FARMERS AUTOMOBILE INSURANCE ASSOCIATION
MEDICAL AND DENTAL BENEFIT PLAN
INACTIVE PLAN

FIRST AMENDMENT

This First Amendment to the Farmers Automobile Insurance Association Medical and Dental Benefit Plan – Inactive Plan ("Plan") is made in duplicate at Pekin, Illinois, on the date noted below, by Farmers Automobile Insurance Association ("Employer").

WHEREAS, the Plan grants the Employer the right to amend the provisions of the Plan, and

WHEREAS, the Employer desires to make such amendments;

NOW, THEREFORE, the Plan is hereby amended as follows, with such amendment to be effective as of January 1, 2018:

1. The General Information Section is hereby deleted and replaced with Exhibit A attached hereto and incorporated by reference.
2. The Schedule of Medical Benefits is hereby deleted and replaced with Exhibit B attached hereto and incorporated by reference.
3. The Schedule of Dental Benefits is hereby deleted and replaced with Exhibit C attached hereto and incorporated by reference.
4. Delete Page 18 Progressive Health Network Coverage;
5. Add the following to the **"DEFINITIONS"** section:

HABILITATIVE SERVICES

Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by the Participant's treating Physician pursuant to a treatment plan to enhance a Child to function with a congenital, genetic, or early acquired disorder. A congenital or genetic disorder includes, but is not limited to, hereditary disorders. An early acquired disorder refers to a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a Child prior to that Child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Congenital, genetic, or early acquired disorder may include but are not limited to autism, Autism Spectrum Disorders, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.

MORBID OBESITY

Morbid Obesity means:

(1) A body mass index of at least thirty-five (35) kilograms per meter squared, with comorbidities or coexisting medical conditions such as cardiovascular disease,

Type 2 diabetes, cardiopulmonary disease, sleep apnea, a history of cardiomyopathy; or

(2) A body mass index of at least forty (40) kilograms per meter squared without co morbidity.

For purposes of this section, body mass index is equal to weight in kilograms divided by height in meters squared.

6. Replace the "**Termination Dates of Dependent Coverage**" with the following:

Termination Dates of Dependent Coverage

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

- The date this entire Plan terminates or with respect to a specific benefit, the date the specific benefit is terminated;
- The date coverage for Dependents and\or Surviving Dependents is discontinued under this Plan;
- The date coverage terminates under this Plan for the Covered Individual upon whom the Dependent depends for eligibility unless he/she qualifies as a Surviving Dependent;
- The period for which the Covered Individual has made a contribution, if the Covered Individual fails to make a required contribution for Dependent coverage when it is due;
- The date the Covered Individual requests coverage for a Dependent be terminated, as long as the request is made on or before the date requested;
- The date a Surviving Dependent is eligible for coverage under another group health plan or is covered by another group health plan;
- The date a Surviving Dependent enters into a Marriage or Civil Union.
- If the Surviving Dependent was receiving benefits as a Child, the date the Surviving Dependent np longer meets this Plan definition of a Child;
- 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;
- In the case of a Child age 26 or older, for whom coverage is being continued due to Total Disability, the earliest of:
    - the date of cessation of such Total Disability;
    - the date proof of the uninterrupted continuance of Total Disability is not provided, including failure to submit to any requested examination; or
- the date the Child is no longer dependent on the Covered Individual for support;
- Immediately after a Covered Individual or a Covered Individual's Covered Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information; or
- The date of the Covered Dependent's death.

If a Covered Dependent or Covered Spouse terminates from the Plan he/she is not eligible to reenroll in the Plan.

7. Add/change the following to the "**MEDICAL BENEFITS**" section:

Amount of Benefit for Covered Medical Expenses

Preventative Care

The Plan will pay 100% of the Regular, Reasonable & Customary charge for Covered Medical Expense incurred for preventive services, but only when provided by a Preferred Provider unless there is no Preferred Provider that can perform the services. Non-Preferred Provider must be Preauthorized to qualify for In-Network coverage. The deductible will not apply to this benefit.

Covered Medical Expenses

- By a physician for:
  - Office visits;
  - Hospital care;
  - Surgical services, including postoperative care following inpatient or outpatient surgery; for multiple surgical procedures performed during the same operative session, Covered Medical Expense will include 100% of the Regular, Reasonable & Customary amount for the first surgical procedure, 50% of the Regular, Reasonable & Customary amount for the second surgical procedure, and 25% of the Regular, Reasonable & Customary amount for each additional surgical procedure;
  - Services of an assistant surgeon when medically necessary to perform the surgery, but no more than 20% of the primary provider's allowable fee;
  - Injections and medication that must be consumed at the physician's office when Case Management Prior Authorization is obtained, as required by the Medical Benefit section of the Plan and outlined in the Schedule of Medical Benefits except for items excluded under Medical Benefits Limitations & Exclusions;
  - An additional surgical opinion following recommendation for elective surgery limited to one consultation and related diagnostic services by a physician (if You request, benefits will be provided for an additional consultation when the need for surgery, in Your opinion, is not resolved by the first arranged consultation);
  - Oral Surgery, as defined herein, including anesthesia and related charges;
  - Dental services rendered by a dentist or physician which are required as a result of accidental injury to the jaws, teeth, mouth, or face;
  - Professional pathology laboratory services which are required to physically analyze a specimen and make a diagnosis, including laboratory tests which do not require the physician to make a personal interpretation as in the case of automated clinical pathology tests;
  - Designated telemedicine provider Virtual Care visits;

- Non-experimental, Medically Necessary surgical treatment of Morbid Obesity when bariatric surgery is performed for the treatment of Morbid Obesity.
  Bariatric surgery is Medically Necessary for Morbid Obesity when ALL of the following medical criteria are met:
    - Completion of a comprehensive multidisciplinary bariatric evaluation proximate to surgery which would include:
        - Physical exam with surgical history with discussion of the specific procedure to be performed; and
        - Clinically appropriate lab data with diagnostics; and
        - Nutritional consultation with counseling/education, which includes a reduced calorie diet program supervised by a dietician or nutritionist; and
        - Mental health evaluation and clearance.
        - A physician's summary letter is not sufficient documentation. Documentation must include medical records documenting compliance with the physician's plan of care and the patient's progress throughout the course of treatment including medical documentation supporting body mass index (BMI) and comorbidities.

    - The Participant is over the age of 21 or if the Participant is under 21 and
        - Two (2) authorized physicians determine that the surgery is necessary to:
            - Save the life of the Participant; or
            - Restore the Participant's ability to maintain a major life activity;

          And
        - Each physician must document in the Participant's medical record the reason for the physician's determination.

  Bariatric surgery requires Case Management Prior Authorization as required by the Plan. See the Third Party Administrator website to obtain a list of covered bariatric surgeries and current clinical coverage guidelines or medical coverage policies.

- For expense incurred for visits for Phase I and Phase II outpatient cardiac rehabilitation services if a Participant has a history of any of the following: acute myocardial infarction, coronary artery bypass graft surgery, percutaneous transluminal coronary angioplasty, heart valve surgery, heart transplantation, stable angina pectoris, compensated heart failure or trans myocardial revascularization, 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. Benefits are limited to the number of visits shown on the Schedule of Medical Benefits during a six month period and must be performed at a Preferred Provider;

- Genetic molecular testing: (specific gene identification) and related counseling when both of the following requirements are met:
    - the insured is an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.)
    - the outcome of the test is expected to determine a covered course of treatment or prevention and is merely informational.

- Medically Necessary expense incurred for an organ or bone marrow transplant, but only when performed at a facility designated as a Transplant Center of Excellence facility, and Case Management Prior Authorization is obtained, as required by the Medical Benefits section of the Plan. Transplant Benefits including preauthorized organ transplants according to the following schedule:
    - Transplant Center of Excellence Facility
        - 100% of Approved Transplant Services after the Preferred Provider Deductible has been met;
        - Organ Procurement and acquisition covered in full;
        - Travel/Lodging Benefit outlined below.
    - Non - Transplant Center of Excellence Facility
        - 90% of the Covered Medical Expense in excess of the Non-Preferred Provider deductible for hospital charges, physician charges, tissue typing and other ancillary services related to the organ transplant. The Participant has to pay 10% of the first $100,000 of Covered Medical Expense for the transplant services listed above; there is no coverage after the first $100,000 of covered expenses for these services.
        - No coverage for organ procurement and acquisition;
        - No coverage for transportation and lodging.

    - Travel/Lodging Benefit for Transplants performed at Center of Excellence Facility
        - When a covered organ transplant is performed at a Transplant Center of Excellence facility, the Plan will provide:
            - Transportation for the Participant patient and one member of the Participant patient's immediate family to accompany the Participant patient to and from the Transplant Center of Excellence; and
            - Lodging at or near the Transplant Center of Excellence for the family member who accompanied the Participant patient, while the Participant is confined at the Transplant Center of Excellence.

      The Plan will authorize the transportation and lodging at no cost to the Participant patient; except that the daily maximum benefit the Plan will pay for food and lodging for the family member who accompanied the Participant is $200.00 with a total maximum of $10,000. The Plan Administrator must be provided with itemized bills for all transportation, food and lodging expenses.

8. Replace the following subsections of the **"PRESCRIPTION MEDICATION BENEFIT"** section:

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:

- Injectable and non-injectable legend drug;
- Insulin and epipens on prescription;
- Disposable insulin needles/syringes;
- Test strips for glucose monitors;
- Lancets for diabetic blood monitoring and other supplies for testing and monitoring diabetes;
- Glucagon emergency kits;
- Tretinoin, all dosage forms (Retin-A), when Medically Necessary;
- Oral contraceptives and female contraceptive devices;
- Medications ordered in conjunction with a covered Infertility Treatment plan as defined in Amount of Benefit for Covered Medical Expenses, Infertility;
- Evidenced-based preventative oral medications that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (at no Cost-Share);
- Erectile dysfunction medications but limited to 6 pills per month;
- Any drug containing nicotine or other smoking deterrent medications as required by law;
- Compound medications if at least one ingredient is a legend drug;
- Any other oral drug which, under the applicable state laws, may be only dispensed upon a written prescription of a Physician or other lawful prescriber.

Prescriptions Purchased at a Retail Pharmacy

Up to a 90 day supply of medication can be obtained from retail pharmacy for all classifications. You must pay the applicable Retail Prescription Copay amount designated for the type of medication purchased as outlined on the Schedule of Medical Benefits and the Pharmacy Benefit Managers formulary tiers, and then the Plan will pay the rest of the Covered Medical Expense at 100%. The retail Copay tiers are outlined in the Schedule of Medical Benefits. All drug classifications are determined by the Pharmacy Benefit Manager.

- The "generic prescription Copay amount" must be paid anytime You purchase a generic medication;

- The “preferred brand prescription Copay amount” must be paid anytime You purchase a preferred brand medication listed on the preferred brand medication list and for which an equivalent generic drug is not available;
- The “brand prescription Copay amount” must be paid anytime You purchase a brand medication that is not on the “preferred brand medication list” and for which an equivalent generic drug is not available;
- The “specialty prescription Copay amount” must be paid anytime You purchase a specialty medication listed on the PBMs specialty medications list.

When purchasing a qualified medication, You must pay the applicable Retail Prescription Copay according to the schedule below:

- 1 copayment for a 1 - 30 day supply;
- 2 copayments for a 31 - 60 day supply;
- 3 copayments for a 61 - 90 day supply.

The Plan will not allow more than the price the Plan has negotiated with the Pharmacy Benefit Manager for a prescription, less the prescription Copay amount for a prescription.

The Plan 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 medication can be obtained from the mail service program for all classifications. You must pay the applicable Mail Order Prescription Copay amount designated for the type of medication purchased as outlined on the Schedule of Medical Benefits and the Pharmacy Benefit Managers formulary tiers, and then the Plan will pay the rest of the Covered Medical Expense at 100%. The Copay will vary based on if the drug is Generic, Brand, Preferred Brand or Specialty. The mail order Copay tiers are outlined in the Schedule of Medical Benefits. All drug classifications are determined by the Pharmacy Benefit Manager.

- The “generic mail order prescription Copay amount” must be paid anytime You purchase a generic medication;
- The “preferred brand mail order prescription Copay amount” must be paid anytime You purchase a preferred brand medication listed on the preferred brand medication list and for which an equivalent generic drug is not available;
- The “brand prescription mail order Copay amount” must be paid anytime You purchase a brand medication that is not on the “preferred brand medication list” and for which an equivalent generic drug is not available;
- The “specialty mail order prescription Copay amount” must be paid anytime You purchase a specialty medication listed on the PBMs specialty medications list.

The Plan will not pay more than the price the Plan has negotiated with the Pharmacy Benefit Manager, less the mail order Copay amount for a prescription.

The Plan 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.

Prescription Drug Card Limitations and 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 Pharmacy Benefit Manager and the Plan Administrator;
- 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 Pharmacy Benefit Manager;
- 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);
- 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, refer to Amount of Benefit for Covered Medical Expenses, Preventative Care;
- Biological sera, blood or blood plasma;
- Minerals;
- Minoxidil (Rogaine) or other similar medications for the treatment of alopecia;
- 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 and folic acid;

- 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 a Participant 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 Except as outlined in Amount of Benefit for Covered Medical Expenses, Clinical Trials;
- Any charge for a prescription drug when the drug does not meet the step therapy requirements of the Pharmacy Benefit Manager;
- Any charge for more than a 90 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;
- Any charge for a prescription drug dosage that exceeds the Pharmacy Benefit Manager's optimum dosage limits;
- 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 except as outlined in Amount of Benefit for Covered Medical Expenses, Infertility;
- Drugs used primarily for cosmetic purposes, regardless of intended use;
- Any charge for a prescription drug that does not meet preauthorization requirements established by the Pharmacy Benefit Manager. The Plan can allow a one-month fill for a prescription drug that a Participant has been taking continuously in the past;
- Convenience packaging when the cost exceeds the cost of the drug when purchased in its normal container;
- Drugs abused or otherwise misused by a Participant;
- Most prescription and non-prescription nutritional and dietary supplements are not Covered Medical Expenses under this benefit.

9. Add the following to the **"MEDICAL BENEFITS LIMITATIONS & EXCLUSIONS**" section:

The following exclusions apply to the Medical Benefits section of this plan.

- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription;

10. Changes to **"PRECERTIFICATION OF SERVICES**" section

PRECERTIFICATION OF 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 Precertification by Utilization Review

You must call the precertification number if:

- You are being admitted as an inpatient to a Hospital or Residential Treatment Center, including observation;
- You are having a non-emergency outpatient MRI, MRA, CT, or PET scanning procedure;
- You are going to receive any of the following: day treatment and intensive outpatient services, partial hospitalization services, opiate replacement therapy, psychotherapy, diagnosis, detoxification and treatment of the medical complications of the use of or addiction to alcohol or drugs on either an inpatient or outpatient basis, and nursing services provided in the home;
- You are going to receive care for the diagnosis and treatment of Autism Spectrum Disorder(s).

Non-Emergency Hospitalization and Procedures

You must call the applicable Precertification number at least 3 business days before You are scheduled for a non-emergency inpatient admission to a Hospital, Residential Treatment Center or other facility, an inpatient surgery, a scanning procedure or Mental Health and Substance Use Disorder Condition treatments/services listed above.

Medical Emergency

You must call the Precertification number within 2 business days (or as soon as reasonably possible if Your condition prevents You from calling within that time frame) after Your emergency admission.

Pregnancy and Newborn stays

You must call the Precertification number if a Hospital stay exceeds:

- 48 hours following a vaginal delivery (not including the day of delivery); or
- 96 hours following a cesarean birth (not including the day of delivery).

Making the Call

You can make the phone call, or You can have a relative or Your Physician make the phone call. You are responsible for making sure that someone calls the applicable Precertification Number, for either a Medical Condition or a Mental Health and Substance Use Disorder condition, on a timely basis. These numbers can be found in the General Plan Information section of the Plan.

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, treatment or scanning procedure;
- the name and phone number for the hospital, facility and ordering physician.

Precertification Process

When a call is made to the Medical Condition or Mental Health and Substance Use Disorder Conditions Precertification telephone numbers found in the General Plan Information section of the Plan, the caller will be given a Precertification number. A review determination will be made to verify Medical Necessity and appropriateness only.

The Precertification process does not confirm that a provider is a Preferred Provider. It does not guarantee benefits for a service. If a Participant wants to know if a service approved by Precertification will be covered under the plan, or if a provider is a Preferred Provider, they must call the phone number for Group Plan Solutions found in the General Plan Information section of the Plan.

Medical Necessity and Appropriateness

No benefit will be payable for any hospitalization, scanning procedure or Medical Condition or Mental Health and Substance Use Disorder Conditions treatment listed above if it is not approved as Medically Necessary and appropriate by the reviewer.

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 applicable Precertification number. You may also file an appeal with the Third Party Administrator.

Failure to Precertify

If the Participant fails to Precertify any service requiring Precertification, the Participant will be responsible for a penalty equal to the first $500 of the total Covered Medical Expense for services received but in no event will the penalty exceed 50% of the total charges. The Precertification penalty does not apply to Participants that Medicare pays primary including ESRD. The Participant will also be responsible for any non-covered, medically unnecessary expenses resulting from the non-certified stay.

It is the responsibility of the Participant to ensure Precertification has been obtained.

11. Change the following in the "CASE MANAGEMENT" section:

CASE MANAGEMENT

The Medical Benefits section of Your Plan requires that certain services have Case Management Prior Authorization. Before obtaining these services, You must receive authorization from the Plan's case management nurse. Services requiring Case Management Prior Authorization are:

- Durable Medical Equipment
- Injectable medications (except for insulin and its administration) or IV Infusions whether taken at home or administered in a physician's office
- Home health care
- Customized orthotics including foot orthotics, purchase, refitting, or replacement of prosthetic devices
- Most covered medical supplies
- Skilled nursing stays
- Hospice care
- Insulin Pumps
- Ostomy supplies
- CPAP or similar machines, oxygen equipment
- Chemotherapy
- Inpatient Rehabilitation
- Transplants
- Therapy is excess of 20 visits per Calendar Year
- Specialty Physician Services by a Non-Preferred Provider
- Genetic Testing
- Infertility Treatment
- Habilitative Services
- Bariatric Surgery
- Clinical Trials
- Radiation Therapy
- Artificial eyes, limbs, or larynx
- Bone anchored Hearing aids
- Oral or dental splints and appliances

Not all services above may be covered under the Plan. Refer to the Schedule of Medical Benefits, Amount of Benefit for Covered Medical Expenses section and Medical Benefits Limitations & Exclusions section.

If a Participant is faced with a serious illness or long-term health concern, the Plan utilizes a registered nurse or case management service to provide assistance to manage the person's healthcare benefits more effectively.

Upon the advice of a case management professional, the Plan Administrator has 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.

DENTAL BENEFITS

The Plan's payment of Dental Benefits is subject to all definitions, provisions, limitations, and exclusions contained in this Plan. Dental Benefits will be payable only for Covered Dental Expenses. Benefit payments (excluding Preventative Dental Services) for a Participant in a Calendar Year will not exceed the Maximum Benefit Amount shown in the Schedule of Dental Benefits and described in the Dental Limitations & Exclusions provision. Basic and Major Dental Services will not be paid until the Calendar Year Deductible has been met.

DENTAL LIMITATIONS & EXCLUSIONS

Dental Limitations

Benefit payments (excluding Preventative Dental Services) for a Participant in a Calendar Year will not exceed the Maximum Calendar Year Benefit Amount shown on the Schedule of Dental Benefits. The maximum benefit payable for the Orthodontic Benefit is as described in the Orthodontic Benefit provision. The Maximum Calendar Year Benefit Amount and the maximum benefit for the Orthodontic Benefit are accumulated separately.

Many dental conditions can properly be treated in more than one way. In determining the benefit, the Plan will use the Regular, Reasonable & Customary Fees for the least expensive procedure that produces a professionally acceptable result.

FARMERS AUTOMOBILE INSURANCE ASSOCIATION

By: Kimberly Leonard

Its: Vice President - HR

EXHIBIT A

INTRODUCTION AND PURPOSE AND GENERAL PLAN INFORMATION

Introduction and Purpose

Farmers Automobile Insurance Association has established the Plan for the benefit of employees, in accordance with the terms and conditions described herein. Participants in the Plan may be required to contribute toward benefit coverage.

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 medical and dental benefits. The Plan Document is maintained by Farmers Automobile Insurance Association and may be inspected at any time during normal working hours by any Participant.

General Plan Information

Name of Plan:	**Farmers Automobile Insurance Association Medical and Dental Benefit Plan**
Plan Sponsor/Employer:	**Farmers Automobile Insurance Association 2505 Court Street Pekin, IL 61558 Phone: 309-346-1161**
Plan Administrator: (Named Fiduciary)	**Farmers Automobile Insurance Association 2505 Court Street Pekin, IL 61558 Phone: 309-346-1161**
Plan Sponsor ID No.	**37-0268670**
Source of Funding:	**Self-Funded**
Applicable Law:	**ERISA**
Calendar/Plan Year:	**January 1 – December 31**
Plan Number:	**508**
Plan Type:	**Welfare Plan**
Original Plan Effective Date:	**January 1, 2016**
Restatement EFFECTIVE DATE:	**January 1, 2017**

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
Precertification and Utilization Review for Medical Conditions: (Other than Mental Health and Substance Use Disorder Conditions)	**Medical Cost Management** **24-hour Precertification** **Phone: 888-641-5304**
Precertification and Utilization Review for Mental Health and Substance Use Disorder Conditions	**Precedence Managed Care** **735 Federal Street, Suite 202** **Davenport, IA 52803** **Phone: 800-361-1492**
Pharmacy Benefit Manager:	**Optum RX** **Customer Service: 844-265-1771** **For Retirees on Medicare: 877-633-4461** **Website:** www.optumrx.com
Preferred Provider Networks:	**UnityPoint Health PLUS (formerly First Choice)** **EDI# 37086** **Group Plan Solutions** **P.O. Box 21424** **Eagan, MN 55121** **Phone: 866-510-2922** **HealthLink - Open Access III** **EDI# 90001** **P.O. Box 419104** **St. Louis, MO 63141** **Phone: 800-624-2356** **PHCS** **EDI#37086** **PO Box 21424** **Eagan, MN 55121** **Phone: 888-955-7427**

	HealthEOS by Multiplan **EDI# 34080** **PO Box 6090** **Depere, WI 54115-6090** **Phone: 800-279-9776** **Travel Network:** **PHCS - Healthy Directions** **EDI# 37086** **P.O. Box 1587** **Pekin, IL 61555-1587**
COBRA Notice:	**Group Plan Solutions Benefit Administration, a Division of Pekin Insurance** **COBRA** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-301-0747** **Fax: 309-478-2912** **Email: inquiry@groupplansolutions.com** **Website:** www.groupplansolutions.com
Participating Employers:	**Farmers Automobile Insurance Association** **Tax ID: 37-0268670** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161 ext. 2451** **Pekin Insurance Company** **Tax ID: 37-6028411** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161 ext. 2451** **Pekin Life Insurance Company** **Tax ID: 37-0866596** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161 ext. 2451**
Agent for Service of Process:	**Farmers Automobile Insurance Association** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161**

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 Employer 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 Employer or to interfere with the right of the Employer 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 Participant 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.

Exhibit B

SCHEDULE OF MEDICAL BENEFITS
Effective 1/1/2018
Farmers Automobile Insurance Association Medical and Dental Benefit Plan
Inactive Plan

Calendar Year Deductible

The amount of the Covered Medical Expenses a Participant is responsible to pay each Calendar Year. The Preferred Provider and Non-Preferred Provider Calendar Year Deductibles are accumulated separately.

	Preferred Providers	Non-Preferred Providers
Individual Deductible (per Calendar Year)	$ 750	$ 1,500
Family Deductible (per Calendar Year)	$ 2,250	$ 4,500

All individual Deductible amounts will satisfy the family Deductible, but no one Participant will be required to pay more than the individual Deductible amount.

Out-of-Pocket Maximum - Medical

The maximum amount of Covered Medical Expenses (excluding prescription drug copays) a Participant must pay per Calendar Year before the Medical Benefits section of the Plan will begin to pay benefits for Covered Medical Expenses at 100% for such Calendar Year. The Preferred Provider Out-of-Pocket Maximum and Non-Preferred Provider Out-of-Pocket Maximum are accumulated separately for the calendar Year.

	Preferred Providers	Non-Preferred Providers
Individual Out of Pocket Maximum (per Calendar Year)	$ 4,000	$ 8,000
Family Out of Pocket Maximum (per Calendar Year)	$ 8,000	$16,000

Out of Pocket Maximum – Medical includes: annual medical deductible, coinsurance, office visit and emergency room copays. All individual Out-of-Pocket amounts will satisfy the family Out-of-Pocket maximum, but no one Participant will be required to pay more than the individual Out-of-Pocket amount.

Out-of-Pocket Maximum – Prescription Drug

The maximum amount of prescription drug Copays an Individual Participant must pay per Calendar Year before the Medical Benefits section of this Plan will begin to pay prescription drug card benefits at 100% for the Calendar Year is $5,000 per Individual.

Coinsurance & Benefit Maximums for Covered Medical Expenses per Participant

Preferred Provider and Non-Preferred Provider Coinsurance percentages are the percentages of Covered Medical Expenses paid by the Medical Benefits section of the Plan. Benefit Maximum is the limit on the Covered Medical Expenses that the Medical Benefits section of the Plan will pay on behalf of any Participants per Calendar Year. Expenses must be eligible under the Medical Benefits section of the Plan, Medically Necessary and the most cost-effective medically appropriate care.

<table>
<tr><th>Medical Services and Supplies</th><th>Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)</th><th>Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)</th><th>Benefit Maximum per Participant, if any</th></tr>
<tr><td>Preventative Care</td><td>100%

(Deductible Waived)</td><td>Not Covered</td><td></td></tr>
<tr><td>Provider Office Visit evaluation and management</td><td rowspan="2">$25 Copay (Deductible Waived - 80% coinsurance applies to additional services.)</td><td>60%</td><td rowspan="2"></td></tr>
<tr><td>Virtual Care Visit with designated telemedicine provider</td><td>Not Covered</td></tr>
<tr><td>Hospital Services - Inpatient

Precertification required</td><td>80%</td><td>60%</td><td></td></tr>
<tr><td>Hospital Services – Outpatient

May require Precertification – See PRECERTICATION OF SERVICES section</td><td>80%</td><td>60%</td><td></td></tr>
</table>

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Serious Mental Health Conditions – Inpatient ***Precertification required***	80%	60%	
Serious Mental Health Conditions – Outpatient	80%	60%	
Ambulatory Surgical Facility	80%	60%	
Physician & Surgeon Services	80%	60%	
Emergency Room (Copay waived if participant is admitted immediately following the emergency room visit) *No coverage for Non-Emergency Services at an Emergency Room*	80% after $75 Copay for Emergency Services	80% after $75 Copay for Emergency Services	
Skilled Nursing Facility ***Case Management Prior Authorization required.***	80%	60%	90 days per Calendar Year maximum
Emergency Ambulance Services (ground & air)	80%	80%	
Outpatient Diagnostic Tests and Laboratory Tests	80%	60%	

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Outpatient Non-Emergency High Tech Diagnostic Services. MRI, MRA, CT and PET. ***Precertification required***	80%	60%	
Outpatient Radiation and Chemotherapy ***Case Management Prior Authorization required.***	80%	60%	
Outpatient Medical Supplies including Durable Medical Equipment ***Case Management Prior Authorization required.***	80%	60%	
Maternity Services – Routine Prenatal	100% (Deductible Waived - 80% coinsurance applies to additional services.)	60%	
Maternity Services-Hospital Inpatient Confinement	80%	60%	
Inpatient Rehabilitation Services ***Case Management Prior Authorization required.***	80%	60%	

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Human Organ or Tissue Transplants ***Precertification required (inpatient) & Case Management Prior Authorization (inpatient & outpatient)***	100% (at Center of Excellence Transplant Facility)	90% of first $100,000. No coverage thereafter	Please see Covered Medical Expenses for complete benefit description.
Transplant Service Lodging and Transportation Allowance when Center of Excellence Transplant Facility is used ***Case Management Prior Authorization required.***	$200 daily maximum	Please see Covered Medical Expenses for complete benefit description.	
Substance Use Disorders – Inpatient and Partial Hospitalization ***Precertification required***	80%	60%	
Substance Use Disorders – Outpatient	80%	60%	
Hospice Care ***Case Management Prior Authorization required.***	80%	60%	

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Home Health Care ***Case Management Prior Authorization required.***	80%	60%	90 visits per Calendar Year maximum.
Temporomandibular Joint Dysfunction (TMJ) services including diagnostic and surgical treatment Oral Appliances for TMJ ***Case Management Prior Authorization required.***	80% 50% for Oral Appliances	60% 50% for Oral Appliances	TMJ benefits limited to $2,500 lifetime. Oral Appliances for TMJ limited to one every 3 years, applied to the $2,500 TMJ lifetime max.

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Oral Appliances for Teeth Grinding ***Case Management Prior Authorization required.***	50%	50%	Benefit Limit for Oral Appliances related to Teeth Grinding limited to one every 3 years and $2,500 Calendar Year maximum.
Oral Appliances for Sleep Apnea ***Case Management Prior Authorization required.***	50%	50%	Benefit Limit for Oral Appliances related to Sleep Apnea limited to one every 3 years and $2,500 Calendar Year maximum
Therapy – Physical, Occupational & Speech	80%	60%	20 visit for each therapy type per Calendar Year additional visits require ***Case Management Prior Authorization required.***

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Therapy – Manipulative (Chiropractic, Osteopathic & Naprapath). Spinal manipulation/adjustment.	$25 Copay (Deductible Waived - 80% coinsurance applies to additional services.)	60%	20 visits Calendar Year Max
Infertility Treatment ***Case Management Prior Authorization required***	80%	60%	4 completed oocytes retrievals while covered under the Medical Benefits section of the Plan
Bariatric Surgery ***Case Management Prior Authorization required***	80%	60%	Please see Covered Medical Expenses for complete benefit description.

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Cardiac Rehabilitation Services	80%	60%	36 treatments per 6 month period
Injectable Medications, administered in an office setting. ***Case Management Prior Authorization required.***	80%	60%	
Reasonable and Customary Percentile Level	95th	95th	

Retail Prescription Drugs (per drug purchased): (1 copay for 1-30 day supply, 2 copays 31-60 day supply, 3 copays 61-90 day supply).	Generic Drugs: $20 Copayment Preferred Brand Drugs: $30 Copayment Non-Preferred Brand Drugs: $50 Copayment Specialty Drugs: $100 Copayment
Mail Order Prescription Drugs (per drug purchased)	Generic Drugs: $60 Copayment Preferred Brand Drugs: $90 Copayment Non-Preferred Brand Drugs: $150 Copayment Specialty Drugs: $300 Copayment

EXHIBIT C

SCHEDULE OF DENTAL BENEFITS
Effective 1/1/2018
Farmers Automobile Insurance Association Medical and Dental Benefit Plan
Inactive Plan

Dental Expense Benefits

Maximum Benefit (per Calendar Year per Individual) Preventative Dental Services do not apply to annual Dental Maximum Benefit.	$1,400
Individual Deductible (per Calendar Year)	$ 50
Family Deductible (per Calendar Year)	$ 150*

Preventative Dental Services – Not subject to deductible, payable at 100%

Basic Dental Services - After Deductible, payable at 80%

Major Dental Services – After Deductible, payable at 50%

*All individual Deductible amounts will satisfy the family Deductible, but no one Participant will be required to pay more than the individual Deductible amount.

Note: Waiting periods and frequency/age limits may apply.

Orthodontic Treatment Benefit

Orthodontia Maximum Benefit (per lifetime per Individual**)	$1,500
Orthodontic Deductible	None
Orthodontia Coinsurance	50%

** Lifetime Orthodontic benefit amount for children under 19. Lifetime Orthodontic benefit is separate from the Calendar Year Maximum Benefit for all other Covered Dental Expenses.

NOTE: Certain services may be covered under the Medical Benefits section of this Plan. The Medical Benefits section of this Plan would pay as primary and the Dental Benefits section of this Plan would pay as secondary.