Any out of network coinsurance share.

The in-network coinsurance share amount is shown on the Schedule of Benefits.

IN-NETWORK DEDUCTIBLE

The amount of covered expense for services provided by a preferred provider that must be incurred in a plan year by a participant before any covered expense is paid by us. It is equal to the lessor of:

- The amount specified under the In-Network Individual Deductible amount shown on the Schedule of Benefits
- The amount needed to satisfy the In-Network Family Deductible amount shown on the Schedule of Benefits.

The amount of covered expense that is incurred during the last three months of a plan year and applied to that year's In-Network Deductible for a participant will be used to reduce the In-Network Individual Deductible for that for that participant for the following plan year.

Copay, Out of Network Deductible, and prescription copay amounts will not be used to satisfy the In-Network deductible amount.

IN-NETWORK FAMILY DEDUCTIBLE

The maximum amount of deductible a covered family must pay in a plan year for services provided by preferred providers. This amount is shown on the Schedule of Benefits. The In-Network Family Deductible may be satisfied by combining all amounts applied to In-Network Individual Deductibles for the covered employee and the covered employee's dependents for the plan year. However, only covered expense that is incurred in a plan year and applied to that same plan year's In-Network Individual Deductible can be used to satisfy the In-Network Family Deductible.

IN-NETWORK INDIVIDUAL DEDUCTIBLE

The maximum amount of deductible that an individual participant must pay in a plan year for services provided by preferred providers.

INPATIENT

Means a confinement in a hospital that results in the hospital making a room and board charge. An overnight stay in an observation unit of a hospital or licensed ambulatory surgical facility will be considered an inpatient stay for pre-certification purposes.

INTENSIVE CARE

Means a separate area in a hospital for the inpatient care of patients who are critically ill which:

- Provides constant nursing care which is not usual in other rooms and wards; and
- Has special lifesaving equipment which is immediately available at all times; and
- Has at least one R.N. on duty at all times.

LATE ENROLLEE

Means an eligible employee or dependent who applies more than 30 days after:

- the date he/she became eligible under this policy, or
- a special enrollment period.

LOSS OF ELIGIBILITY OF COVERAGE

Means a loss of coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment. It also means a loss of coverage under the COBRA continuation provision he/she was covered under because the period of time allowed for coverage under COBRA has been exhausted. It does not mean loss of coverage due to failure to timely pay required contributions or premiums or loss of coverage for cause, such as fraud or intentional misrepresentation.

MAIL ORDER PRESCRIPTION COPAY AMOUNT

The amount the participant must pay for each prescription order obtained through the mail service program.

MANIPULATIVE THERAPY

Treatment consisting primarily of manipulation, heat, ultrasound, diathermy or similar types of treatment, regardless of the medical degree of the person providing the treatment.

MAXIMUM ALLOWABLE AMOUNT

Means the cost of a procedure, drug, or device that would adequately accommodate treatment of a Participant's condition.

MEDICALLY NECESSARY

Means treatment that is or will be provided for the diagnosis, evaluation, and treatment of an illness or injury and that is:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the patient's illness or injury;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting, or level of service that can safely be provided to the patient, and which cannot be omitted consistent with recognized professional standards of care; for a hospitalization, it means that safe and adequate care could not be obtained in a less comprehensive setting or level of care;

- Cost-effective compared to alternative interventions, including no intervention;
- Not experimental/investigational; The fact that a service is the only available treatment for a condition will not make it eligible for coverage if it is Experimental/Investigational according to the definition in this Plan;
- Not primarily for the convenience of the patient, the patient's family, or the provider.

The fact that a provider may prescribe, order, recommend, or approve any care or treatment does not, of itself, make any care or treatment Medically Necessary or a covered expense and does not guarantee payment.

MEDICARE

Title XVIII of the Social Security Act as amended.

MINOR

A person who is under the legal age of competence.

NEWBORN CHILD

A dependent child born to the employee while he/she is a Participant under this Plan.

NEW ENROLLEE

Means an eligible employee or dependent who applies for insurance within 30 days of his/her date of eligibility under this Plan.

NEVER EVENT

Means any occurrence on a United States list of inexcusable outcomes in a health care setting compiled by the National Quality Forum. They are defined as "adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability."

NON-PREFERRED BRAND PRESCRIPTION

Means a medication designated a non-preferred brand medication by the RX Company. A prescription's status as a non-preferred brand prescription may change at any time. A brand prescription that is not designated as a preferred brand prescription on the website of the RX Company and the third party administrator, is a non-preferred brand prescription.

NON-PREFERRED PROVIDER

Means any medical provider who has not entered into a written agreement with us or the designated Preferred Provider Organization under contract with us to provide services to our Participants at a negotiated rate. However, it does not mean a provider within 50 miles of the Participant's residence if the nearest Preferred Provider is more than 50 miles from the Participant's residence.

OUT OF NETWORK

Means covered expense provided by a non-preferred provider unless we agree to make an exception and designate the provider In-Network for a treatment episode, or a portion of a treatment episode. Our approval must be in writing.

OUT OF NETWORK COINSURANCE SHARE

The amount of covered expense that a participant must pay for services provided by a non-preferred provider in a plan year, after we have paid the coinsurance amount. Out of network coinsurance share does not include:

- Any copay or deductible amounts
- Any amount the participant had to pay under the prescription medication benefit
- Any penalty for noncompliance with plan requirements
- Any in-network coinsurance share.

The out of network coinsurance share amount is shown on the schedule of benefits.

OUT OF NETWORK DEDUCTIBLE

The amount of covered expense for services provided by a non-preferred provider that must be incurred in a plan year by a participant before any covered expense is paid by us. It is equal to the lessor of:

- The amount specified under the Out of Network Individual Deductible amount shown on the Schedule of Benefits
- The amount needed to satisfy the Out of Network Family Deductible amount shown on the Schedule of Benefits.

The amount of covered expense that is incurred during the last three months of a plan year and applied to that year's Out of Network Deductible for a participant will be used to reduce the Out of Network Individual Deductible for that participant for the following plan year.

Copay, In- Network Deductible, and prescription copay amounts will not be used to satisfy the Out of Network deductible amount.

OUT OF NETWORK FAMILY DEDUCTIBLE

The maximum amount of deductible a covered family must pay in a plan year for services provided by non-preferred providers. This amount is shown on the Schedule of Benefits. The Out of Network Family Deductible may be satisfied by combining all amounts applied to Out of Network Individual Deductibles for the covered employee and the covered employee's dependents for the plan year. However, only covered expense that is incurred in a plan year and applied to that same plan year's Out of Network Individual Deductible can be used to satisfy the Out of Network Family Deductible.

OUT OF NETWORK INDIVIDUAL DEDUCTIBLE

The maximum amount of deductible that an individual participant must pay in a plan year for services provided by non-preferred providers.

PARTICIPANT

Means any Participant employee or Participant dependent who is covered for benefits under this Plan.

PHYSICIAN

Means a practitioner of the healing arts, licensed by the state he/she practices in. He/she must be performing only those services he/she is licensed to perform.

POST-SERVICE CLAIM

Means any claim for benefit under this policy that is not a pre-service claim or an urgent care claim.

PREFERRED BRAND PRESCRIPTION

Means a prescription designated a preferred brand prescription by the RX Company. A prescription's status as a preferred brand prescription may change at any time. Preferred brand prescriptions are posted on the website of the RX Company and the third party administrator.

PREFERRED PHYSICIAN

Means a physician who is a member of the Preferred Provider Organization listed on the Participant's Summary of Benefits. It also means a physician who is a member of the preferred provider travel network listed on the back of the Participant member's identification care, if the treatment being provided is for an unexpected illness or injury while traveling outside the Participant's primary PPO service delivery area.

PREFERRED PROVIDER

Means a medical provider who has entered into a written agreement to provide services to our participants at a negotiated rate. We recommend that you verify that the provider you are using or considering is currently a preferred provider.

It also means a provider who is a member of the preferred provider travel network listed on the back of the Participant member's identification care, if the treatment being provided is for an unexpected illness or injury while traveling outside the Participant's primary PPO service delivery area.

PRESCRIPTION COPAY

The amount the participant must pay for each prescription order obtained at a retail pharmacy. It is shown on the Schedule of Benefits.

PRE-SERVICE CLAIM

Means a claim for benefits under the policy for services that are not covered under the policy unless approval in advance is obtained.

PROOF OF INCAPACITY

Medical proof that a dependent child is incapable of self-support, and solely dependent on the Participant for maintenance and support due to mental retardation or physical handicap.

PROOF OF LOSS

Consists of:

- A properly completed claim form; and
- Any other information we need to process the claim.

QUALIFYING CREDITABLE COVERAGE

Coverage by an individual under:

- A group health plan, including church or governmental plans;
- Individual or group health insurance coverage;
- Medicaid or Medicare;
- State health risk pools;
- Military sponsored health care;
- Public health benefits; or
- The Federal Employees Health Benefit Plans.

Days of creditable coverage that occur before a significant break in coverage will not be counted as qualifying creditable coverage. Days in a waiting period are not counted as creditable coverage.

QUANTITY LIMIT

Means guidelines established by the RX Company restricting the quantity of certain medications. Guidelines are based upon FED guidelines, plan limitations, and other industry standards. Quantity Limit guidelines are posted on the websites of the RX Company and the Third Party Administrator.

REGULAR, REASONABLE & CUSTOMARY

A charge for a service that is correctly billed according to standard billing practices, including but not limited to CPT guidelines, NCCI edits, CMS guidelines, UB04 guidelines, EDI guidelines, HCFA guidelines, and HCPCS guidelines.

It is the lesser of:

- The actual charge;
- What the provider will accept for the same service or supply in the absence of insurance or in the absence of a PPO agreement;
- The amount that would have been billed had the provider correctly billed the charges according to standard billing practices;
- The reasonable charges as determined by the Plan Administrator, based upon billing data provided by the company the Plan Administrator uses to determine reasonable

charges, the Reasonable & Customary percentile designated by the Plan, and any other factors deemed appropriate by the Plan Administrator;

- For durable medical equipment and similar services, the amount that the third party administrator is able to obtain the service for under any contract the third party administrator has with a vendor, but never to exceed the purchase price of an item;
- For hospital charges, it is the amount that would be billed for similar treatment by other hospitals qualified to efficiently and effectively treat the condition as determined by data obtained by the Plan;
- The amount the provider has agreed to charge under a preferred provider agreement with the Plan;
- For an urgent care visit it is the amount that would be charged for an office visit by a physician. If there is a charge for use of the facility in addition to a charge for the services of a physician, we will combine the two charges and only allow up to what a regular, reasonable, and customary fee for a comparable office visit service would have been.

It is never a:

- Charge that is incurred as a result of inefficiency or mistakes upon the part of the provider, or due to failure or recall of a medical device or implant;
- Charge that is billed as a result of a facility treating a patient in a facility when that facility is not best equipped to treat the condition;
- Charge incurred as a result of a never event;
- Charge that is incorrectly or improperly billed according to standard billing practices even if billed by a preferred provider;
- A charge for any device that is implanted in the body, when the charge for the device exceeds a markup of 200% over the invoice cost;
- Charge for services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients;

Reasonable and customary for surgery will be determined as follows for all surgical procedures by preferred and non-preferred providers:

- For multiple surgical procedures performed during the same operative session, we will allow up to 100% of the regular, reasonable, and customary amount for the first surgical procedure, 50% of the regular, reasonable, and customary amount for the second surgical procedure, and 25% of the regular, reasonable and customary amount for each additional surgical procedure;
- For charges by a physician assistant surgeon, we will allow up to 20% of the amount allowed for the primary surgical procedure, but only when an assistant is deemed medically necessary. For charges by a non-hospital based registered nurse (RN) for assisting at surgery, we will allow 10% of the amount allowed for the primary surgical procedure, but only when an assistant is deemed medically necessary.

We retain discretionary authority to determine whether service(s) and/or fee(s) are regular, reasonable, and customary.

SALARY

The basic salary of the Participant employee. It does not include commission, overtime or bonuses.

SCHEDULE OF BENEFITS

A list which states those benefits that we have decided to provide to participants.

SIGNIFICANT BREAK IN COVERAGE

A period of 63 consecutive days during all of which an individual did not have any qualifying creditable coverage. Waiting periods are not taken into account in determining if a significant break in coverage has occurred.

SKILLED NURSING FACILITY

Means a legally operated institution or a part of an institution for the treatment of inpatients. Treatment must be under the supervision of a Physician. The facility must provide 24 hour nursing service under the supervision of a R.N. It must maintain daily medical records of each patient. This definition does not include:

- a rest home or home for the elderly;
- an institution, nor a unit of an institution, used for custodial or educational care;
- an institution, nor a unit of an institution, used for the treatment of alcoholics, drug addicts, or the mentally ill.

SPOUSE

Husband or wife.

STABILIZE

Means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

STEP THERAPY

Means a program administered by the RX Company which requires a trial of certain medications before the Plan will pay for another medication. The program requires first use of the most cost effective, therapeutically effective medication before allowing other more costly medication. Authorization to progress beyond the first step medication is made by the RX Company based upon criteria determined by the RX Company. Step therapy guidelines are posted on the websites of the RX Company and the Third Party Administrator.

TERMINALLY ILL PERSON

A person who has been diagnosed by a physician as having a life expectancy of six months or less.

TOTAL DISABILITY

Continuous inability to perform any and all duties of the Participant's job. For a dependent Participant who does not work, it means inability to perform all of the normal activities of a person of the same age or sex. Total disability must be certified by a physician. The person must be receiving treatment by a physician.

TRANSPLANT CENTER OF EXCELLENCE

Means a facility which has entered into an agreement through a national organ transplant network to render approved transplant services to our Participants. The transplant center of excellence facility may or may not be located within the Participant's geographic area. A list of transplant center of excellence facilities is available from us.

URGENT CARE CLAIM

Any pre-service claim for medical care or treatment where, in the opinion of a physician with knowledge of the claimant's medical condition, a delay in determining if the service is approved under the policy could seriously jeopardize the claimant's life or health, or ability to regain maximum function.

Upon receipt of a pre-service claim, we will make a determination if it is an urgent care claim. However, if a physician with knowledge of the claimant's medical condition determines that the claim is an urgent care claim, we will treat the claim as an urgent care claim.

US, WE, OUR

Means the Plan Administrator.

YOU, YOUR

Means a Plan Participant.

ELIGIBILITY FOR COVERAGE
EFFECTIVE DATE OF COVERAGE

Eligibility for Employee Coverage

All active full-time employees of Dixon Fisheries are eligible to become covered under the plan once they have completed 30 consecutive days as a full-time employee of Dixon Fisheries.

Effective Date for Employee Coverage

An eligible employee will become covered under the Plan on the 31st day after 30 consecutive days of full-time employment if he/she submits an enrollment form within 30 days of the date he is eligible to become covered.

Eligibility for Dependent Coverage

An employee's dependents are eligible to be covered under this Plan on the earliest of the following dates:

- The date the employee becomes covered under this Plan;
- The first date the employee has an eligible dependent.

The employee must enroll any eligible dependents within 30 days of the date they are first eligible for them to become covered as a dependent under the Plan.

A person cannot be covered as both a dependent and an employee under the Plan. A dependent child cannot be covered as a dependent of more than one Employee who is covered under the Plan.

Special Enrollment Periods

For Persons Who Previously Declined Coverage

A person who previously declined coverage in writing because they were covered under another group health plan or health insurance coverage may have a 30 day special enrollment period if they lose that coverage.

The 30 day special enrollment period will begin for that person on the day the person experiences a loss of eligibility for coverage. The person must submit a special enrollment form during that time to become covered by the Plan.

Coverage will become effective on the 31st day following the 30 day special enrollment period.

Due to a Change in Family Status

A person will have a 30 day special enrollment period to apply for coverage beginning on the date a family status change occurs. The person must submit a special enrollment form during that time to become covered by the Plan. If the form is not submitted during that time, enrollment in the Plan will not occur.

In the case of a family status change due to marriage, coverage will begin on the 31st day after the 30 day special enrollment period.

In the case of a family status change due to the birth of a dependent child, coverage will begin on the child's date of birth, if the special enrollment form is form is received during the special enrollment period.

In the case of a family status change due to adoption or placement for adoption, coverage will begin on the date of the adoption or placement for adoption, if the special enrollment form is form is received during the special enrollment period.

Open Enrollment for Late Enrollees

A late enrollee will become covered under this Plan on March 1st, following the date he/she completes an enrollment form. He/she should complete the enrollment form during the February before the March 1st he/she wants to become covered person.

Qualified Medical Child Support Order

The plan administrator will enroll for immediate coverage under this Plan any alternate recipient who is the subject of a Medical Child Support Order that is a Qualified Medical Child Support Order ("QMCSO") if such an individual is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

Alternate Recipient means any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible dependent, but for purposes of the reporting and disclosure requirements under ERISA, an alternate recipient shall have the same status as a participant.

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

- Provides for child support with respect to a Participant's child or directs the participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
- Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

National Medical Support Notice or "NMSN" means a notice that contains the following information:

- Name of an issuing State agency
- Name and mailing address (if any) of an employee who is a Participant under the Plan
- Name and mailing address of one or more alternate recipients, and
- Identity of an underlying child support order.

Qualified Medical Child Support Order or "QMCSO" is a medical child support order that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or eligibile dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

- The name and last known mailing address (if any) of the Participant and the name and mailing address of each such alternate recipient covered by the order
- A reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined
- The period of coverage to which the order pertains, and
- The name of this Plan.

In addition, a NMSM shall be deemed a QMCSO if it:

- Contains the information outlined in the definition of National Medical Support Notice
- Identifies either the specific type of coverage or all available group health coverage. If the employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and Plan Administrator will assume that all are designated
- Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any)
- Specifies that the period of coverage may end for the alternate recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as qualified if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible plan participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to medical child support orders, as described in Social Security Act §1098 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

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

- Notify the Participant and each alternate recipient covered by the Order in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO, and
- Make an administrative determination if the order is a QMCSO and notify the Participant and each alternate recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
    - Whether the child is covered under the Plan, and
    - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage, and
- Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

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

- Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice, and
- Permit any alternate recipient to designate a representative for receipt of copies of the notices that are sent to the alternate recipient with respect to the Order.

TERMINATION OF COVERAGE

Termination Dates of Employee Coverage

The coverage of any Employee under this Plan will end on the earliest of the following dates:

- the date this entire Plan terminates;
- the date he/she requests coverage be terminated, as long as the request is made on or before the date requested;
- the last day of the period for which the Employee has made a contribution, if he/she fails to make a required contribution for coverage when it is due;
- the date he/she ceases to be eligible for coverage under the Plan;
- the date his/her employment is terminated; or
- immediately after an Employee or his/her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under this Plan will end on the earliest of the following dates:

- the date this entire Plan terminates;
- the date coverage for Dependents is discontinued under this Plan;
- the date the Employee's coverage under this Plan ends;
- the last day of the period for which the Employee has made a contribution, if he/she fails to make a required contribution for Dependent coverage when it is due;
- In the case of a child age 26 or older, for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest of:
    - The date of cessation of such inability;
    - The date proof of the uninterrupted continuance of such inability is not provided, including failure to submit to any requested examination;
    - The date the child is no longer dependent on the Employee for his or her support;
- The day immediately after the date such person ceases to be a Dependent as defined in this Plan, except as may be provided for in other areas of this section; or
- Immediately after an Employee or his/her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

"Michelle's Law" prohibits a group health plan from terminating coverage of a Dependent child due to a qualifying "Medically Necessary Leave of Absence" from, or other change in enrollment at, a postsecondary educational institution prior to the earliest of:

- The date that is one year after the first day of the medically necessary leave of absence; or
- The date on which such coverage would otherwise terminate under the terms of the Plan.

In order to a Medically Necessary Leave of Absence the student's leave must:

- Begin while the dependent child is suffering from a serious illness or injury;
- Be Medically Necessary; and
- Cause the Dependent child to lose student status for purposes of coverage under the terms of this plan.

The Medically Necessary Leave of Absence must be certified by the child's treating physician.

Employer Continuation Coverage

As long as contributions by the Employee continue, coverage will be continued for eligible Participants if any of the following events occurs:

- In the event of a layoff, coverage will continue for 90 days following the date of layoff;
- In the event of total disability, coverage will continue for 90 days following the last date of active employment;
- In the event of a leave of absence which does not meet the requirements of FMLA leave, coverage will continue for 30 days.

Continuation During Family and Medical Leave

In accordance with the Family and Medical Leave Act of 1993 ("FLMA"), continuation coverage under the Plan is available to Participants under certain specified conditions.

A covered employee who takes a leave of absence under applicable provisions of FMLA is entitled to continued coverage under the Plan for himself and his covered dependents. Benefits under the Plan are available to the same extent as if the Covered Employee had been actively at work during the entire leave period, subject to the following terms and conditions:

- Coverage shall cease for a Covered Employee (and his covered dependents) for the duration of the leave if at any time the Covered Employee is more than 30 days late in paying any required contribution.
- A covered employee who declines coverage during the leave or whose coverage is terminated as a result of his failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same terms as prior to taking the leave, without any qualifying period, physical examination, or exclusion of pre-existing conditions.
- If a covered employee who is a key employee does not return from leave when notified by the Employer that substantial or grievous economic injury will result from his reinstatement, the key employee's entitlement to Plan benefits continues unless and until the covered employee advises the employer that he does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.
- Any portion of the cost of coverage which had been paid by the covered employee prior to the leave, must continue to be paid by the covered employee during the leave. If the cost is raised or lowered during the leave, the covered employee shall pay the new rates. If the leave is unpaid, the covered employee and the employer shall negotiate a reasonable means for paying the covered employee's portion of the cost.
- If the employer provides a new health plan or benefits or changes the health benefits or Plan while the covered employee is on leave, the covered employee is entitled to the new or changed Plan and benefits to the same extent as if the covered employee were not on leave.
- The employer may recover its share of the cost of benefits paid during a period of unpaid leave if the covered employee fails to return to work after the covered employee's leave entitlement has been exhausted or expires, unless the reason the covered employee does not return to work is due to:
    - The continuation, recurrence, or onset of a serious health condition which would entitle the covered employee to additional leave under the FMLA, or
    - Other circumstances beyond the covered employee's control.

If a covered employee fails to return to work because of the continuation, recurrence, or onset of a serious health condition, thereby precluding the employer from recovering its share of the cost of benefits paid on the covered employee's behalf during a period of unpaid leave, the employer may require medical certification of the covered employee's or the covered dependent's serious health condition. The covered employee is required to provide medical certification within thirty days from the date of the employer's request. If the employer requests medical certification and the covered employee does not provide such certification in a timely manner, the employer may recover the costs of benefits paid during the period of unpaid leave.

Employees on Military Leave

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights apply only to employees and their dependents covered under the Plan before leaving for military service.

- The maximum period of coverage of a person under such an election shall be the lesser of:
    - The 24 month period beginning on the date on which the person's military leave begins, or
    - The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
- A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the employee's share, if any, for the coverage.
- An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not be terminated because of service. However, an exclusion may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

Certificates of Creditable Coverage

The plan generally will automatically provide a Certificate of Coverage to anyone who loses coverage in the Plan. In addition, a Certificate of Coverage will be provided upon request, at any time while the individual is covered under a plan and up to 24 months after the individual loses coverage under the Plan.

The Plan will make reasonable efforts to collect information applicable to any Dependents and to include that information on the Certificate of Coverage, but the Plan will not issue an automatic Certificate of Coverage for Dependents until the Plan has reason to know that a Dependent is no longer covered under the Plan.

AMOUNT OF BENEFIT FOR COVERED HEALTH EXPENSES

PREVENTIVE CARE

We will pay 100% of the regular, reasonable, and customary charge for covered expense incurred for preventive services, but only when provided by a preferred provider. The deductible will not apply to this benefit.

We will pay the regular, reasonable, and customary charge for covered expense incurred for preventive services when provided by a out of network provider. Our benefit will be subject to the out of network deductible, and out of network coinsurance, and out of network maximum coinsurance share.

Preventive Services means:

- Items or services with a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for the person receiving the immunization
- Preventive care and screenings provided for in the comprehensive guidelines supported by the health Resources and Services Administration for infants, children, and adolescents
- Preventive care and screenings for women as provided for by the Health Resources and Services Administration
- It includes:
    - Colorectal cancer examination and screening as recommended by the American Cancer Society
    - Shingles vaccine for Participants 60 years of age or older
    - Human papilloma virus vaccines
    - Screening mammography and clinical breast exams
    - Pap test for cervical cancer
    - Digital rectal examination and a prostate-specific antigen test
    - CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination for Participants having a family history of one or more first-degree relatives with ovarian cancer, or with clusters of women relatives with breast cancer, or a family history of nonpolyposis colorectal cancer, or a positive BRCA1 or BRCA2 mutation test.

It does not mean similar services when prescribed to monitor or diagnose a Participant who is having current symptoms or who has been diagnosed with an illness.

BENEFIT FOR COVERED EXPENSE BY A PREFERRED PROVIDER (PPO) PRIMARY CARE PHYSICIAN

We will pay 100% of the covered expense for evaluation and management services provided by a primary care PPO physician in the office or hospital, that is in excess of the primary care evaluation and management copay amount.

Before we pay any benefit for other covered expense provided by a primary care PPO physician, covered expense equal to the in-network deductible must be incurred during the Plan Year. We will then pay benefits for covered expense that is in excess of the in-network deductible at the in-network coinsurance percentage for the remainder of the Plan Year. When the amount of covered expense the Participant pays for In-network coinsurance share during a Plan Year equals the In-Network Maximum Coinsurance Share, we will then pay the covered expense for these services at 100% for the remainder of the Plan Year.

BENEFIT FOR COVERED EXPENSE BY A PREFERRED PROVIDER (PPO) SPECIALIST PHYSICIAN

We will pay 100% of the covered expense for evaluation and management services provided by a specialist PPO physician in the office or hospital, that is in excess of the specialist evaluation and management copay amount.

Before we pay any benefit for other covered expense provided by a specialist PPO physician, covered expense equal to the in-network deductible must be incurred during the Plan Year. We will then pay benefits for covered expense that is in excess of the in-network deductible at the in-network coinsurance percentage for the remainder of the Plan Year. When the amount of covered expense the Participant pays for In-network coinsurance share during a Plan Year equals the In-Network Maximum Coinsurance Share, we will then pay the covered expense for these services at 100% for the remainder of the Plan Year.

BENEFIT FOR COVERED EXPENSE PROVIDED BY OTHER PREFERRED PROVIDERS

Before we can pay any benefit for other services provided by a Preferred Provider, covered expense equal to the In-Network deductible must be incurred in a Plan Year. We will then pay benefits for covered expense provided by a Preferred Provider that are in excess of the In-Network deductible for the remainder of the Plan Year. These benefits will be paid at the In-Network coinsurance percentage shown on the Schedule of Benefits for the remainder of the Plan Year. If the amount of covered expense the Participant pays for In-network coinsurance share during a Plan Year equals the In-Network maximum Coinsurance share, we will then pay the covered expense for these services at 100% for the remainder of the Plan Year.

BENEFIT FOR COVERED EXPENSE FOR EMERGENCY SERVICES PROVIDED IN A HOSPITAL EMERGENCY ROOM

When you incur covered expense for emergency services provided in a hospital emergency room, you must pay a $200 emergency room copay amount. We will then pay the covered expense for emergency room services by the hospital at 100%, once the emergency room copay amount has been met. We will also pay the charge by a physician for emergency room evaluation and management services at 100%. Other covered expense for services incurred while being treated in the emergency room will be subject to any applicable in network deductible and in network coinsurance percentages.

BENEFIT FOR COVERED EXPENSE PROVIDED BY A NON-PREFERRED PROVIDER

When you incur covered expense for inpatient hospital services provided by a non-preferred hospital, you must pay the first $500 of covered expense. This amount must be paid each time you are admitted as an inpatient to a non-preferred provider hospital. This amount is in addition to any deductible and coinsurance share amounts.

Before we can pay any other benefits, covered expense equal to the Out of Network deductible must be incurred in a plan year. We will then pay benefits for covered expense provided by a non-preferred provider that are in excess of the Out of Network deductible for the remainder of that plan year. These benefits will be paid at the Out of Network coinsurance percentage shown on the Schedule of Benefits for the remainder of the Plan Year. When the amount of covered expense the Participant pays for Out of Network coinsurance share during a Plan Year equals the Out of Network Maximum Coinsurance share, we will then pay the covered expense for these services at 100% for the remainder of the Plan Year.

USE OF NON-PREFERED PROVIDERS

When you use a non-preferred provider:

- **The amount of payment is based upon a reduced allowable amount, and not the actual billed charge; and**
- **You may be expected to pay a larger portion of the bill, even after we have paid the percentage of eligible expense provided under the Plan.**

BENEFIT FOR EMERGENCY CARE PROVIDED BY A NON-PREFERRED PROVIDER

Emergency care provided by a non-preferred provider will be paid as if the services were provided by a preferred provider.

COVERED HEALTH EXPENSES UNDER THIS PLAN

Benefits are payable for covered expense.

Covered Expense means the medically necessary, regular, reasonable, and customary charges for medical services and supplies that are incurred:

- By a Participant while this policy is in force; and
- Before coverage ends; and
- For the treatment of an illness or injury.

In determining whether an expense is a covered expense under this Plan, we may take into consideration:

- The definitions, provisions, limitations, and exclusions in the plan, including any attachments, amendments, riders and endorsements;

- Any clinical coverage guidelines or medical policy as posted for us on the third party administrator's website;
- Medical peer reviews and recommendations provided by nationally recognized public and private organizations that review the medical effectiveness of health care services and technology.

Covered expenses are charges:

- By a hospital for:
    - Semiprivate room and board
    - Care in the Intensive Care Unit
    - Hospital services and supplies which are to be used while in the hospital
    - Emergency services in a hospital emergency room
    - Outpatient medical care and treatment
- For outpatient surgery performed in a licensed ambulatory surgical facility
- By a physician for:
    - Office visits
    - Hospital care
    - Surgical services, including postoperative care following inpatient or outpatient surgery
    - Services of an assistant surgeon when medically necessary to perform the surgery
    - Injections and medication that must be consumed at the physician's office
    - Professional pathology laboratory services which are required to physically analyze a specimen and make a diagnosis, but not for laboratory tests which do not require the physician to make a personal interpretation as in the case of automated clinical pathology tests.
- For other services and supplies for:
    - Anesthesia and its administration
    - X-rays and radiation therapy
    - Chemotherapy, or similar treatment, provided in the office, hospital, or the home, but the covered expense for chemotherapy provided through a hospital or physician's office will not exceed the regular, reasonable, and customary fees for home chemotherapy
    - Laboratory tests
    - Blood, blood plasma, and its administration
    - Ostomy supplies
    - Allergens dispensed by a physician
    - Wigs and hair prosthesis when necessary as a direct result of chemotherapy or radiation therapy, but not to exceed $250 per Participant while covered under this Plan
    - Durable medical equipment, when we have preauthorized the rental
    - Insulin, diabetic syringes and needles, and glucagon emergency kits
    - One breast prosthesis per breast or reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to produce a symmetrical appearance; replacement breast prosthesis once

every two years; three post-mastectomy surgical bras every six months, limited to the standard model
    - For treatment of physical complications of a mastectomy, including lymphedema
    - Initial purchase of artificial eyes and larynx when preapproved by us; replacement of these items when they can no longer be made to fit, subject to approval by us;
    - Crutches
    - Braces when pre-approved by us
    - The standard prosthetic limb that meets your needs as determined by us; fitting and adjusting of the limb; repair, refitting and/or replacement of a prosthetic limb as long as it has been properly maintained and not subjected to abuse or misuse, and when not covered by product warranty
    - One pair of custom-made orthotics in a plan year.
- For home health care visits not to exceed:
    - The number of visits shown on the Schedule of Benefits during one plan year, and
    - The cost for such care in an inpatient facility
- For care in a licensed skilled nursing facility when pre-approved by us, but not for longer than the number of days shown on the Schedule of Benefits during one plan year
- For hospice care when preapproved by us
- For expense incurred for outpatient physical therapy, outpatient occupational therapy, and outpatient speech therapy not to exceed a total of 50 visits for all services combined in a plan year, and only when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time
- For expense incurred for 30 days of inpatient stay in an inpatient rehabilitation facility per plan year, but only when the patient is able to participate in intensive therapy and treatment of at least 3 hours per day, and there is documented measureable improvement occurring as a result of the therapy, treatment, and stay
- For expense incurred for 36 visits for outpatient cardiac rehabilitation per plan year, but only when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time
- For expense incurred for 20 visits for outpatient pulmonary rehabilitation per plan year, but only when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time
- For expense incurred for chiropractic treatment and/or manipulative therapy, but not to exceed 10 visits in a plan year
- Local ground ambulance transportation to the nearest preferred provider hospital able to provide the care, not to exceed $1,000 per trip
- Air ambulance transportation to the nearest preferred provider hospital able to provide the care, not to exceed $10,000 per trip
- Injections for contraceptive purposes, including depo-provera and norplant
- Contraceptive devices which require a written prescription before dispensing; elective sterilization surgery
- The first pair of eyeglasses or corrective lenses following cataract surgery performed while coverage is in force for the patient under this Plan
- Expense incurred for pregnancy
- Expense incurred for a well or ill newborn, but only if dependent coverage has been added for the newborn within 30 days following the newborn's birth
- Expense incurred for the diagnosis and treatment of all mental illnesses, psychiatric conditions, and alcoholism and substance abuse, including:

    - Individual outpatient mental health or rehabilitation care visits to qualified physicians, licensed clinical psychologists or clinical social workers as may be necessary and appropriate for evaluation, short-term treatment and crisis intervention services
    - Inpatient mental health or rehabilitation care at an inpatient facility or hospital when preapproved by us
    - Diagnosis, detoxification and treatment of the medical complications of the abuse of or addiction to alcohol or drugs on either an inpatient or outpatient basis, when preapproved by us
- Expense incurred for an organ or bone marrow transplant, but only when performed at a facility designated as a transplant Center of Excellence facility by us.

BENEFIT FOR SELF-INJECTED MEDICATIONS OTHER THAN INSULIN

We will pay 75% of the covered expense for a 30 day supply of medication that is intended to be self-injected (other than insulin which is covered under the prescription medication benefit). However, you will not have to pay more than $150 for covered expense for a 30 day supply of medication that is intended to be self-injected. Once you have paid $150 in coinsurance, we will pay the rest of the cost for the 30 day supply at 100%. The medication must be approved by our case management. It must be purchased from the provider that our case management makes arrangements with.

Any amount paid as coinsurance for self-injected medications will not accumulate toward the in-network or out of network maximum coinsurance share amount.

PRESCRIPTION MEDICATION BENEFIT

The prescription benefit provides benefit for expense incurred for drugs which require a written prescription, and which are dispensed by a licensed pharmacist. The program also provides benefit for expense for insulin, syringes for administration of insulin and glucagon emergency kits, when prescribed by a physician and dispensed by a licensed pharmacist.

This prescription drug card benefit is administered by the prescription drug card company, hereafter referred to as the RX Company.

AMOUNT OF BENEFIT

The covered person must pay a prescription copay amount each time he/she places a prescription order. The amount of copay he/she must pay will vary by the type of medication purchased, and the place of purchase.

ALLOWABLE COVERED PRESCRIPTION EXPENSE

A prescription drug order is a request for each separate prescription drug, and/or each authorized refill, if ordered by a physician.

Expense incurred for a prescription drug order for the following items will be considered allowable covered prescription expense:

- Non-injectable legend drugs
- Insulin on prescription

- Disposable insulin needles/syringes
- Test strips for glucose monitors
- Glucagon emergency kits
- Tretinoin, all dosage forms (Retin-A), for individuals through the age of 25 years
- Oral contraceptives
- Compounded medication, if at least one ingredient is a legend drug
- Any other drug which, under the applicable state laws, may only be dispensed upon the written prescription of a physician or other lawful prescriber.

PRESCRIPTIONS PURCHASED AT A RETAIL PHARMACY

You may purchase a prescription drug order at a retail pharmacy, as long as the order does not exceed a 30 day supply. You must pay the prescription copay amount designated for the type of medication purchased, and then we will pay the rest of the covered expense at 100%.

- For a generic prescription, you must pay a $15 prescription copay
- For a preferred brand prescription, you must pay a $30 prescription copay
- For a non-preferred brand prescription, you must pay a $60 prescription copay.

We will not pay more than the price we have negotiated with the RX Company, less the prescription copay amount for a prescription. We will not pay the difference in charge between a brand drug and a generic drug, if the generic drug has been designated a generic equivalent.

PRESCRIPTIONS PURCHASED FROM THE MAIL SERVICE PROGRAM

Up to a 90 day supply of a medication can be obtained from the mail service program. You must pay the mail order prescription copay amount designated for the type of medication purchased, and then we will pay the rest of the covered expense at 100%.

- For a generic prescription, you must pay a $45 mail order prescription copay
- For a preferred brand prescription, you must pay a $90 mail order prescription copay
- For a non-preferred brand prescription, you must pay a $180 mail order prescription copay

We will not pay more than the price we have negotiated with the RX Company, less the mail order copay amount for a prescription. We will not pay the difference in charge between a brand drug and a generic drug, if the generic drug has been designated a generic equivalent.

HOW TO FILE A CLAIM

To file a prescription claim, present your prescription drug card information to the participating pharmacy. The pharmacist will use the information on your card to electronically submit a claim to us.

PRESCRIPTION DRUG CARD EXCLUSIONS

A prescription drug order does not include and no benefit will be payable for the following, regardless of the reason for which prescribed:

- The amount of expense for a medication that is in excess of the amount agreed upon between the RX Company and us;
- The difference between the cost of a Brand name drug and an equivalent generic drug, if the generic drug has been designated an equivalent generic drug by the RX Company;
- For duplicate prescriptions or prescriptions refilled more frequently than the prescribed dosage indicates (a prescription purchased at retail pharmacy cannot be refilled until the patient has used 75% of the medication as prescribed; a prescription purchased at mail order cannot be refilled until the patient has used 60% of the medication as prescribed);
- Any prescription drug that is not intended to be self-administered;
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, rest home, sanitarium, Skilled Nursing Facility, convalescent care facility, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- Drugs dispensed by a physician;
- Fluoride supplements, hematinics;
- Immunization agents, biological sera, blood or blood plasma;
- Injectable drugs, except insulin;
- Minerals;
- Minoxidil (Rogaine) for the treatment of alopecia;
- Nicorette (or any other drug containing nicotine or other smoking deterrent medications);
- Anorexiants (any drugs used for purposes of weight control);
- Non-legend drugs other than insulin;
- Tretinoin, all dosage forms (Retin-A), for individuals 26 years of age or older;
- Vitamins, singly or in combination, except for legend prenatal vitamins;
- Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed under Allowable Covered Prescription Expense;
- Charges for the administration or injection of any drug;
- Prescriptions which an eligible person is entitled to receive without charge under any Worker's Compensation law;
- Drugs labeled "Caution-limited by federal laws to investigational use", or experimental/investigational drugs, even though a charge is made to the individual;
- Any prescription that is not compliant with the RX Company's recommended guidelines for Dosage Limits, Quantity Limits, and Step Therapy;
- Any charge for more than a 30 day supply of a prescription drug at a retail pharmacy;
- Any charge for more than a 90 day supply of a prescription drug at the mail order pharmacy;
- For prescriptions refilled in excess of the number ordered by the physician;
- For prescriptions refilled after one year from the physician's original order;
- for prescriptions to replace lost or damaged prescriptions;
- For prescriptions for the treatment of infertility or in vitro fertilization.

- For oral antihistamines.

PRE-EXISTING CONDITION LIMITATION

Any expense incurred for treatment of a pre-existing condition during a Participant's first 12 months of coverage under this plan will not be considered a covered expense. We begin counting the 12 month period from the enrollment date. The 12 month period will be reduced by the number of days of qualifying creditable coverage the Participant has as of the enrollment date.

Pre-existing condition means any illness or injury, whether physical or mental, for which medical advice, care, or treatment was recommended for or received by the Participant within the six month period before his/her enrollment date. However, a pregnancy will not be considered a preexisting condition.

For the purposes of this section, treatment means:

- any examination, diagnostic test, or actual treatment by a physician, which demonstrates the presence of an illness or injury, or symptoms of an illness or injury
- any medication or other service or supply dispensed in regard to an illness or injury or symptoms of an illness or injury
- any checkup or examination to determine if a previously existing illness or injury is recurring.

This provision does not apply to a Participant who is under the age of 19.

EXPENSE NOT COVERED BY THE PLAN

These exclusions apply to all health benefits of this plan.

This plan does not cover loss caused by:

- An act of war
- Service in the armed forces
- Suicide, attempted suicide, or intentionally self-inflicted injury
- Complications arising from excluded treatment
- Commission of a felony or illegal activities.

This Plan does not pay any benefit for expense for:

- Services that aren't medically necessary
- Services for which no benefit is defined or described in this Plan
- Incidental appendectomies
- Treatment of educational or training problems, learning disorders, marital counseling, or social counseling
- Services provided by an employee of a school district, or a person contracted to provide services for a school district, or services available through a school system
- Any experimental/investigational service, supply, or treatment

- The use of any services or facilities of a federal, Veteran's administration, state, county or municipal hospital, except where we or the covered person are legally required to pay the expenses
- Treatment of an injury or illness caused by or resulting from an illness or injury of the covered person, if the illness or injury is recognized as a compensable loss by the provisions of any worker's compensation act, employer liability laws, occupational disease law, or any similar law of a state or federal government, or other governmental subdivision, under which the person is or could be protected on a mandatory basis, whether or not such protection is afforded; or would have been recognized had the covered person made claim within the appropriate time limits. If the worker's compensation type coverage has denied a claim, but the covered person is still pursuing coverage with the worker's compensation type coverage through a state or federal commission or agency, or other legal entity, benefits will not be payable under this Plan until the covered person certifies he/she no longer intends to pursue coverage through the worker's compensation type coverage
- Hearing aids, contact lenses, dentures
- Eye glasses except as provided under the section titled Covered Health Expenses Under This Plan
- Eye examinations for the correction of vision or fitting of glasses or contact lenses; Vision therapy or orthoptics treatment (eye exercises)
- Any dental treatment, dental surgery, or extractions, except that the policy will provide coverage for:
    - The treatment of injuries to whole natural teeth. The treatment must be performed during the first 30 days after the date of injury
    - Treatment of congenital defects and birth abnormalities, including cleft palate or cleft lip, for a child
- Any orthodontic procedure or appliance
- Treatment or surgery for temporomandibular joint disorder
- Any service or supply not recommended or approved by a licensed medical practitioner
- Any treatment or surgery that results in the improvement of appearance, except for that which is the result of breast reconstruction following a mastectomy, or treatment of congenital defects and birth abnormalities, including cleft lip or cleft palate repair, or which is the result of an injury. The treatment must be performed during the first 12 months after the date of injury
- Services or supplies that are not for the diagnosis or treatment of an existing illness or injury, except as provided under the section titled "Preventive Care"
- Immunizations or vaccinations, including Synagis or similar immunization agents, except as provided under the section titled "Preventive Care"
- Abortions, except where the mother's life is threatened
- Reversal of sterilization procedures
- Nonmedical services and supplies
- Durable medical equipment unless we have preauthorized the rental of the equipment
- Any service or supply that the covered person is not legally required to pay for, including any forgiveness of deductible, copay, or coinsurance by a provider or any write off of an outstanding balance by a provider
- Any surgery for the correction of a refractive error
- Treatment received in an emergency room of a hospital except when emergency services are being rendered
- The replacement of a piece of durable medical equipment or a prosthesis, unless we approve the replacement; under no circumstances will these items be covered if replacement is due to the desire to upgrade to a newer design or model;

- Custodial care
- Services furnished by the employee or a member of his/her or his/her spouse's immediate family, or by a person who regularly lives in his/her home
- Any medical treatment, surgical procedure, weight reduction program, membership dues, or clinic fees for the treatment of obesity or morbid obesity, except where we determine them to be medically necessary
- Treatment related to the restoration of fertility or promotion of conception including in vitro fertilization
- Fetal treatment
- Any surgical procedure to remove excess tissue caused by weight loss
- Nutritional supplements
- Animal to human organ transplants
- Replacement of human organs by artificial or mechanical devices
- Treatment of nicotine, caffeine, gambling, computer or similar addictions
- Services provided by a midwife, except where specifically licensed by the state to practice midwifery
- By a registered nurse (RN) for private duty professional nursing services
- Sclerotherapy for varicose veins
- Sex transformation procedures, treatments, or studies
- Devices used specifically as safety items or to affect performance primarily in sports-related activities
- Medical or surgical treatment of upper or lower jaw alignment conditions or malformations, including orthognathic surgery, expect for direct treatment of acute traumatic injury or cancer
- Wigs or hair prosthesis, except as provided under the section titled "Covered Health Expenses Under the Plan"
- Routine foot care related to corns, calluses, flat feet, fallen arches, weak feet, or chronic foot strain, except that routine foot care for patients with diabetes will be covered;
- Physical conditioning programs such as athletic training, body-building exercises, fitness and flexibility programs
- Physical therapy, occupational therapy, manipulative therapy, or speech therapy services if an expectation for practical improvement in the level of functioning within a reasonable period of time does not exist
- Any charge for therapy where the same equipment could be utilized at a health club or gym
- Physical therapy, occupational therapy, manipulative therapy, or speech therapy when the service being provided is supervised exercise, or when the service being provided does not require a licensed physician to be performed
- The services of a massage therapist, athletic trainer, or masseuse; acupuncture or acupressure treatment
- Ambulance usage when another type of transportation or another level of ambulance service could have been used without endangering the patient's health
- Any charge that does not meet the definition of regular, reasonable and customary for an otherwise covered expense
- Any implantable device when we have not been provided the actual invoice for the device by the provider
- Any charge for a service that exceeds the maximum allowable amount
- Care required while incarcerated in a federal, state or local penal institution or while in custody of federal, state, or local law enforcement authorities, unless otherwise required by law or regulation
- Court ordered testing or care unless medically necessary or unless otherwise required by law or regulation

- Surrogate parenting
- Breast reduction surgery, except when performed in conjunction with reconstructive surgery following a mastectomy
- Treatment performed outside the United States, except when an emergency
- Removal of breast implants that were implanted solely for cosmetic reasons
- Growth hormone treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to growth hormone deficiency, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AID wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the covered person's condition
- Self-injected prescription medications, except when pre-approved by us
- Removal and/or replacement of a defective or recalled implant or device, or expense incurred as a result of medical malpractice
- Expense that exceeds any maximum allowable amount
- Any oral medication intended to be self-administered except as may be provided under the Prescription Medication Benefit
- The pathology professional component fee for automated clinical pathology tests
- An organ transplant at a provider other than a organ transplant Center of Excellence.

PRE-CERTIFICATION OF SERVICES

In addition to requiring preapproval for many services, this Plan includes a utilization review program. The purpose of this program is to:

- Promote the efficient utilization of quality health care services;
- Assure the patient and payer that health care benefits are used for quality, medically necessary services
- Assure that all services are provided in the most cost effective, appropriate setting, and
- Minimize the risk of retrospective payment denials.

SERVICES REQUIRING PRE-CERTIFICATION BY UTILIZATION REVIEW

You must call the Pre-certification Hotline if:

- You are being admitted as an inpatient to a hospital or skilled nursing facility;
- You are going to have surgery performed outside of your primary care physician's office
- You are having a non-emergency outpatient MRI, CT, or PET scanning procedure.

Non-Emergency Hospitalization, Surgeries, and Procedures

You must call the Pre-Certification Hotline at least 10 days before you are scheduled for a non-emergency hospital or skilled nursing facility inpatient admission, surgery, or scanning procedure.

Medical Emergency

You must call the Pre-Certification Hotline within one business day (or as soon as reasonably possible if your condition prevents you from calling within that time frame) after your emergency admission, or surgery.

Making the Call

You can make the phone call, or you can have a relative or your physician make the phone call. However, you are responsible for making sure that someone calls the Pre-Certification Hotline on a timely basis.

When the call is made, the following information should be available:

- The patient's name, date of birth, sex, and the member number and plan name
- The proposed (or actual) date and reason for admission, surgery, or scanning procedure
- The name and phone number for the hospital, skilled nursing facility, scanning facility and ordering physician.

Pre-certification Process

When a call is made to the Pre-Certification Hotline, the caller will be given a pre-certification number. A review determination will be made to verify medical necessity and appropriateness only.

The pre-certification process does not confirm that a provider is a PPO provider. It does not guarantee benefits for a service. If a covered person wants to know if a service approved

by pre-certification will be covered under the plan, or if a provider is in-network, they must call the phone number for Group Plan Solutions.

Medical Necessity and Appropriateness

No benefit will be payable for any hospitalization or skilled nursing facility stay, surgery, or scanning procedure if it is not approved as medically necessary and appropriate by the reviewer. The fact that a physician or another health care provider has prescribed or ordered an admission, surgery, continued stay, or scanning procedure, does not necessarily mean the stay is medically necessary or appropriate.

Right to Appeal

You or your physician may, at any time, initiate a request for reevaluation or extension of a reviewer's decision by calling the Precertification Hotline. You may also file an appeal with us.

Failure to Precertify

If you fail to precertify a service as required by this provision, then the first $500 of covered expense incurred as a result of the service will not be covered under this Plan, in addition to any medically unnecessary expense.

CASE MANAGEMENT

Your Plan requires that certain services have Case Management prior authorization. Before obtaining these services, you must receive authorization from our case management nurse. Services requiring case management authorization are:

- Durable medical equipment
- Injectable medications (except for insulin and its administration) whether taken at home or administered in a physician's office
- Home health care
- Orthotics, prosthetics
- Most medical supplies
- Skilled nursing stays
- Hospice care
- Insulin pumps, diabetic supplies, ostomy supplies
- Purchase, refitting, or replacement of prosthetic devices
- CPAP or similar machines, oxygen equipment.

If a Participant is faced with a serious illness or long-term health concern, we have a registered nurse available to provide assistance to manage the person's healthcare benefits more effectively.

Upon the advice of a case management professional, we have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result can be achieved without a sacrifice to quality of care for the patient.

FILING A CLAIM
INTERNAL CLAIM AND APPEAL PROCEDURES

HOW TO FILE A CLAIM FOR BENEFIT

Except for urgent care claims, a claim for Plan benefits is made when a claimant (or authorized representative) submits a written claim for benefits to us. A claim will be treated as being received by us on the date it is received at the office of our third party administrator.

POST-SERVICE CLAIMS

Written proof of loss of a post-service claim must be filed within 90 days following receipt of a medical service, treatment, or product for which the claim is being filed, or as soon as reasonably possible. Proof of loss provided more than one year late will not be accepted unless, evidence satisfactory to us, is submitted that shows it was not reasonably possible to submit proof within the time specified.

URGENT CARE CLAIMS

Because decisions on urgent care claims must be decided more quickly than other claims, an urgent care claim for benefits may be submitted to us by telephone at 888-301-0747, by fax to 309-478-2912, or by email at inquiry@groupplansolutions.com. The claim must identify that it is an urgent care claim and include at the least the following information:

- The identity of the claimant;
- The specific medical condition or symptom; and
- A specific treatment, service or product for which approval or payment is requested.

HOW INCORRECTLY FILED CLAIMS ARE TREATED

These claim procedures will not apply to any request for benefits that is not made in accordance with these claim procedures, except:

a. In the case of an incorrectly filed pre-service claim, we will notify the claimant as soon as possible, but no later than 5 days following receipt of the claim that it was an incorrectly filed claim; and
b. In the case of an incorrectly filed urgent care claim, we will notify the claimant as soon as possible, but no later than 24 hours after we receive the incorrectly filed claim.

Notice of an incorrectly filed claim will contain an explanation that the request is not a claim, and will describe the proper procedures for filing a claim. The notice may be oral unless a written notice is specifically requested by the claimant.

TIMEFRAME FOR DECIDING INITIAL BENEFIT CLAIMS

PRE-SERVICE CLAIMS

We will make a decision on an initial pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after we receive the claim.

URGENT CARE CLAIMS

We will make a decision on an initial urgent care claim as soon as possible, taking into account the medical urgencies, but no later than 24 hours after we receive the claim.

CONCURRENT CARE EXTENSION REQUEST

If a claim is a request to extend a concurrent care decision involving an urgent care claim, and if the claim is made at least 24 hours before the end of the initially approved period of time or number of treatments, the claim will be decided within no more than 24 hours after we receive the claim. Any other request to extend a concurrent care decision will be decided under the applicable timeframes for pre-service, urgent care, or post-service claims.

CONCURRENT CARE EARLY TERMINATION

If we make a decision to reduce or terminate an initially approved course of treatment, it is an adverse benefit decision that may be appealed as outlined under the section titled "BENEFIT APPEALS". We will provide the claimant with notification of our decision to reduce or terminate an initially approved course of treatment sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse decision and receive a decision on review under the procedures prior to the reduction or termination.

POST-SERVICE CLAIM

We will make a decision on an initial post-service claim within a reasonable time but no later than 30 days after we receive the claim.

PERMITTED EXTENSIONS OF TIME

Nothing prevents the claimant from voluntarily agreeing to extend the timeframe for the deciding of initial benefit claims. In addition, if we are not able to decide a pre-service or post-service claim within the above timeframes, due to matters beyond our control, one 15-day extension of the applicable timeframe is permitted. We will notify the claimant in writing of the extension prior to the end of the initial timeframe applicable to the claim. Our extension notice will include a description of the matters beyond our control that justify the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

INCOMPLETE CLAIMS

If any information needed to process a claim is missing, the claim will be treated as an incomplete claim.

INCOMPLETE URGENT CARE CLAIMS

If an urgent care claim is incomplete, we will notify the claimant as soon as possible, but no later than 24 hours after we receive the incomplete claim. The notification may be made orally to the claimant, unless the claimant requests written notice. The notice will describe the information necessary to complete the claim and will specify a reasonable time, but not less than 48 hours, within which the claim must be completed. We will make a decision on the claim as soon as possible, but not later than 24 hours after we receive the completed claim.

OTHER INCOMPLETE CLAIMS

If a pre-service or post-service claim is incomplete, we may deny the claim or may take an extension of time, as described above. If we take an extension of time, we will send an extension of time notice that will list the missing information and specify a timeframe of not less than 45 days in which the necessary information must be provided. The timeframe for deciding the claim will be suspended from the date the claimant receives the extension notice until the date the missing necessary information is provided to us. If the requested information is provided, we will decide the claim within the extended period outlined in the extension notice. If the requested information is not provided within the time specified, we may decide the claim without that information.

NOTIFICATION OF AN INITIAL BENEFIT DECISION

PRE-SERVICE AND URGENT CARE CLAIMS

We will provide written notification of our decision on a pre-service or urgent care claim whether or not the decision is an adverse benefit determination.

NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION

Written notification of an adverse benefit determination will be provided to the claimant and will contain the following information:

- The specific reason for the decision;
- Reference to the specific policy provision on which the decision is based;
- A description of any additional material or information necessary to perfect the claim and why such information is necessary;
- A description of the Plan procedures and time limits for appeal of the decision, and the right to obtain information about those procedures and the right to sue in federal court;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- If the decision involves a scientific or clinical judgment, either:
    - An explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances; or
    - A statement that such explanation will be provided at no charge upon request; and

- In the case of an urgent care claim, an explanation of the expedited review methods available for such claims.

Notification of an adverse benefit determination on an urgent care claim may first be provided orally, but written notification will be furnished not later than three days after the oral notice.

YOUR RIGHT TO INTERNAL APPEALS

You are entitled to a full and fair review of any claim. You can appeal an adverse benefit determination under these claim procedures. You have the right to two internal appeals for each adverse benefit determination.

HOW TO FILE YOUR APPEAL FOR AN URGENT CARE CLAIM

Because urgent care claims have a shortened period of time to be decided, an urgent care appeal may be submitted to us by telephone at 888-301-0747, by fax to 309-478-2912, or by email at inquiry@groupplansolutions.com.

The appeal should include at least the following information:

- The identity of the claimant;
- A specific medical condition or symptom;
- A specific treatment, service or product for which approval or payment is requested; and
- Any reasons why the appeal should be processed on a more expedited basis.

HOW TO APPEAL ALL CLAIMS OTHER THAN AN URGENT CARE CLAIM

An appeal of an adverse benefit decision on a claim other than an urgent care claim is filed when a claimant submits a written Request for Review form to:

Group Plan Solutions
ATTN: Request for Appeal
2505 Court Street
Pekin, IL 61558

Request for Review forms may be obtained by contacting the Group Plan Solutions Claim Department or from our public website, www.groupplansolutions.com.

A Request for Review form will be treated as received by us on the date it is received at 2505 Court Street, Pekin, IL 61558.

A claimant has the right to submit documents, written comments, or other information in support of an appeal.

IMPORTANT APPEAL DEADLINE

The appeal of any adverse benefit decision must be filed within 180 days following the claimant's receipt of the notification of adverse benefit determination, except that the appeal of a decision by us to reduce or terminate a concurrent care claim must be filed within 30 days after the claimant receives notification of our adverse benefit determination. Failure to comply with these important deadlines may cause the claimant to forfeit any right to any further review of an adverse benefit determination under these procedures or in a court of law.

HOW YOUR APPEAL WILL BE DECIDED

When you submit an appeal, we will provide a full and fair review. Your appeal will be referred to a different individual than the person who made the initial claim decision. The person will not be a subordinate of the person who made the initial claim decision. We will follow these procedures when deciding any appeal:

- We will take into account all the information submitted by the claimant, whether or not it was presented or available at the time of the initial claim decision. We will not give deference to the initial claim decision.
- If the initial claim was denied on the grounds of a medical judgment, we will consult with a health professional with appropriate training and experience. The health care professional who is consulted on the appeal will not be the same individual who was consulted, if any, regarding the initial claim decision or a subordinate of the individual.
- If a claimant requests access to copies of all documents, records, and other information relevant to their claim for benefits, we will provide the information to the claimant free of charge. If the advice of a medical or vocational expert was obtained in connection with the initial claim decision, the names of each expert consulted will be provided if requested, regardless of whether the advice was relied on by us.
- All necessary information in connection with an urgent care appeal will be transmitted between the claimant and us by telephone, fax, or email.

TIMEFRAMES FOR DECIDING BENEFITS APPEALS

PRE-SERVICE CLAIMS

We will decide the appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after we receive the completed Request for Review form.

URGENT CARE CLAIMS

We will decide the appeal of an urgent care claim as soon as possible, but no later than 72 hours after we receive the Request for Review.

POST-SERVICE CLAIMS

We will decide the appeal of a post-service claim within a reasonable time but no later than 60 days after we receive the completed Request for Review form.

CONCURRENT CARE CLAIMS

We will decide the appeal of our decision to reduce or terminate an initially approved course of treatment for a concurrent care claim before the proposed reduction or termination takes place. For an appeal of a denial to extend any concurrent care claim, we will determine if the appeal is a pre-service, post-service, or urgent care appeal, and will handle the appeal accordingly.

NOTIFICATION OF THE APPEAL DECISION

We will provide written notification of the appeal decision to the claimant. If the appeal is an adverse benefit determination, we will provide the following information:

- The specific reason for the appeal decision
- A reference to the specific Plan provision on which the decision is based;
- Either a statement disclosing any internal rule, guidelines, protocol or similar criteria relied on in making the adverse benefit determination, or an offer to provide such information free of charge upon request;
- Information regarding the right to an external review.

RIGHT TO AN EXTERNAL REVIEW

If you have exhausted our internal grievance procedure, and the outcome of our final internal appeal is an adverse benefit determination, you may request an external review by an Independent Review Organization. Your request for an external review or an expedited external review must be made within 4 months after the date you received notice of an adverse determination or a final adverse determination. We will pay the cost for conducting the external review.

You may also request an external review if we have not provided a written decision on the appeal within 30 days after it was filed, and you or your authorized representative have not agreed to a longer period of time for us to make a decision. You may also request an external review if we notify you that we have waived the requirement that you exhaust the internal appeals procedure.

REQUESTING AN EXTERNAL REVIEW

All requests for external review must be made in writing to:

Group Plan Solutions
ATTN: Request for External Review
2505 Court Street
Pekin, IL 61558

REQUESTING AN EXPEDITED EXTERNAL REVIEW

At the same time you request an internal review, You may request an expedited external review if:

- the adverse benefit determination is for an urgent care claim; or
- the final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but you have not been discharged from a facility; or
- the denial of coverage is based upon a determination that the recommended or requested health care service or treatment is experimental or investigational and your treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective is not promptly initiated.

BINDING NATURE OF EXTERNAL REVIEW DECISION

The Independent Review Organization will provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to you, your authorized representative, and to us.

An external review decision is binding upon us, except to the extent other remedies are available under applicable law. If the Independent Review Organization reverses our adverse determination or final adverse determination, we will immediately approve the coverage that was the subject of the Independent Review.

An external review decision is binding upon you, except to the extent other remedies are available under applicable federal or State law.

You may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which you have already received an external review decision.

MEDICARE AS PRIMARY PAYER

When Medicare is primary payer, we will coordinate our benefits with Medicare in accordance with the "Coordination of Benefits" provision in this Plan.

If a covered person is eligible for Medicare as primary payer, but does not enroll or apply for it on time, we will estimate what Medicare would have paid if the covered person had made timely application.

We will determine if Medicare is primary payer based upon Medicare regulations and the status of the Participant on the date a covered expense is incurred.

COORDINATION OF BENEFITS

If a Participant has medical or dental coverage under another group-type plan, we will coordinate our benefits with those of that plan. One plan is primary. One plan is secondary. The primary plan pays its regular benefits. The secondary plan pays a reduced amount, which when added to the benefits paid by the primary plan, will normally equal 100% of the allowable expense. The benefits payable under the secondary plan cannot exceed the benefit that would be payable if there was no other group-type plan.

RULES FOR ORDER OF PAYMENT

The primary plan is:

- The plan which does not coordinate its benefits with any other plan.
- The plan which covers the person as an employee or student, rather than as a dependent. However, if a person is also a Medicare beneficiary, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent, for example a retired employee.
- The plan of the parent whose birthday (excluding year of birth) occurs earlier in a calendar year, if both parents are living together. If both parents have the same birthday, the plan that has covered a parent the longest is primary. If the other plan does not have this provision in their policy, then the plan which covers the father as an employee will be primary, rather than the plan which covers the mother as an employee.
- The plan of the parent with custody of the child, if the parents are divorced or separated. The secondary plan will be the plan of the spouse of the parent with custody. The final plan will be the plan of the parent without custody.
- If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, then the plan of the parent who has responsibility will be primary over the other parent or stepparent's plan. This provision does not apply until we have been informed of the terms of the court decree. Any benefits paid prior to our knowledge of the terms of the court decree will be subject to the other sections of this provision.
- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, then the plan of the parent whose birthday occurs earlier in the calendar year is primary.
- The plan which covers a person as an active employee, rather than the plan which covers the person as a laid-off or retired employee. The primary plan is the plan which covers the person as a dependent of an active employee, rather than the plan which covers the person as a dependent of a laid-off or retired employee.

- The plan which covers the person as an employee, or the dependent of an employee, rather than the plan which covers the person under any continuation coverage. If the other plan does not have a rule regarding continuation coverage, and as a result, the plans do not agree on which plan is primary, then this rule will be ignored.
- If none of the above rules apply, then the plan which has covered the Participant the longest is the primary plan. The length of time a person has been covered under a plan is measured from the claimant's first date of continuous coverage under the Plan.

REIMBURSING THE OTHER PLAN

If another plan has paid their benefit in error according to this provision, we can make payment directly to them to satisfy the intent of this provision. Any payment made by us for this reason will fully discharge us of any liability under this plan.

HEALTH INSURANCE CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under certain circumstances, you have the right to temporarily extend your health coverage under this plan under a federal continuation provision called COBRA. COBRA continuation coverage is a continuation of health coverage when coverage would otherwise end because of a life event known as a "qualifying event". After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if coverage under this plan is lost because of a qualifying event.

The health coverage that will be extended is the same coverage that is provided to active covered employees.

Qualified beneficiaries who elect COBRA continuation coverage must pay the premiums for COBRA continuation coverage.

WHEN YOU BECOME A QUALIFIED BENEFICIARY

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under this plan because of one of the following qualifying events:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct.

If you are the covered spouse of an employee, you will become a qualified beneficiary if you lose your coverage under this plan because any of the following qualifying events happens:

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reason other than his/her gross misconduct
- Your spouse becomes entitled to Medicare benefits under Part A, Part B, or both
- You become divorced or legally separated from your spouse.

A covered dependent child will become a qualified beneficiary if he/she loses coverage under this plan because any of the following qualifying events happens:

- The covered employee parent dies
- The covered employee parent's hours of employment are reduced
- The covered employee parent's employment ends for any reason other than his/her gross misconduct
- The covered employee parent becomes entitled to Medicare benefits under Part A, Part B, or both
- The parents become divorced or legally separated
- The child no longer meets the definition of a dependent child under this plan.

WHEN IS COBRA COVERAGE AVAILABLE?

We, or our designated representative, will notify you of your right to continue coverage under COBRA once we have been notified that a qualifying event has occurred. We will be aware when the qualifying event is end of employment or reduction of hours of employment, death of the employee.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For all other qualifying events, you must notify us, or our designated representative, in writing of the qualifying event within 60 days after the event occurs. If we, or our

designated representative, are not notified within this time frame, COBRA continuation cannot be offered. In order to take advantage of the disability extension, you must also notify us within sixty days of a determination by Social Security that you or a dependent are disabled.

OUR NOTIFICATION RESPONSIBILITIES

Once we, or our designated representative, receive notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their children.

COBRA ELECTION PERIOD

You or your dependents have the responsibility to notify us, or our designated representative, of your desire to continue coverage within sixty days from the later of the date of notification or loss of coverage. Upon acceptance, you or your dependent will be notified of any enrollment forms that must be completed. Qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date termination from the Plan would have occurred.

If a covered person decides to continue this coverage, the first premium payment is due 45 days following the date he/she returns the election form. Coverage is provided only when the full premium for the applicable period is received. The covered person must pay any premiums after that within 30 days of the date the premium is due. Premium payments must be made to us, or our designated representative. Coverage is not in force for any period for which premium is not paid.

If you or a covered dependent experience a qualifying event and do not receive a qualifying event notification in a timely fashion, you should contact us, or our designated representative, immediately.

LENGTH OF CONTINUATION

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify us in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the social security Administration determination must be provided to us within 60 days of the date of the determination and prior to the end of the 18th month of continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

PERSONS WHO CANNOT CONTINUE

A covered person cannot continue this coverage under the COBRA continuation provision if:

- They are considered a spouse under the policy due to a state law that recognizes a same sex domestic partner as a spouse.
- At the time of his/her termination, the covered person is a nonresident alien with no earned income from sources within the United States, or is the dependent of such person.

COBRA TERMINATION

Although COBRA continuation coverage has a maximum time frame, you may voluntarily terminate coverage at anytime by notifying us, or our designated representative, in advance. In addition, COBRA states that continuation coverage will end for one or more of the following reasons:

- The date the maximum continuation period has been exhausted
- The date the employer ceases to maintain any group health plan for any employee
- The date the covered person is covered by another group health plan which does not include a preexisting condition clause or which would have the preexisting condition limitation period reduced by qualifying previous coverage
- The date the covered person becomes covered by Medicare Part A and/or Part B
- The date any premium that is due is not paid within the time allowed.

A covered person's continuation under this Plan will terminate anytime this Plan is terminated.

GENERAL PROVISIONS

RIGHT TO RECEIVE AND RELEASE INFORMATION

We have the right to seek and to release any necessary information to any other insurance company, plan, or organization, for the purpose of implementing the provisions of this Plan. We can do this without consent or notice to any concerned person. Any person claiming benefits under this Plan must provide us with any necessary information to implement the Plan provisions.

RIGHT TO RECOVERY

If we made a payment in error, we can recover our payment from another plan, the Participant, or anyone else to whom we have made payment .

PHYSICAL EXAMINATIONS

We reserve the right to have a Physician of our choosing examine any Partcipant whose condition, illness or injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

AUTOPSY

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

PAYMENT OF BENEFITS

All benefits under this Plan are payable to the covered employee whose illness or injury, or whose covered dependent's illness or injury, is the basis of a claim. In the event of the death or incapacity of a covered employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan, is or was providing the care and support of such Employee.

ASSIGNMENTS

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

No participant shall at any time, either during the time in which he or she is a participant in the Plan, or following his or her termination as a participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have

assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

- In error;
- Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
- With respect to an ineligible person;
- In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
- Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

CLERICAL ERROR/DELAY

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

FRAUD

The following actions by any Participant, or a Participant's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Participant is a member:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Participant of the Plan
- Attempting to file a claim for a Participant for services which were not rendered or Drugs or other items which were not provided
- Providing false or misleading information in connection with enrollment in the Plan, or
- Providing any false or misleading information to the Plan.

HEADINGS

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

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppels against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppels. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

WRITTEN NOTICE

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic

equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Participant(s) fails to file a claim or pursue damages against:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker's compensation or other liability insurance company; or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorney's fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of a fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

EXCESS INSURANCE

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker's compensation or other liability insurance company; or
- any other source, including but not limited to crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

OBLIGATIONS

It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

- to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information, and any other requested additional information;
- to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- to not settle or release, without the prior consent of the Plan, any claim to the

extent that the Plan Participant may have against any responsible party or Coverage.

If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plans' attempt to recover such money from the Plan Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

OFFSET

Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

MINOR STATUS

In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in this Plan.

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services.

Plan Admininstrator

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

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator have maximum legal discretionary authority to:

- construe and interpret the terms and provisions of the Plan
- to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental/Investigational)
- to decide disputes which may arise relative to a Participant's rights, and
- to decide questions of Plan interpretation and those of fact relating to the Plan.

The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

- to administer the Plan in accordance with its terms
- to determine all questions of eligibility, status and coverage under the Plan
- to interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms
- to make factual findings
- to decide disputes which may arise relative to a participant's rights and/or availability of benefits
- to prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials
- to keep and maintain the Plan documents and all other records pertaining to the Plan
- to appoint and supervise a third party administrator to pay claims
- to perform all necessary reporting as required by ERISA
- to establish and communicate procedures to determine whether a medical child support order is a QMCSO
- to delegate to any person or entity such powers, duties and responsibilities as it deems appropriate, and
- to perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settler of the Plan, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents.

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

PARTICIPANT'S RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants are entitled to:

Receive Information About our Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for Pre-existing Conditions under your group health plan, if you have Creditable Coverage from another Plan.

You should be provided a Certificate of Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-existing Condition exclusion for 12 months after your Enrollment Date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without

charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof

HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Plan Participant's PHI, and inform him/her about:

- The Plan's disclosures and uses of PHI;
- The Plan Participant's privacy rights with respect to his/her PHI;
- The Plan's duties with respect to his/her PHI;
- The Plan Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
- The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

- To carry out Payment of benefits;
- For Health Care Operations;
- For Treatment purposes; or
- If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Establish safeguards for information, including security systems for data processing and storage;
- Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
- Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
- Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
- Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    - The following employees, or classes of employees, or other persons under control of the Plan
    - Sponsor, shall be given access to the PHI to be disclosed:
    - Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
    - In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for

obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Plan Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.

Other Covered Entities: The Plan may disclose PHI 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, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

- a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
- report reactions to medications or problems with products or devices regulated by

the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
- locate and notify persons of recalls of products they may be using; and
- a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by the above-listed, when required or authorized by law, or with the Plan Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

Decedents: The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.

Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

Disclosures to Plan Participants: The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a Plan Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Plan Participant's personal representative if it has a reasonable belief that the Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Plan Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Participant.

Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Plan Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Rights to Individuals

The Plan Participant has the following rights regarding PHI about him/her:

Request Restrictions: The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

Right to Receive Confidential Communication: The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests.

Copy of this Notice: The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

Accounting of Disclosures: The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years

prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Compliance Coordinator.

Access: The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Plan Participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.

Amendment: The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Plan Participant's request in certain cases, including if it is not writing or if he/she does not provide a reason for the request.

Questions or Complaints

If the Plan Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Privacy Compliance Coordinator Contact Information:

Dixon Fisheries
Plan Administrator
1807 N Main Street
East Peoria, IL 61611
Phone: 309-694-1457
Fax: 309-694-0539

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions:

"Electronic Protected Health Information" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

"Security Incidents" is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR §164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.
- Report to the Plan any security incident of which it becomes aware. Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

- Notify the individual whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.
- Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State

or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.

- Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.
- When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998
ANNUAL NOTICE TO HEALTH PLAN PARTICIPANTS

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to provide participants with notices of their rights under WHCRA, to provide certain benefits in connection with a mastectomy, and to provide other protections for participants undergoing mastectomies.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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;
- Protheseses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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

Please keep this information with your other group health plan documents. If you have any questions about the Plan's coverage of mastectomies and reconstructive surgeries, please call Group Plan Solutions at 888-301-0747.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group health plans from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth:

- following a normal vaginal delivery to less than 48 hours, and
- following a cesarean section, to less than 96 hours.

We may not require that a provider obtain authorization from us for prescribing any such length of stay. Regardless of these standards, an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, we may not:

- deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage
- provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage
- provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage
- require a mother to give birth in a hospital
- restrict benefits for any portion of a period within a hospital length of stay described in this notice.

- These benefits are subject to the plan’s regular deductible and co-pay. For further details, refer to your Summary Plan Description.