FAMILY & CHILD LEARNING CENTERS OF N.E. WISCONSIN

Employee Benefit Health and Dental Plan

Effective July 1, 2011

Administrative Services Manager:
3PAdministrators, Inc.
1113 Riders Club Road
Onalaska, WI 54650
Phone: 888-540-0094 or 608-779-3000
www.3pa.com

SUMMARY OF BENEFITS

Benefit	PPO Providers	Non-PPO Providers
Annual Maximum	$5,000,000	
Deductible	$500 Single/$1,000 Family Per Calendar Year	$1,000 Single/$2,000 Family Per Calendar Year
Coinsurance Percentage Payable	80% after Deductible of the first $5,000 of Covered Expenses per Calendar Year,100% thereafter	60% after Deductible of the first $5,000 of Covered Expenses per Calendar Year,100% thereafter
Maximum Out-of-Pocket	$1,500 Single/$3,000 Family Per Calendar Year	$3,000 Single/$6,000 Family Per Calendar Year
Physician/Clinic Office Visits	Subject to Deductible and Coinsurance	
Emergency Room	Subject to Deductible and Payable at 80%	
Urgent Care	Subject to Deductible and Coinsurance	
Physician/Clinic Other Services Including: Durable Medical Equip., Pregnancy, MRI, labs, x-rays, Hospice, etc.	Subject to Deductible and Coinsurance	
Hospital Services Inpatient/Outpatient	Subject to Deductible and Coinsurance	
Wellness/Routine Visits	First $500 paid at 100%, no Deductible Charges in excess of $500, subject to Deductible and Coinsurance	
Ambulance	Subject to Deductible and Payable at 80%	
Chiropractic Care	Subject to Deductible and Coinsurance up to 20 visits	
Home Health Care	Subject to Deductible and Coinsurance up to 40 visits per Calendar Year	
Nursing Home	Subject to Deductible and Coinsurance up to 30 days per confinement	
Outpatient physical, speech, occupational, massage & respiratory therapy	Subject to Deductible and Coinsurance up to a combined maximum of 40 visits per Calendar Year	
Prescription Drugs	Retail: $10 co-pay for generic, $20 co-pay for formulary brand name and $35 co-pay for non-formulary brand name, 34 day supply Home Delivery: $20 co-pay for generic, $40 co-pay for formulary brand name and $70 for non-formulary brand name, 90 day supply	
Mental or Nervous Conditions and Substance Abuse	Inpatient: Subject to Deductible and Coinsurance Transitional: Subject to Deductible and Coinsurance Outpatient: Subject to Deductible and Coinsurance	

This serves as a summary only. Please check the following plan document for more details.

SUMMARY OF DENTAL BENEFITS	
Annual Maximum	$1,200
Deductible	$100 per person per Lifetime
Preventative Services	Payable at 100% after Deductible
Preventative Includes:	Routine exams and cleanings – 1 visit every 6 months Bitewing x-rays – once every 6 months Full mouth or panoramic x-rays – once every 24 months Fluoride treatments for dependents under age 19 - limited to once every 12 months Sealants on molars for dependents under age 14 Emergency palliative treatment
Basic Services	Payable at 100% after Deductible
Basic Includes:	Restoration of diseased or broken teeth Oral surgery Periodontic procedures Endodontic procedures Recementing crowns and bridges
Major Services	Payable at 50% after Deductible
Major Includes:	Crowns, inlays and onlays Dentures and bridges
Orthodontics	Maximum $300 per Calendar Year and $1,200 Lifetime
Orthodontic Services	Payable at 50% after deductible. Subject to orthodontic Calendar Year and Lifetime maximums and does not apply to dental annual maximum
Orthodontics Includes:	Initial exam, x-rays, impressions, space maintainers, appliance, etc. Payment is made on the initial billing with quarterly or monthly payments on the balance. Applies to dependents under age 19
Late enrollees to the plan are not eligible for major services for the first 12 months of coverage. Pre-authorization of services is recommended for courses of treatment exceeding $500.00. All payments are subject to usual and customary reductions. This plan will pay as secondary on any procedures that are eligible through the patient's medical plan. **The above lists of services are not intended to be all inclusive.** **Please check Section 6 for more detailed information**	

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1 INTRODUCTION

THIS document HAS BEEN PREPARED to help you understand your medical benefits as a participant in YOUR EMPLOYER'S Group Health Plan ("Plan"). Please carefully read this document. The Schedule of Benefits provides an overview of your coverage. Terms that are capitalized are defined in the Definitions section or in the section in which the term is used.

Patient Protection and Affordable Care Act

This group health Plan believes this Plan is a "Grandfathered Health Plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator or to the Administrative Services Manager at the addresses shown below

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

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.

The Plan Administrator (the Employer) shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies 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 Participants rights; and to determine all questions of fact and law arising under the Plan.

You must notify the Plan Administrator as described in the Pre-Admission and Utilization Review section before receiving any care at any Qualified Treatment Facility and to obtain maximum benefits for elective admissions to a Hospital, Hospice Care Agency or Skilled Nursing Facility. You must also notify the Plan Administrator during the first trimester of a pregnancy or upon enrollment in the Plan with a pre-existing pregnancy of you or anyone receiving benefits under this Plan through you. See Section 7 for more details. You must report as soon as possible to the Plan Administrator ANY CHANGE OF ELIGIBILITY for You or for anyone receiving benefits under this Plan through you. Examples of changes of eligibility include such events as:

Total Disability
Retirement
Change of address
Medicare eligibility

Section 4 of this Plan Description provides specific details regarding eligibility/enrollment, termination and continuation of coverage.

The benefits described in this document are effective with the Plan Year beginning on July 1, 2011.

A. Specific Information About the Plan

PLAN NAME	Family & Child Learning Centers of N.E. WI, Inc. Employee Health and Dental Welfare Benefit Plan
TYPE OF PLAN	A self-funded welfare benefit plan providing certain medical and dental benefits to covered Employees. This Plan is not financed or administered by an insurance company. The Plan benefits are not guaranteed by a contract of insurance.
FUNDING	Claims under the Plan are paid from the general assets of the Employer.
PLAN EFFECTIVE DATE	July 1, 2011
GROUP NUMBER	1001
PLAN YEAR FOR GOVERNMENT REPORTING	July 1 through June 30
PLAN ADMINISTRATOR AND PLAN SPONSOR	Family & Child Learning Centers of N.E. WI, Inc. 1860 N. Stevens Street Rhinelander, WI 54501 715-369-5688
PLAN SPONSOR TIN	39-1333300
ADMINISTRATIVE SERVICES MANAGER	3PAdministrators 1113 Riders Club Road PO Box 247 Onalaska, WI 54650 608-779-3000 or 888-540-0094
AGENT FOR SERVICE OF LEGAL PROCESS	Family & Child Learning Centers of N.E. WI, Inc. 1860 N. Stevens Street Rhinelander, WI 54501

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

2 DEFINITIONS

The following words and phrases are used in this Plan and will have the meaning assigned in this section unless a different meaning is clearly required by the context or is defined within the Section.

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

Actively at Work: Actively at Work means performing on a regular full-time basis all customary occupational duties at the Employer's business establishment or another location of business when Your job requires travel. "Full-time basis means regularly working at least thirty (30) hours per week, including full-time faculty paid over 12 months. You will be deemed to be Actively-at-Work if You are absent from work due to a health factor. You will be considered Actively-at-Work if You are on a holiday or vacation that Your Employer has approved if You were Actively-at-Work on Your last regularly scheduled working day before such holiday or vacation. In no event will an Employee be considered Actively-at-Work if employment with Employer has been effectively terminated.

Administrative Services Manager: Administrative Service Manager is the person or firm employed by the Plan Administrator to provide certain services in connection with the operation of the Plan including the processing of claims. The Plan Administrator has retained 3PAdministrators, Inc. ("3PA") as the Administrative Services Manager for the Plan. The Administrative Service Manager will mean the Plan Administrator if the Plan Administrator does not employ an Administrative Service Manager.

ADA: ADA means the American Dental Association.

AHA: AHA means the American Hospital Association.

AMA: AMA means the American Medical Association.

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

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

Appliance: Appliance means any dental device other than a Prosthetic Device.

As Allowed by the Plan: As Allowed by the Plan means charges are subject to Deductible and coinsurance.

Autism Spectrum Disorder: Autism Spectrum Disorder includes autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified.

Birthing Center: A Birthing Center means a licensed facility that:

1. Provides prenatal care;
2. Provides delivery and immediate postpartum care;
3. Provides care of a child born at the birthing center;
4. Is directed by a Qualified Practitioner specializing in obstetrics and gynecology;
5. Has a Qualified Practitioner or certified nurse midwife present at all births and during the immediate postpartum period;
6. Extends Staff privileges to Qualified Practitioners who practice obstetrics and gynecology in the area;
7. Has at least two birthing rooms for use by patients during labor and delivery;
8. Has full-time skilled nursing services (directed by a RN or certified nurse midwife) in the delivery and recovery;
9. Provides diagnostic x-ray and laboratory services for the mother and newborn;
10. Has the capacity to administer a local anesthetic and perform minor surgery (including episiotomy

and repair of perineal tear);
11. Is equipped and staffed to handle medical emergencies and provide immediate life support measures;
12. Has a written agreement with an area Hospital for Emergency transfer of patients and ensures its staff is aware of the procedure;
13. Provides an ongoing quality assurance program; and
14. Keeps a medical record for each patient.

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

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

Child: Child means any of the following:
1. Your natural child under the age of 26, including any child for whom You are required to provide coverage under a Qualified Medical Child Support Order. The Child cannot have coverage available to them through their own employer.
2. A child who, before reaching age 18, was either adopted by You or placed in Your home for adoption;
3. Your unmarried child of any age who because of a physical or mental disability is incapable of sustaining his or her own financial support or independent living, if the disability began before the child attained age 26 and while covered under this Plan. Coverage may continue for as long as the child remains disabled, unmarried and wholly dependent on You for financial support (consistent with the Internal Revenue Code). The Plan may require You at any time to submit a physician's statement certifying the child's physical or mental disability;
4. Your stepchild under age 26 who does not have coverage available through their own employer.
5. A foster Child if he or she lives with You and meets the qualifications under (a) above.

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

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

Complication of Pregnancy: Complications of Pregnancy means:
1. Conditions whose diagnosis are distinct from Pregnancy, but adversely affected by Pregnancy or caused by Pregnancy. Examples of such conditions include acute nephritis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia, and miscarriage;
2. Non-elective cesarean section surgical procedure;
3. A terminated ectopic Pregnancy; or
4. A spontaneous termination of Pregnancy which occurs during a period of gestation in which a viable birth is possible.

Complications of Pregnancy do not include:

1. False Labor;
2. Occasional spotting;
3. Prescribed rest during the period of Pregnancy; or
4. Similar conditions associated with the management of a difficult Pregnancy, but not constituting a distinct complication of Pregnancy.

Confinement: Confinement means being a resident patient in a Hospital for at least 15 consecutive hours per day, or being a resident bed patient in a Convalescent Nursing Home or other Qualified Treatment Facility 24 hours per day. Successive Confinements are considered one Confinement if due to the same Injury or Sickness; and separated by fewer than 30 consecutive days when You are not confined.

Convalescent Nursing Home: A Convalescent Nursing Home is an institution, or distinct part of a nursing home that is lawfully run in the jurisdiction where it is located that maintains and provides:
1. Permanent and full-time bed care facilities for resident patients;

2. A Qualified Practitioner's services available at all times;
3. A registered nurse (RN) or Qualified Practitioner in charge and on full-time duty and one or more registered nurses (RN's) or licensed vocational or practical nurses on full-time duty; and
4. A daily record for each patient; and continuous skilled nursing care for persons during their convalescence from Sickness or Injury.

Convalescent Nursing Home also includes any institution referring to itself as a skilled nursing facility or extended care facility. A Convalescent Nursing Home is **not**, except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of drug addicts or alcoholics.

Cosmetic Surgery or Cosmetic: Cosmetic Surgery or Cosmetic means any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury or for correction of a functional disorder due to a congenital defect. Cosmetic Dentistry is any service performed to improve appearance without any dentally necessary reason.

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

Covered Person: A Covered Person is an eligible Employee and any Eligible Dependent of an Eligible Employee who has met all of the conditions for coverage under the Plan and is enrolled in the Plan.

Creditable Coverage: Creditable Coverage means prior medical coverage that an individual had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the Uniformed Services and their Dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act.

Solely for the purposes of illustration and not in limitation of the foregoing, Creditable Coverage generally includes periods of coverage under an individual or group health plan, (including Medicare, Medicaid, governmental and church plans) that are not followed by a Significant Break in Coverage and excludes coverage for liability, limited scope dental or vision benefits, specified disease and /or other supplemental-type benefit.

Custodial Care: Custodial Care means care or Confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparing special diets, assistance in walking or getting in and out of bed, supervision over medication, which can normally be self-administered, and all domestic activities.

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

1. The fee which the Qualified Practitioner most frequently charges the majority of patients for the service or supply;
2. The prevailing range of fees charged in the same area by Qualified Practitioners of similar training and experience for the service or supply; and
3. Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular service or supply.

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

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

1. A Spouse of an Employee;
2. A Child of an Employee; or
3. A grandchild of an Employee provided that the parent of the Child is a covered Dependent and is under 18 years of age.

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

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

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

Durable Medical Equipment: Durable Medical Equipment means equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of a Sickness or Injury; and
4. Is appropriate for use in the home.

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

Employee: Employee means a person who the Employer classifies as an Employee under W-2 provisions.

Employer: Employer means Family & Child Learning Centers of N.E. WI, Inc., the sponsor of this Plan.

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

Evidence-based Therapy: Evidence-based Therapy is based on medical and scientific evidence and is determined to be beneficial treatment toward meeting established goals.

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

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

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug administration and the AMA's Council on Medical Specialty Societies.

All phases of clinical trials will be considered experimental. Drugs that are not commercially available for purchase or that the Food and Drug Administration have not approved for general use are Experimental.

Family Member: Family Member means Your Spouse, Child, parent, grandparent, brother or sister.

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

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

Full-time Employee: An employee who is regularly scheduled to work 30 hours per week and is classified by the Employer as a Full-time Employee.

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

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

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

1. Is primarily engaged in and duly licensed to provide skilled nursing services and other therapeutic services, if such licensing is required by the appropriate authority where services are provided;
2. Has policies established by a professional group associated with the agency or organization. This professional group must include at least one registered nurse (RN) to govern the services provided and it must provide for full-time supervision of such services by a Qualified Practitioner or registered nurse;
3. Maintains a complete medical record on each patient;
4. Has a full-time administrator; and
5. Is approved by Medicare.

Hospice Care Agency: Hospice Care Agency means an agency that has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meet all of the following requirements:

1. Has obtained any required certificate of need;
2. Provides 24-hour-a-day, seven days a week service;
3. Supervised by a Qualified Practitioner;
4. Has a full-time coordinator;
5. Keeps written records of services provided to each patient;
6. Has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and
7. Has a licensed social service coordinator.

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

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

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

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

1. Provides medical and surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. Is under the supervision of a staff of Physicians;
3. Provides 24-hour-a-day nursing service by registered nurses;

4. Is duly licensed as a hospital, except that this requirement will not apply in the case of state tax-supported Qualified Treatment Facility;
5. Is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a Custodial or training-type Qualified Treatment Facility, or a Qualified Treatment Facility which is supported in Whole or in part by a federal government fund; and
6. The Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA accredits the facility.

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

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

Intensive-level Services: Intensive-level Services for the treatment of Autism are evidence-based behavioral therapies that are directly based on and related to therapeutic goals and skills as prescribed by a Qualified Practitiioner.

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

Late Enrollee: Late Enrollee means an individual who is enrolled for coverage after the expiration of the initial eligibility date described in section 4. Late Enrollee does not include anyone who qualifies as a Special Enrollee, anyone who requests coverage within 60 days after the loss of eligibility for Medicaid or loss of eligibility for premium assistance subsidy under Medicaid, or anyone court ordered for coverage as a Spouse or Dependent under a covered Employee's Plan.

Maintenance Care: Maintenance Care is care given when the patient's condition is not changing. Maintenance Care may provide relief of symptoms but is without proof that it is effectively improving the patient's condition.

Maximum Allowable Charge: Maximum Allowable Charge(s) will be the lesser of:

1. The Usual and Customary amount;
2. Reasonable charges;
3. The allowable charge specified under the terms of the Plan;
4. The negotiated rate established in a contractual arrangement with a provider; or
5. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Reasonable, Usual and Customary.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, upcoding, duplicate charges, and charges for services not performed.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Reasonable, Usual and Customary.

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

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

Medically Necessary: Medically Necessary and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Covered Person for the purposes of evaluation, diagnosis or treatment of the Covered Person's Sickness or Injury. The purpose of the service or supply must be to restore health. Medically Necessary means services or supplies that are determined by the Plan to be:

1. Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical condition, Sickness, or Injury;
2. Provided for the diagnosis or direct care and treatment of the medical condition, Sickness, or Injury;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for the convenience of the Covered Person, the Covered Person's Qualified Practitioner or another provider of service;
5. The most appropriate supply or level of service that can safely be provided.
6. No more costly than alternative interventions; and
7. Not maintenance therapy or maintenance treatment.

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

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity.

The mere fact that the service is furnished, prescribed or approved by a Qualified Practitioner does not mean that it is Medically Necessary.

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

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

Morbid Obesity: Morbid Obesity means a condition in which the body weight is in excess of the norm for a person of the same age, sex and height. An individual is considered Morbidly Obese if: (a) the Body Mass Index (BMI) is 35 or higher for anyone age 19 or over; or (b) falls above the 85 percentile on the growth chart for those under age 19. BMI is defined as the individual's weight in kilograms divided by the square of their height in meters.

Named Fiduciary: Named Fiduciary means Family & Child Learning Centers of N.E. WI, Inc., which has the authority to control and manage the operation of the Plan.

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

Nonintensive-level Services: Nonintensive-level Services for the treatment of Autism are evidence-based therapies that occur after completion of Intensive-level Services and are designed to sustain and maximize gains achieved.

Open Enrollment: Open Enrollment is the month of June when eligible Employees not previously covered by the Plan may submit an application for coverage to be effective July 1st.

Orthodontic Treatment: Orthodontic Treatment means the movement of one or more teeth by the use of Active Appliances. It includes: (a) diagnostic services; (b) treatment plan; (c) the fitting, making and placement of an Active Appliance; and (d) all elated office visits, including post-treatment stabilization.

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

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

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

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

Pre-admission Tests: Pre-admission Test means those Diagnostic Services done prior to a scheduled surgery, if:

1. The tests are approved by both the Hospital and the Qualified Practitioner;
2. The tests are performed on an outpatient basis prior to Hospital admission; and
3. The tests are performed at the Hospital into which Confinement is scheduled, or at a Qualified Treatment Facility designated by the Qualified Practitioner who will perform the surgery.

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

A Pre-existing Condition limitation will apply if You, Your Spouse or Child has a 63 consecutive day break in Creditable Coverage.

Coverage will be available for the Pre-existing Condition on the day immediately following the expiration of 12 months, less the period of Creditable Coverage.

Pre-existing Condition limitations cannot apply to:

1. Any participant or Dependent who has not yet reached the age of 19;
2. Any condition based on genetic testing information that has not been diagnosed by a Qualified Practitioner; or
3. Pregnancy.

Pregnancy: Pregnancy means carrying a child, resulting in childbirth, miscarriage or non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits under this Plan.
PPO (Preferred Provider Organization): PPO means the preferred provider network ("PPO Network") that has agreed to discounted fees for services to Covered Persons. The PPO will be identified on the Covered Person's identification card.

Psychiatric Hospital: Psychiatric Hospital means a Qualified Treatment Facility constituted, licensed, and operated according to the laws that apply to Hospitals in the state in which it is located, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided; It is licensed as a psychiatric hospital;
3. It requires that every patient be under the care of a Physician; and it provides 24-hour-a-day nursing service.

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

Qualified Practitioner: Qualified Practitioner means a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, physician's assistant, certified nurse anesthetist, certified

psychiatric/mental health clinical nurse, or other duly licensed provider operating within the scope of practice authorized under applicable law for such license; or other practitioner or facility defined or listed in this Plan; or other practitioner or facility approved by the Plan Administrator.

Qualified Treatment Facility: Qualified Treatment Facility means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, Psychiatric Treatment Facility, Substance Abuse Treatment Center, Home Health Care Center, or any other such facility that the Plan approves.

Reasonable: The Plan will only pay fee(s) that, in the administrator's discretion, are for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating provider. Determination that fee(s) are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. 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, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for fee(s) to be considered not Reasonable.

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

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

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

1. Within 30 days of losing other health coverage; or
2. For newly acquired Spouse or Child, within 30 days of the marriage, birth, adoption or placement for adoption.

Spouse: Spouse means an individual who is legally married to an Employee as determined under applicable state law (and who is treated as a spouse under the Internal Revenue Code).

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

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

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or

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

Total Disability or Totally Disabled: For an Employee covered under this Plan, Total Disability means that, during the first 12 months of disability, the Employee is prevented by Injury or Sickness from performing each material duty of his occupation. After the first 12 months disability, Total Disability or Totally Disabled means that the Employee is at all times prevented by Injury or Sickness from engaging in any job or occupation for wage or profit for which he is reasonably qualified by education, training, or experience.

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

Usual And Customary: Only Usual and Customary charges are covered expenses. When determining whether an expense is Usual and Customary, the Plan Administrator will take into consideration the fee(s) which the provider most frequently charges the majority of patients for the service or supply and the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, with "area" meaning a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers rendering such service or furnishing such supplies.

The term "usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term "customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "same geographic locale" and/or "area" means a city, county, or such greater area as may be necessary to establish a representative cross section of persons or organizations regularly furnishing the type of treatment, services, or supplies for which a specific charge is made.

The term "usual and customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the usual charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may alternatively be determined and established by the Plan using normative data such as Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Waiting Period: Waiting Period means the period before an eligible Employee may become covered under this Plan.

You and Your: You and Your refers to an eligible covered Employee, or where appropriate in context and unless otherwise indicated.

3 GENERAL INFORMATION

A. INTRODUCTION TO YOUR MEDICAL COVERAGE

Employer, the Plan Administrator, has established the ”Plan” to provide medical benefits for Employees eligible to participate and their covered Dependents consistent with the terms and conditions in this Plan description to help to offset the economic effects arising from a non-occupational Injury or Sickness. Containing health care costs requires that each Covered Person use health care resources efficiently to maximize benefits to all individuals participating in the Plan combined with effective plan design by the Employer. This Plan is “self-funded,” which means that Employer pays the benefit expenses for covered services as claims are incurred. Covered Persons in the Plan may be required to contribute toward their benefits.

Employer has contracted to provide networks of health care providers and pharmacies, claims processing, pre-certification and other administrative services. Employer, however, is solely responsible for payment of Your claims.

Employer has the power to delegate specific duties and responsibilities. Any delegation by Employer may also allow further delegations by such individuals or entities to which the delegation has been made. The Plan Administrator may rescind any delegation at any time. Each person or entity to which a duty or responsibility has been delegated will be responsible for only those duties or responsibilities and will not be responsible for any act or failure to act of any other individual or entity.

Employer reserves the right to change or terminate this Plan at any time. This includes, but is not limited to, Amendments to contributions, deductibles, co-payments, out-of-pocket maximums, benefits payable and any other terms or conditions of the Plan. The Employer may change or terminate the Plan for any reason, including responding to changes in federal or state laws governing health and welfare benefits.

B. SUMMARY OF BENEFITS

The purpose of this Plan Document and Summary Plan Description is to state the terms and provisions of the Plan. This description of the Plan includes a Schedule of Benefits that states the amount payable for the Covered Expenses. You should read this description of the Plan carefully. Many of its provisions are interrelated; reading just one or two provisions may give You incomplete information regarding Your rights and responsibilities under the Plan. Many of the terms used in this Plan description have special meanings; they are capitalized and are specifically defined in this Summary. You should keep your Summary Plan Description in a convenient place for future reference.

Your Employer sponsors this Plan exclusively for Covered Persons. Your rights under the Plan are legally enforceable. You will be given a copy of the Plan Document and You may also view the Plan Document along with any Amendment(s) on the Web at www.3pa.com, on the Employer’s intranet, or inspect it at any time during normal working hours at the office of Plan Administrator.

C. PLAN ADMINISTRATOR AND DUTIES OF THE PLAN ADMINISTRATOR

The Plan is administered by the Plan Administrator consistent with ERISA. The Employer may appoint an individual or entity to be the Plan Administrator. The Employer may appoint a new Plan Administrator or the Employer will serve as the Plan Administrator if the Plan Administrator resigns, is unable to perform, is dissolved, or is removed from the position.

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

The duties of the Plan Administrator include the following:

- To administer the Plan consistent 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 that may arise relative to a Covered Person's rights;
- 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 perform all necessary reporting as required by ERISA;
- To appoint and supervise an Administrative Service Manager to pay claims;
- To delegate to any person or entity such powers, duties and responsibilities it deems appropriate; and
- To perform each and every function necessary for or related to the administration of the Plan.

D. ADMINISTRATIVE SERVICE MANAGER

The Plan has retained the services of an Administrative Service Manager to provide certain claims processing and other technical services in connection with this Plan. The Administrative Services Manager may arrange for additional parties to provide certain administrative services, including claim processing services, subrogation, utilization management, medical management and complaint resolution assistance. The Administrative Services Manager cannot make modifications or Amendments to the Plan.

E. IDENTIFICATION CARD

The Plan will issue an identification card to You that contains coverage information. Please verify that the information on Your ID card is accurate and notify 3PAdministrators of any errors. If any information on Your identification card is incorrect, claims or bills for medical care provided to You or any person covered through You may be delayed or temporarily denied. You must show Your ID card every time You request medical care services from providers in the PPO Network or obtain prescription drugs. If You do not show your ID card, the PPO Network provider or pharmacy has no way of knowing You are eligible for benefits and may bill You for the entire cost of the services provided.

F. RECORDS

Certain facts are needed for plan administration, claims processing, utilization management, quality assessment and case management. By enrolling in this Plan, You authorize and direct any person or organization that has provided services to You or any person receiving benefits from the Plan through You to furnish the Plan or any of its agents or designees at any reasonable time, upon its request, all information and records or copies of records relating to the services provided.

The Plan or its agents or designees will have the right to release all records concerning health care services that the Plan determines are necessary to implement and administer the terms of the Plan, for appropriate medical review, quality assessment or subrogation. The Plan and its agents or designees will maintain confidentiality of such information consistent with existing law. This authorization applies to each Covered Person who receives Plan benefits through You, regardless of whether each Dependent signs the application for enrollment.

You are encouraged to review the Notice of Privacy Practices of the Plan in Section 16 or on the web at www.3pa.com.

4 ELIGIBILITY AND PARTICIPATION

A. CONDITIONS OF PARTICIPATION

You and each Covered Person must comply with each of the following as conditions of participation and receipt of benefits under this Plan:

1. Comply with the Plan provisions, rules and regulations;
2. Consent to inquiries by the Administrative Services Manager or Plan Administrator with respect to any provider of services involved in a claim under this Plan;
3. Submit to the Plan Administrator or its designee all reports, bills, and other information required by the Plan or which the Administrative Services Manager or Plan Administrator determines necessary;
4. Cooperate with all reasonable requests by the Administrative Services Manager or Plan Administrator for proper and efficient operation of the Plan;
5. Notify the Employer as soon as possible of a loss of eligibility for You or Your Dependents;
6. Not submit fraudulent, altered, or duplicate claims or billings;
7. Not enroll or allow another person who is not Your child or spouse under this Plan to use Your coverage; and
8. Not provide false information on Your enrollment or that of any Covered Person.

Failure by You or any Covered Individual to comply with the any of the above conditions of participation in any circumstance relieves the Plan, Plan Administrator, Administrative Services Manager and Employer of any obligations under this Plan.

B. EMPLOYEE ELIGIBILITY

An Employee is eligible to participate in this Plan if You are within one of the following categories of Employees:

1. Employees who were eligible and covered under any group health plan this Plan replaces will be eligible on the Effective Date of this Plan. Any Waiting Period or portion of a waiting period satisfied under the prior plan will be applied toward satisfaction of the Waiting Period under this Plan; or
2. Employees who have completed 90 days of employment with the Employer while classified by the Employer as a Full-time Employee.

Your eligibility date is the date You satisfy the above conditions. Your effective date is the first of the month following Your eligibility date.

In no event can a person receive coverage both as an Employee and as a Dependent of another Employee. For example, You may not have coverage for yourself as an Employee and be a Dependent on the coverage of Your Spouse who has family coverage as an Employee.

C. DEPENDENT ELIGIBILITY

Your eligible Dependents may participate in this Plan if You are concurrently a participant. "Eligible Dependents" include any of the following:

1. Your Spouse;
2. Your Child; or
3. Your grandchild, provided the parent of the Child is a covered Dependent and is under age 18.

Dependents do not include parents or any other relatives not listed previously.

If You and Your Spouse are both Employees, either one of You, but not both may cover Your eligible Dependents. This also applies to two divorced, legally separated, or unmarried Employees who share legal responsibility for any Dependent Child.

D. DEPENDENT COVERAGE

1. Your newborn Child or newly adopted Child will be eligible from the moment of birth or placement for adoption provided the Child is enrolled using the proper enrollment form for the Child with the Plan Administrator within thirty one (31) days of the Child's date of birth or placement for adoption. The Plan will waive the Pre-existing Condition Limitation for an adopted Child under age 18 of an Employee, and for a Child under age 18 placed in the home of an Employee in anticipation of adoption, provided the adoption (or placement for adoption) occurs while the Employee is covered under the Plan and coverage for such Child becomes effective within thirty one (31) days of the adoption or placement for adoption.
2. Your Spouse will be an eligible Dependent from the date of marriage if You properly file the proper enrollment form for Your Spouse with the Plan Administrator within thirty one (31) days of the date of marriage.
3. Your Dependent You acquire other than at birth, due to a court order, decree, or marriage will be eligible from the date of such court order, decree, or marriage if You properly file the proper enrollment form with the Plan Administrator within thirty one (31) days of the date of the order, decree or marriage.
4. Your Dependent acquired through a Qualified Medical Child Support Order, a National Medical Support Notice or a Medical Child Support Order will be subject to eligibility and the effective date provisions contained in the "Qualified Medical Child Support Order".

Your eligible Dependents may participate in this Plan only if You are concurrently a participant.

E. EFFECTIVE DATE OF COVERAGE

Coverage under this Plan for You and Your eligible Dependents if You have enrolled on forms furnished and accepted by the Plan Administrator, will begin at 12:01 a.m. on the following date ("Effective Date") if you are Actively-at Work:

1. The initial date of coverage is the first day of the month following Your eligibility date with the Employer as a full-time Employee. Employee must be Actively-at-Work on the effective date of coverage, or coverage for You and Your eligible Dependents will be delayed until the first day You are Actively-at-Work.. Your coverage will not be delayed, however, if you are not Actively-at-Work on the initial effective date of coverage due to your health status, medical conditions, or disability, or that of your Dependent, as defined in Section 902(a) of the Internal Revenue Code;
2. Coverage for Your newly acquired Dependents will become effective for those Dependents on their eligibility date or the first day of the month following the date the Plan Administrator receives Your completed application for coverage. A newborn Child, an adopted Child or a Child placed for adoption can only be added on the date of birth, adoption or placement for adoption, or during the next Open Enrollment period; or
3. Coverage for Your Dependent acquired through a Qualified Medical Child Support Order, a National Medical Support Notice or a Medical Child Support Order will be subject to eligibility and the effective date provisions contained in the "Qualified Medical Child Support Order".

Coverage for Your eligible Dependent will not be effective in any case prior to the effective date of Your coverage.

In all cases, You must file your enrollment for coverage under the Plan with the Plan Administrator within 31 days (60 days for newborns) of the event permitting enrollment. You must use the enrollment form designated by the Plan Administrator and your enrollment form must include the following information: name, date of birth, gender, Social Security number, and relationship to the employee. If the Plan Administrator receives Your completed enrollment forms **more than thirty one days after** Your eligibility date or the eligibility date for Your Dependent, respectively, You or the Dependent, as applicable, will be a **Late Enrollee** subject to a 90 day waiting period.

If Your Dependent Child becomes an eligible Employee of the Employer, the Child is no longer eligible as Your Dependent and must apply for coverage as an eligible Employee. Refer to "Special Enrollment" in this section for more information.

F. INITIAL ENROLLMENT

You must complete Your enrollment for You and any eligible Dependents **within 31 days of the date** the eligibility requirements are satisfied. If You fail to enroll within 31 days of the date You meet the eligibility requirements, You and any of Your eligible Dependents will not have coverage and You and Your eligible Dependents will each be a Late Enrollee and subject to a 90 day Waiting Period. Coverage for any Late Enrollee will be effective the first of the month following completion of the Waiting Period if You are an eligible Employee at that time.

You must complete enrollment for a newly acquired eligible Dependent within 31 days of the date You first acquire the eligible Dependent (e.g. marriage). Failure to enroll Your newly acquired eligible Dependent within 31 days will result in the Dependent being a Late Enrollee and subject to a 90 day Waiting Period. Coverage for any Late Enrollee will be effective the first of the month following completion of the Waiting Period if the Dependent is eligible at that time.

G. IMPORTANT NOTICE FOR ACTIVE EMPLOYEES AGE 65 AND OVER

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

1. Continuing coverage under this Plan in which case Medicare benefits would be secondary; or
2. Electing Medicare coverage as primary in which case no benefits would be payable under this Plan.

Other provisions apply for disabled individuals and others entitled to Medicare. Please see Section 10 Coordination of Benefits or contact the Plan Administrator if You would like further information.

H. SPECIAL ENROLLMENT

1. You are eligible to enroll in the Plan during a Special Enrollment Period if You meet all of the following requirements:
   (a) You are eligible for coverage under the Plan but are not currently covered under the Plan;
   (b) You previously declined to enroll in the Plan and signed a written waiver of coverage, stating as the reason the existence of alternative group or other health coverage; and
   (c) You were covered under such alternative group or other health coverage at the time You signed the waiver, and such coverage is no longer available for any of the reasons below.

2. Your Dependent is entitled to enroll in the Plan during a Special Enrollment Period if the Dependent meets all of the following requirements:
   (a) The Dependent is eligible for coverage under the Plan but is not currently covered under the Plan;
   (b) The Employee, Dependent or another appropriate person declined, on the Dependent's behalf, to enroll in the Plan and signed a written waiver of coverage, stating as the reason the existence of alternative group or other health coverage; and
   (c) the Dependent was covered under such alternative group or other health coverage at the time the waiver was signed and such other health coverage is no longer available for any of the reasons below.

3. Coverage is considered no longer available for purposes of this subsection when:
   (a) Coverage terminates due to Loss of Eligibility. "Loss of Eligibility" means loss of coverage resulting from:
      i. termination of employment, reduction in hours of employment, or any loss of eligibility after a period that is measured based on any of those events;
      ii. legal separation or divorce; or
      iii. death.

      Loss of Eligibility will not mean loss of coverage resulting from an individual's failure to pay premiums on a timely basis or any termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of fact in connection with such coverage.);
   (b) Coverage terminates because termination of employer contributions toward the cost of such coverage; or
   (c) COBRA coverage is exhausted.

4. You are entitled to enroll Yourself and Your newly acquired Dependents in the Plan during a Special Enrollment Period if all of the following requirements are met:
   (a) You are eligible for coverage under the Plan but are not currently covered under the Plan;
   (b) You previously declined to enroll in the Plan; and
   (c) An individual became Your Dependent through marriage, birth, adoption or placement for adoption.

   NOTE: This special enrollment right applies only to the Employee, the Spouse of the Employee and the newly acquired Dependent(s).

5. "Special Enrollment Period" will mean with respect to "Special Enrollment for Individuals Losing Coverage", the period that ends 30 days after:
   (a) The date COBRA coverage was exhausted; or
   (b) The date on which the coverage terminated because of Loss of Eligibility or termination of employer contributions toward the cost of such coverage, for other group or individual health coverage.

6. "Special Enrollment for new Dependents" will mean the period which ends 30 days after the date of one of the following events that triggers special enrollment rights:
   (a) Marriage;
   (b) Birth;
   (c) Adoption; or
   (d) Placement for adoption.

7. Coverage for Employees or Dependents enrolling during a Special Enrollment Period will become effective at 12:01 AM on:
   (a) the date of marriage or the date following the loss of coverage or the first day of the month following receipt by the Plan of the required enrollment forms in the case of loss of coverage or marriage; or
   (b) the date of birth, adoption or placement for adoption in the case of such events.

Enrollment must be in writing on a form furnished and acceptable by the Plan Administrator, and must be received by the Plan Administrator within 30 days of the eligibility date under the "Special Enrollment Period". All other conditions for effectiveness of coverage under the Plan apply to persons enrolling during a Special Enrollment Period.

Certain Special Enrollment rights are also provided under the State Children's Health Insurance Program (SCHIP). If an Employee has declined enrollment in the Plan for him or herself or his or her Dependents because of coverage under Medicaid or the Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government provided coverage. A request for enrollment must be made within 60 days after the government provided coverage ends.

Additionally, if an Employee has declined enrollment in the Plan for him or herself or his or her Dependents, and later becomes eligible for state assistance through a Medicaid or Children's Health Insurance Program that provides help with paying for Plan coverage, then there also may be a right to enroll for this Plan. The enrollment request must be made within 60 days after the determination of eligibility for state premium assistance.

I. COVERAGE WAIVER AND REVOKING A COVERAGE WAIVER

1. New Eligible Employee and during Special Enrollment. You have the option as a new Eligible Employee and during a Special Enrollment Period to waive coverage, which means You and Your eligible Dependents do not have coverage, or to decrease medical coverage. The following status change events also allow You to waive or decrease medical coverage midyear:
   (a) Your legal marriage;
   (b) You gain medical coverage through your Spouse;

(c) You move to a new location outside of Your current plan's service area and Your current plan is not available; or
(d) You retire.

2. Revoking a Waiver of Coverage. If You waived coverage under this Plan, You can revoke Your waiver and elect coverage again during a Special Enrollment Period.

J. QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

"Alternate Recipient" will mean any child of a Covered Person who is recognized under a QMSCO as having a right to enrollment under this Plan as an eligible Dependent.

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

"Medical Child Support Order" will mean 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 Covered Person's child or directs the Covered Person to provide coverage under a health benefits pursuant to a state domestic relations law (including 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" will mean a notice that contains the following information:

- Name of an issuing agency;
- Name and mailing address (if any) of an Employee who is a Covered Person under the Plan;
- Name and address of one or more Alternate Recipients (i.e., the child or children of the Covered Person or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipient(s); 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 Covered Person 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 address (if any) of the Covered Person and the name and 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 National Medical Support Notice will be deemed QMCSO if it:

- Contains the information contained in the above 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 the Plan Administrator will assume that all are designated;
    - Informs the Plan Administrator that, if a group health plan has multiple options and the Employee is not enrolled, the issuing agency will make a selection after the NMSN is qualified, an, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any) and

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

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

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

1. Notify the Covered Person and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the Order is a QMCSO and notify the Covered Person and each affected Alternate Recipient of such determination.

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

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support or National Medical Support Notice; and
2. Permit an Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

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

K. TERMINATION OF COVERAGE

Coverage for You and/or Covered Person will terminate at 12:01 AM on the earliest of the following dates:

1. The end of the month in which You cease to be eligible for coverage or cease to be in a class of employees eligible for coverage;
2. The date the Employer terminates this Plan;
3. The date You or Your Dependent exhausts maximum benefits of this Plan;
4. The date the Employee enters the military service on a full-time, active duty basis other than scheduled drills and other training not exceeding one month in any Calendar Year;
5. The end of the month in which Your Dependent ceases to be a Dependent as defined under this Plan;
6. The date Your Dependent enters full-time military, naval, or air service of any country;
7. The date You or any Covered Person fails to comply with any Condition of Participation;
8. The date You or Your eligible Dependent makes a fraudulent misstatement regarding the eligibility of the Dependent for coverage;
9. For an enrollee who is directly billed, the last day of the month for which the last full premium payment was timely received by Employer at its designated address; or
10. For any enrollee whose coverage is continued under COBRA, the last day of the month for which the last full premium payment was timely received by Employer at its designated address if enrollee fails to pay the full COBRA premium with 30 days of date payment was due.

L. PERIOD OF DISABILITY, LEAVE OF ABSENCE OR LAYOFF

During a period of Employer Certified total Disability, leave of absence or layoff, Your coverage can remain in force for up to 6 consecutive months if You continue to pay any required Plan contribution. Coverage that is required by the Family and Medical Leave Act will reduce any period under this provision. COBRA continuation will be offered at the end of the 6 month period.

M. REINSTATEMENT OF COVERAGE

A terminated Employee who is rehired will be treated as a new hire, subject to all eligibility and enrollment requirements unless the terminated Employee maintained coverage under this Plan through COBRA until the date of return to work. This COBRA Employee is not subject to the Waiting Period or Pre-Existing Conditions to the extent these provisions were previously satisfied.

N. CERTIFICATE OF CREDITABLE COVERAGE

The Plan Administrator will issue a certification of creditable coverage when You or Your eligible Dependents terminate coverage under this Plan and if applicable, any continuation of coverage period. The certification of coverage will state Your coverage dates under this Plan and any probationary periods You are required to satisfy. The certification of creditable coverage will contain all of the information another medical plan will need to determine if you had prior continuous coverage that should be credited toward any pre-existing condition limitation period. Medical plans may require that You submit a copy of the certification of creditable coverage when You apply for coverage. The Plan Administrator will also provide an additional copy of the certification of coverage if You request a copy at any time within 24 months after Your coverage under this Plan terminates.

O. PRE-EXISTING CONDITIONS

A Pre-existing Condition limitation will apply to You and Your eligible Dependents entering or reentering the Plan after the Effective Date except as stated in HIPAA and the Patient Protection and Affordable Care Act. No coverage is provided for expenses in connection with a Pre-existing Condition.

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

A “Late Enrollee” is an eligible Employee or Dependent who requests enrollment in the Plan more than 31 days from the date he or she became eligible. Late Enrollees are subject to a 90 day Waiting Period. A “Special Enrollee” is an eligible Employee or Dependent who enrolls in the Plan under the provisions for Special Enrollment.

P. COVERAGE CONTINUATION

You or Your covered Dependents may continue coverage under this Plan if Your current coverage ends because of any of the qualifying events described below. You or Your eligible Dependent must be covered under this Plan on the day before the date the qualifying event occurs in order to continue coverage. In all cases continuation coverage ends if the Employer terminates this Plan or the required premium is not paid when due.

The following section generally describes continuation coverage under this Plan. You should also refer to the COBRA Notice in Section 17 for more information:

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, certain leaves of absence, layoff, or reduction in hours or dismissal (except if due to gross misconduct)	Employees and Dependents	Earlier of: 1. Enrollment date in other group coverage, or 2. 18 months
Divorce or legal separation or Medicare	Former Spouse and any Dependents who lose coverage	Earlier of: 1. Date coverage would otherwise end, 2. Enrollment date in other group coverage, or 3. 36 months
Death of Employee	Surviving spouse and Dependent children	Earlier of: 1. Enrollment date in other group coverage, 2. Date coverage would otherwise end, or 3. 36 months

Dependent Child loses eligibility	Dependent Child	Earlier of: 1. Thirty-six (36) months from the date of losing eligibility, 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Retirees of the Employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one year of filing)	Retiree and Dependents	Lifetime continuation
Surviving Dependent of retiree on lifetime continuation due to bankruptcy of Employer	Surviving Spouse and Dependents	Thirty-six (36) months following retiree's death
Termination or reduction in hours of Employee within 18 months of Employee becoming entitled to Medicare	Spouse and Dependents	Earlier of: 1. Thirty-six (36) months; 2. Date total disability ends, or 3. Date coverage would otherwise end
Disability of a qualified beneficiary*	Employee, Spouse and Dependents	Earliest of: 1. 29 months after the employee leaves employment, 2. Date disability ends, 3. Date of enrollment in Medicare, or 4. Date coverage would otherwise end

* If the qualified beneficiary is disabled at the time the employee leaves employment or becomes disabled within the first 60 days of continuation of coverage, continuation for the Dependent may be extended beyond the 18 months of continuation. In order to qualify, the disabled Dependent must meet the following notice requirements during the 18 months of continuation:

- The qualified beneficiary must apply for Social Security benefits and be determined to have been totally disabled at the time of the qualifying event or within the first 60 days of continuation of coverage.
- The qualified beneficiary must notify the COBRA Administrator of the disability determination within 60 days after the disability determination.

Q. CHOOSING CONTINUATION COVERAGE

If You lose coverage due to termination of Your employment with the Employer, the Plan will notify You within 14 days after employment ends of the option to continue coverage. You or any Covered Person must notify the Plan Administrator in writing within 30 days of a divorce, legal separation, or any other change in Dependent status. To elect to continue coverage, You or any Covered Person receiving benefits through You must notify the Plan by filing a completed application within 60 days, starting with the date of the notice of continuation or the date coverage ended, whichever is later. You or any Covered Person failing to elect to continue coverage within the required period will be ineligible to choose continuation at a later date. You or any Covered Person receiving benefits through You have 45 days from the date of filing the application for continuation coverage to pay the first continuation charges. After this initial grace period, each Covered Person must pay continuation charges monthly in advance to the Plan Administrator to maintain coverage in force. The monthly charges for continuation for this Plan is the group rate plus a two-percent (2%) administration fee. You must pay all charges consistent with the instructions in the COBRA Continuation Coverage form.

R. ADDITIONAL QUALIFYING EVENTS

A qualified beneficiary, who is any individual covered under the Plan the day before the qualifying event, as well as a Child who is born or placed for adoption with You during the initial period of continuation of coverage, may be entitled to inDependent continuation coverage election rights and an extended continuation period if a second qualifying event occurs during the initial coverage continuation period. This extension only applies when the initial qualifying event for coverage continuation was Your termination of employment, reduction in hours, retirement, leave of absence or layoff. A qualified beneficiary must notify the Employer within 31 days after a second qualifying event occurs in order to elect to extend continuation coverage. Continuation charges must be paid in the same manner as for the initial qualifying event.

S. SPECIAL RULE FOR PRE-EXISTING CONDITION CONTINUATION

If You or Your covered Dependent(s) obtain other group coverage that excludes benefits for pre-existing conditions, You or Your covered Dependent(s) may choose to remain on continuation coverage for a pre-existing condition until the date continuation coverage would otherwise end or until the pre-existing clause of the new plan is met, whichever occurs first. This Plan is primary and determines benefits first for the pre-existing condition. This Plan is not primary for any other condition. For a newborn child born during continuation, the other plan is primary starting on the date of birth.

T. AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (ARRA)

The COBRA continuation coverage provisions of the Plan shall be administered in accordance with the requirements of ARRA Section 3001 in respect to "assistance eligible individuals," as defined in ARRA Section 3001(a)(3) to allow for (1) payment of reduced premiums and the provision of a second election period by certain COBRA qualified beneficiaries, and (2) the provision for additional COBRA notices. Notwithstanding any other Plan provision to the contrary, the Plan shall determine whether an individual has had a 63 day break in coverage for purposes of determining creditable coverage under the Health Insurance Portability and Accountability Act (HIPAA), in accordance with the terms of ARRA Section 3001, allowing for exceptions to the rules for crediting certain prior coverage.

U. SPECIAL ENROLLMENT FOR PREVIOUSLY ENROLLED PARTICIPANTS

There will be a 30 day open enrollment period for any eligible Employee or Dependent whose coverage was previously terminated for exceeding the Lifetime Maximum. This period will run through the month of August with coverage effective on September 1st. Anyone wishing to re-enter the Plan must submit an enrollment form to the Plan Administrator within the 30 day enrollment period. Forms received after 30 days will not be accepted and You will not be covered under the Plan.

5 PREFERRED PROVIDER ORGANIZATION

A. PREFERRED PROVIDER ORGANIZATION PROVISIONS

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

You should consider using PPO Providers for the following reasons:

- The PPO negotiates fees for medical services resulting in lower costs for You when You use Hospitals, Qualified Treatment Facilities, Qualified Practitioners and other providers in the PPO network.
- You may receive a better benefit and Your out-of-pocket expenses will be minimized.
- You will have a wide variety of selected Hospitals, Qualified Treatment Facilities, Qualified Practitioners and other providers in the PPO network to help You with Your medical care needs.

The highest level of benefits under this Plan is available for services through PPO Providers; however, You may choose any provider You wish for Your care. Any provider who is not a member of the PPO Network at the time You received care or treatment is a Non-PPO Network Provider ("Non-PPO Provider").

B. HOW TO SELECT A PROVIDER

Your Plan contracts with the Healtheos Plus provider network. To check if a physician or facility participates in the network, You can call the number below, search for a doctor on the Healtheos website or contact the Administrative Services Manager at 888-540-0094.

HealthEOS Plus
PO Box 6090
DePere, WI 54115
800-279-9776
www.healtheos.com

Your Plan also has access to national networks for services required while traveling out of the area or for dependent students attending school in other states. Services with a provider participating in these national networks will be considered at the highest level of benefits

C. PPO BENEFIT EXCEPTION PROVISION

All Emergency medical care will be considered at the PPO level of benefits. Services from a Non-PPO provider will be considered at the PPO level of benefits only if You receive treatment from a PPO provider that results in necessary, covered services from a non-PPO provider who is an anesthesiologist, pathologist, radiologist or emergency room physician.

6 BENEFITS UNDER THIS PLAN

A. OUTLINE OF MEDICAL BENEFITS

Benefits When Using PPO Providers:

Annual Maximum	$5,000,000	
Deductible	$500 Individual	$1,000 Family (all members combined)
Coinsurance	80% after Deductible of the first $5,000 of Covered Expenses each year, 100% thereafter	
Maximum out-of-pocket	$1,500 Individual	$3,000 Family (all members combined)

Benefits When Using Non-PPO Providers:

Annual Maximum	$5,000,000	
Deductible	$1,000 Individual	$2,000 Family (all members combined)
Coinsurance	60% after Deductible of the first $5,000 of Covered Expenses each year, 100% thereafter	
Maximum out-of-pocket	$3,000 Individual	$6,000 Family (all members combined)

B. DEDUCTIBLE INFORMATION

This is the amount of Covered Expense You must pay before the Plan will reimburse Covered Expenses in excess of the Deductible amount. The Deductibles apply to each Covered Person, each Calendar Year. Deductible satisfied with a PPO provider will apply towards satisfying the Non-PPO Deductible.

C. COINSURANCE INFORMATION

Covered Expenses will be reimbursed at the coinsurance percentages, up to the Maximum benefits, shown in the Outline of Benefits and contained in the “Schedule of Benefits - Medical Expenses”, “Medical Covered Expenses”. Coinsurance amounts applied to the PPO maximum out-of-pocket will also be applied to the Non-PPO maximum out- of-pocket. Co-payments are not applied towards the out-of-pocket maximums.

D. SCHEDULE OF BENEFITS - MEDICAL EXPENSES

The benefits under this Plan are intended to cover a wide range of services. This section describes important additional information on the types of services covered under this Plan. Please also refer to the section, "Limitations and Exclusions" for information on expenses that this Plan does not cover. In addition, You may find the "Definitions" section helpful in understanding the terms used in this Plan Description.

Information in this section is intended to give You a convenient outline of the Plan provisions and is not all-inclusive. "As Allowed by the Plan" indicates services are subject to the Deductible and coinsurance as shown in the Outline of Benefits and Schedule of Benefits - Medical Expenses. Charges for services received from Non-PPO Providers are subject to Customary, Usual and Reasonable guidelines.

Hospital Benefits	Semi-private room and board, intensive care or coronary care and miscellaneous charges As Allowed by the Plan.
Assisting the Primary Surgeon	25% of the allowable fee for primary surgeon.
Qualified Practitioner's Benefits:	As Allowed by the Plan.
Wellness Benefit	First $500 in charges payable at 100%, no Deductible. Charges in excess of $500 are subject to Deductible and coinsurance. Includes routine vision and hearing exams.
Immunizations	Payable at 100%. Does not include immunizations required for travel.
Prescription Drug Benefits	Retail: 34 day supply: $10 co-pay for generic, $20 co-pay formulary brand name and $35 co-pay for brand name drugs. Home Delivery; 90 days supply: $20 co-pay for generic, $40 co-pay for formulary brand name and $70 for brand name drugs.
Outpatient Hospital Benefits	As Allowed by the Plan.
Emergency Room Medical Care	As Allowed by the Plan.
Ambulatory Surgical Center/ Free Standing Surgical Facility	As Allowed by the Plan.
Ambulance Service Benefit	Subject to the PPO Deductible and Coinsurance
Pregnancy Benefit	As Allowed by the Plan.
Newborn Benefits	As Allowed by the Plan. Refer to section 4 "Eligibility and Participation" of this Plan description for important Information Dependent Coverage.
Birthing Center Benefit	As Allowed by the Plan.
Convalescent Nursing Home Benefit	As Allowed by the Plan up to 30 days per Confinement.
Home Health Care Benefit	As Allowed by the Plan up to 40 visits per Calendar Year. Benefits are available when Home Health Care is in lieu of Confinement in a Hospital or Nursing Home.
Hospice Care Benefit	As Allowed by the Plan.

Mental or Nervous Conditions Benefit/ Substance Abuse:…..Inpatient, Transitional and Outpatient services As Allowed by the Plan.

Chiropractic Care Benefit……..As Allowed by the Plan. Maintenance care is not covered.

Acupuncture Therapy…….As Allowed by the Plan for participants over age 18. Only for the treatment of postoperative or chemotherapy nausea and vomiting and postoperative dental pain.

Durable Medical Equipment……..…As Allowed by the Plan.

Outpatient Therapy……As Allowed by the Plan. Includes physical, speech, occupational, massage and respiratory therapy where measurable improvement is expected within 60 days of initiating treatment. Combined maximum visits of 40 per Calendar Year.

Cardiac Rehab……As Allowed by the Plan up to 48 visits per Illness.

Hearing Aid/Cochlear Implants..……..As Allowed by the Plan for participants age 18 or younger.

Autism……..As Allowed by the Plan.

Nutritional Counseling……As Allowed by the Plan. Certain restrictions apply.

Organ Transplants……..As Allowed by the Plan.

Other Covered Expenses……..As Allowed by the Plan.

Refer to the Medical Covered Expense section and the Exclusions and Limitations sections for information on other types of services and supplies.

Expenses that do not apply to satisfying the Deductible or out-of-pocket maximums include prescription drug co-pays, charges in excess of a specified limitation and services that are not covered by the plan.

E. MEDICAL COVERED EXPENSES

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

1. HOSPITAL BENEFITS COVERED

Expenses will be reimbursed, as shown in the Schedule of Benefits - Medical Expenses, for the following services by a Qualified Treatment Facility or Hospital.

(a) Room and Board. Average daily semi-private, ward, intensive care, isolation or coronary care room charges and general nursing services for each day of Confinement. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the Hospital where the Covered Person is confined. If the Hospital in which the Covered Person is confined has private rooms only, or if a private room is Medically Necessary, the private room rate will be covered. Intensive care unit charges are paid based on the actual charge.

(b) Hospital Miscellaneous Charges. Charges made by the Hospital on its own behalf for services and supplies furnished for the Covered Person's treatment during Confinement, including the following charges made by a Qualified Practitioner, whether billed directly or separately by the Hospital:

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

ii. Professional services of an anesthesiologist.

2. PRE-ADMISSION TESTING

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits - Medical Expenses, for Pre-admission Testing. Benefits are payable when pre-admission testing is performed in a Qualified Practitioner's office or the outpatient department of a Hospital, within seven (7) days of a covered inpatient Confinement and accepted by the inpatient facility in lieu of like tests performed after admission of the Covered Person.

3. QUALIFIED PRACTITIONER BENEFITS

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

(a) Office calls;
(b) Administration of anesthesia;
(c) A surgical procedure, including post-operative care;
(d) Multiple or bilateral surgical procedures including post-operative care. If multiple surgical procedures are performed at one operative session, the amount eligible as a Covered Expense will be limited to the Customary, Usual and Reasonable fee for the primary surgical procedure, 75% of the Customary, Usual and Reasonable fee for the Bilateral procedure and 25% of the Customary, Usual and Reasonable fee for the third and subsequent procedures;
(e) Second surgical opinions.

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

4. DENTAL CARE

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits - Medical Expenses, for dental services rendered by a Dentist or dental surgeon for the following services;

(a) Repair of a fractured jaw or accidental Injuries to sound natural teeth within six months of the accident. Damage resulting from biting or chewing will not be considered an Injury;
(b) Extraction of teeth to prepare the jaw for radiation treatment;
(c) Sealants on existing teeth to prepare the jaw for chemotherapy treatment;
(d) Surgical removal of impacted, un-erupted teeth;
(e) Surgical procedures to correct Injuries to the jaws, cheeks, lips, tongue, mouth;
(f) Excision of benign bony growths of the jaw and hard palate;
(g) External incision and drainage of cellulitis;
(h) Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
(g) Frenectomy;
(h) Functional osteotomy;
(i) Osseous surgery;
(j) Gingivectomy;
(k) Apicoectomy;
(l) Root canal therapy when performed in conjunction with an apicoectomy;
(m) Alveolectomy;
(n) Incision of sensory sinuses, salivary glands or ducts.

General anesthesia and x-rays will be reimbursed for covered dental care.

Hospital or Ambulatory Surgery Center charges related to dental care will be considered a Covered Expense if provided to:

(a) A child under 5 years of age;
(b) A person with a chronic disability;
(c) A person with a medical condition that requires hospitalization for such dental care; or
(d) A person with a medical condition that requires general anesthesia for such dental care.

Anesthetic charges will be included under this benefit.

5. WELLNESS BENEFIT

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits - Medical Expenses, for the following services. If a diagnosis is indicated after a routine exam, the exam will still be payable under the wellness benefit. However, all charges related to the diagnosis (except the initial exam) will be payable as any other illness.

Routine examinations include:

(a) Routine x-ray and laboratory tests;
(b) Physical exams;
(c) Routine mammograms;
(d) Routine pap smears for any Covered female person;
(e) Routine PSA (prostate specific antigen) for any Covered male person;
(f) Blood lead tests for participants age 5 and under; and
(g) Immunizations/vaccinations. Immunizations for travel purposes are not covered.

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

No benefits are payable under this provision for:

- Medical examinations for Injury or Sickness;
- Third party requested physicals: or
- Any dental examinations.

6. PRESCRIPTION DRUG BENEFIT

Charges for drugs and medicines required by law to be obtained on the written prescription of a Qualified Practitioner or dentist are payable as shown on the Schedule of Benefits - Medical Expenses. Investigational new drugs that have reached a Phase 3 clinical investigation for the treatment of HIV infection are included in this benefit. Oral contraceptives, contraceptive patches, NuvaRing, pre-natal vitamins, pediatric vitamins prescribed to treat a specific condition and diabetic supplies are covered expenses.

Excluded from this benefit are: birth control devices, nutritional supplements, smoking cessation drugs, drugs associated with weight loss and Viagra, Minoxidil, Rogaine or equivalents of these drugs. This excluded listing is not all inclusive.

7. OUTPATIENT HOSPITAL BENEFIT

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

(a) Hospital miscellaneous charges for services and supplies of a Hospital provided on an outpatient basis; and
(b) Regularly scheduled treatments, such as physical therapy, kidney dialysis, chemotherapy, inhalation therapy and radiation therapy, when ordered by Your attending Qualified Practitioner and rendered on an outpatient basis.

8. EMERGENCY ROOM MEDICAL CARE

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

(a) Emergency Accident treatment provided within 48 hours of the Accident;
(b) A surgical procedure; or
(c) Treatment of a Sickness that is a medical emergency.

9. AMBULATORY SURGICAL CENTER

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

10. X-RAY AND LABORATORY TESTS

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

11. AMBULANCE SERVICE BENEFIT

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits - Medical Expenses, for local professional ground or air ambulance service. Such service may be from Your home or place of a medical emergency to a Hospital; between a Hospital and skilled nursing facility; or from a Hospital or skilled nursing facility to Your home. If Your Injury or Sickness requires special treatment not available in a local Hospital, appropriate transportation to the nearest Hospital equipped to provide the necessary treatment is covered.

12. PREGNANCY BENEFIT

Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits - Medical Expenses, for services by Qualified Treatment Facilities and Qualified Practitioners on behalf of any female Covered Person on the same basis as a Sickness.

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

13. NEWBORN BENEFITS

Note: The benefits described in this section are available only if You apply for coverage for Your newborn Dependent within 60 days of birth. If You have other eligible Dependents and declined Dependent coverage when You originally enrolled in the Plan, such Dependents may be added only as provided under "Special Enrollment Period" in section 4 of this Plan.

Refer to the "Eligibility and Participation" section of this document for more information.

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

(b) *Sick-Newborn* Covered Expenses will be reimbursed, subject to the Deductible and coinsurance as shown in the Schedule of Benefits - Medical Expenses for expenses Incurred for necessary care and treatment of Injury or Sickness or premature birth, medically diagnosed birth defects and abnormalities; and surgery to repair or restore any body part necessary to achieve normal body functioning.

Covered Expenses DO NOT include Expenses incurred for plastic or Cosmetic Surgery, except surgery for:

i. Reconstruction due to Injury, infection or other disease of the involved part; or
ii. Congenital disease or anomaly which resulted in a functional defect.

14. BIRTHING CENTER BENEFIT

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

15. CONVALESCENT NURSING HOME BENEFIT (EXTENDED CARE FACILITY)

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits - Medical Expenses, for the following services by a Convalescent Nursing Home which:

(a) Begins within 24 hours after discharge from a Hospital Confinement or prior Convalescent Nursing Home Confinement;
(b) Is necessary for care or treatment of the same Injury or Sickness which caused the prior Confinement; and
(c) Occurs while You are under the regular care of the Qualified Practitioner who certified the required Convalescent Nursing Home Confinement.

Covered Expenses will include semi-private daily room and board, including general nursing services and necessary miscellaneous services and supplies. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the facility where You are confined. Benefits will not be paid for Custodial Care.

16. HOME HEALTH CARE BENEFIT

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits - Medical Expenses, for Home Health Care, as described below:

(a) The Maximum weekly benefit for such coverage will not exceed the Customary, Usual and Reasonable fee for weekly care in a Convalescent Nursing Home facility;
(b) Each visit by a person providing services under a home health care plan, evaluating the need for, or developing a plan of home health care will be considered as one home health care visit;
(c) Up to four hours of home health aide service in a 24-hour period is considered one home health care visit;
(d) A home health aide visit of four hours or more is considered one visit for every four hours or part thereof; and
(e) Benefits are limited as detailed in the Schedule of Benefits – Medical Expenses.

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

- Hospitalization or Confinement in a Convalescent Nursing Home would be required if home care was not provided;
- Necessary care and treatment are not available from members of the immediate family of the Covered Person or other persons residing with the Covered Person, without causing undue hardship. Immediate family, for purposes of this section, means the Spouse, Child, parents, grandparents, brothers and sisters and their spouses of the Covered Person; and
- The home health care services will be provided or coordinated by a state-licensed, Medicare-certified Home Health Care Agency, or certified rehabilitation agency.

If the Covered Person was hospitalized immediately prior to the commencement of home health care, the Qualified Practitioner who was the primary provider of services during hospitalization of the Covered Person must also initially recommend the home health care plan.

The home health care plan may consist of:

- Part-time or intermittent home nursing care by or under the supervision of a registered nurse (RN);
- Part-time or intermittent home health aide services which are necessary as part of the home health care plan, provided under the supervision of a registered nurse (RN) or medical social worker, and which consist solely of caring for the patient;
- Physical, respiratory, occupational or speech therapy;
- Medical supplies, Drugs and medications prescribed by a Qualified Practitioner and laboratory services by or on behalf of a Hospital, when necessary under the home care plan and to the extent such items would be covered under the Plan if You had been hospitalized;
- Nutritional counseling provided under the supervision of a registered dietician, when such services are necessary as part of the home care plan; and
- The evaluation of the need for and the development of a plan of home health care by a registered nurse (RN), physician assistant or medical social worker, when home health care is recommended or requested by Your attending Qualified Practitioner.

Covered Expense excludes the services of immediate family, social worker, transportation services, housekeeping services, and meals.

17. HOSPICE CARE BENEFIT

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits - Medical Expenses, for Hospice care when it is furnished in a Hospice Facility or by a Hospice Care Agency in the home of the Covered Person. A Qualified Practitioner must certify that the Covered Person is terminally ill with a life expectancy of six months or less.

The immediate family is considered to be the Spouse, Child, siblings or parent of the Covered Person for hospice care only.

(a) When Hospice Care is in lieu of a covered Confinement in a Hospital or Convalescent Nursing Home, Covered Expenses may include:
- Room and board and other services and supplies;
- Part-time nursing care by or supervised by a registered nurse (RN);
- Counseling services by a licensed clinical social worker or pastoral counselor for the hospice patient and immediate family;
- Medical social services provided to You or Your immediate family under the direction of a Qualified Practitioner. Services include:
  - assessment of social, emotional and medical needs, and the home and family situation,
  - identification of the community resources available and assisting in obtaining those resources;
- Dietary counseling;
- Consultation and case management services by a Qualified Practitioner;
- Physical or occupational therapy;
- Part-time home health aide service;
- Bereavement counseling for family members; and
- Medical supplies, Drugs and medicines prescribed by a Qualified Practitioner.

(b) Covered Expenses for Hospice Care do not include:
- Private or special nursing services;
- A Confinement not required for pain control or other acute chronic symptom management;
- Funeral arrangements, or financial or legal counseling, including estate planning or drafting of a will;
- Homemaker or caretaker services including a sitter or companion services;
- House cleaning or household maintenance;
- Services of a social worker, other than a licensed clinical social worker;
- Services by volunteers or persons who do not regularly charge for their services; or
- Services by a licensed pastoral counselor to a member of his congregation.

18. MENTAL OR NERVOUS CONDITIONS OR SUBSTANCE ABUSE

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

- Charges made by a Qualified Practitioner;
- Charges made by a Qualified Treatment Facility;
- Charges for Drugs that may be obtained only on the written prescription of a Qualified Practitioner.

(a) *Inpatient Benefits* - Covered Expenses while confined as a registered bed patient in a Qualified Treatment Facility are subject to Deductible and coinsurance.

(b) *Outpatient Benefits* - Covered Expenses for outpatient services are subject to Deductible and coinsurance

(c) *Transitional Benefits* – Covered Expenses for transitional services are subject to Deductible and coinsurance.

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

19. HEARING AIDS AND COCHLEAR IMPLANTS

For covered children under 18 who are certified as deaf or hearing impaired by a Physician or audiologist, Covered Expenses will be reimbursed as shown in the Schedule of Benefits – Medical Expenses for:

(a) One hearing aid per ear every three years;
(b) Cochlear implants; and
(c) Treatment or procedures related to hearing aids and cochlear implants.

20. NUTRITIONAL COUNSELING

Covered Expenses will be reimbursed subject to Deductible and coinsurance for nutritional counseling for a participant who is diagnosed with Morbid Obesity or any other health condition other than an eating disorder such as bulimia or anorexia nervosa.

21. AUTISM

Covered Expenses will be reimbursed, as shown in the Schedule of Benefits - Medical Expenses, for participants with a verified diagnosis of Autism Spectrum Disorder for Intensive Level Services and Non-intensive Level Services. Benefits will not include:

(a) Acupuncture;
(b) Animal based therapy;
(c) Auditory integration training;
(d) Chelation therapy;
(e) Child care fees;
(f) Cranial sacral therapy;
(g) Hyperbaric oxygen therapy;
(h) Custodial or respite care;
(i) Special diets or supplements; or
(j) Charges that are not for actual treatment such as travel expenses or facility charges.

22. GENETIC SERVICES

Covered Expenses will be reimbursed as shown in the Schedule of Benefits – Medical Expenses for the following services:

(a) Genetic counseling;
(b) Amniocentesis during pregnancy;
(c) Chorionic villus sampling during pregnancy;
(d) Identification of infectious agents;
(e) Molecular testing of pathological specimens; or
(f) Related to the diagnosis or treatment of certain illnesses.

23. OTHER COVERED MEDICAL EXPENSES

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

1. Services of a registered nurse (RN) or licensed practical nurse (LPN) for nursing care ordered by the attending Qualified Practitioner of the Covered Person.
2. Inpatient private duty nursing is covered only when care is Medically Necessary and not for Custodial Care, and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
3. Outpatient private duty nursing is covered only when Medically Necessary and will be payable under the Home Health Care benefit.
4. Blood and/or blood plasma that is not replaced by donation and administration of blood and blood products including blood extracts or derivatives.
5. Oxygen and other gases, and rental of equipment for their administration.
6. Prosthetic appliances for the replacement of the loss of natural limbs and eyes. Replacement appliances will only be covered when necessary due to a pathological change. Repair and maintenance expenses are not a Covered Expense under this Plan. Casts, splints, surgical dressings, trusses, braces, crutches and other Medically Necessary medical and surgical supplies.
7. Special supplies when prescribed by Your attending Qualified Practitioner, including:
    i. Catheters,
    ii. Colostomy bags, belts and rings,
    iii. Flotation pads,
    iv. Needles and syringes,
    v. Initial contact lenses or eyeglasses following cataract surgery.
8. Rental up to the total purchase price or, when approved by the Plan, purchase of a wheelchair, Hospital bed, respirator or other Durable Medical Equipment. It is recommended that purchase be pre-approved with the Plan Administrator. Repair and maintenance expenses are not a Covered Expense under this Plan. Not included in this benefit are motor vehicles, lifts for wheel chairs, scooters and stair lifts.
9. Mechanical medical devices implanted in a body cavity to aid the function of an internal body organ.
10. Chiropractic Care for the treatment of an Injury or Sickness. Routine or maintenance Chiropractic Care is not a Covered Expense.
11. Services and supplies in connection with elective sterilizations, vasectomies and tubal ligations, for covered Employee and Spouse only.
12. Diabetic supplies for the treatment of diabetes that are not covered under the prescription Drug card. Installation and use of an insulin infusion pump, other equipment and supplies used in the treatment of diabetes, and diabetic self-management education programs, including medical nutritional therapy. Benefits are provided for individuals with gestational, Type I or Type II diabetes. Coverage for an insulin infusion pump is limited to the purchase of one pump per year. The pump must be in use for 30 days before purchase.
13. Treatment by a licensed physical, speech or occupational therapist to restore loss or to correct impairment due to an Injury or Sickness. Speech therapy to correct a congenital defect is also considered eligible.
14. Radiation therapy and chemotherapy.
15. Acupuncture when used as an anesthetic in place of anesthesia services that would have been covered under the Plan.
16. The following organ or tissue transplants when the transplant is provided from a donor to a living human transplant recipient and performed at a Transplant Center of Excellence:
    i. Artery or vein transplants and bone or skin grafts;
    ii. Bone marrow transplants;
    iii. Cornea transplants;
    iv. Lung transplants;
    v. Heart transplants;
    vi. Heart-lung transplants (combined procedures);
    vii. Liver transplants;
    viii. Kidney transplants;
    ix. Pancreas transplants;

x. Kidney-pancreas transplants (combined procedures);
xi. Small bowel transplants; and
xii. Small bowel-liver transplants (combined procedures).

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

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

When only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. The benefits are limited to only those not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program available to the recipient. No benefits are provided to the non-covered transplant recipient.

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

17. The treatment of kidney disease, including dialysis.
18. Diagnostic testing for infertility. There are no benefits for the treatment of infertility.
19. Covered Expenses incurred outside the United States provided the Covered Person did not travel there for the purposes of receiving treatment. There must be an itemized statement of services and any payments will be sent directly to the Employee.
20. Screening mammograms for any Covered female participant.
21. Office visit and lab charge for one routine pap smear each Calendar Year for any Covered female.
22. Services in connection with a mastectomy for which benefits are payable under the Plan and reconstructive surgery has been elected in a manner determined in consultation with the attending Physician and the patient:
    (a) Reconstruction of the breast on which the mastectomy has been performed;
    (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
    (c) Prosthesis to replace the breast on which the mastectomy has been performed; and
    (d) Physical complications resulting from all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).
23. Blood lead tests for Covered Dependent Children under six years of age.
24. Cardiac rehabilitation provided under the supervision of a Qualified Practitioner initiated within 12 weeks after other treatment for the medical condition ends. Benefits are only available if you have a recent history of the following:
    (a) Heart attack;
    (b) Coronary bypass surgery; or
    (c) Coronary occlusion.
25. Routine endoscopic surgeries such as a colonoscopy.
26. Expenses incurred during participation in a cancer clinical trial when the expense would be covered if provided outside the trial. This would include such items such as blood cell count lab, CAT scans, MRI, and anti-nausea medications.

F. GENERAL EXCLUSIONS AND LIMITATIONS – MEDICAL

This Plan excludes from benefits coverage and does not pay for service and supply charges that are:

1. For any treatments, services, or supplies that are not Medically Necessary for the diagnosis and treatment of an Injury or Sickness.
2. Out-of Network charges in excess of the Customary, Usual and Reasonable fee for the service or supply.
3. For any Injury or Sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain.
4. Eye refractive disorders, vision therapy (orthoptics), radial keratotomy or keratoplasty to correct refractive disorders, eyeglasses, hearing aids or the fitting or repair of any hearing aid or eyeglasses. The initial purchase of eyeglasses or contact lenses following cataract surgery is a Covered Expense.

5. For any Injury or Sickness for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, employer liability law, or any similar law, regardless of whether a claim was filed for such benefits.
6. Paid, or payable under any medical payment, personal injury protection, automobile, or other coverage that is payable without regard to fault, including charges that are applied toward any Co-payment or Coinsurance requirement of such a policy.
7. Furnished while the Covered Person was not under the regular care of a Qualified Practitioner;
8. Not authorized or prescribed by a Qualified Practitioner.
9. For which the Covered Person is not charged, or for which the Covered Person would not be legally obligated to pay if the Covered Person did not have coverage under this Plan.
10. For exams or other services directed or requested by a court of law or any other third party, or for purposes relating to employment, licensure, insurance, or occupation.
11. Pre-existing Conditions to the extent specified in the "Pre-existing Conditions Limitations" section.
12. Any loss to a Covered Person who is not a member of the armed forces which was caused or contributed to by:
    (a) War or any act of war, whether declared or not, or
    (b) Any act of international armed conflict, or
    (c) Any conflict involving armed forces or any international authority.
13. Furnished in the treatment of any Uniformed Service-related Injury or Sickness (past or present) while the Covered Person is confined in a Hospital or institution owned or operated by the United States Government or any of its agencies.
14. Charges that would have been paid by the primary plan, as determined by the Coordination of Benefit rules of this Plan, if the Covered Person had complied with all of the requirements of that plan, including any penalties for failure to pre-certify the services.
15. Paid or payable under Medicare.
16. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid).
17. Charges for or related to reconstructive plastic, or Cosmetic Surgery or cosmetic health services, including any charges related to, resulting from complications of, or for reversal of any such surgery, except as specified in the Medical Covered Expenses section unless for reconstructive surgery due to Injury, infection, other disease of the involved part or for correction of a functional disorder due to a congenital defect.
18. Any medical equipment, supplies, prescribed drugs, procedures, or treatment which are Experimental or investigational in nature and have not been established as safe or effective, or are not in accordance with generally accepted professional standards, or which do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time the service is rendered.
19. Care that is not normally provided as preventive care (such as heart scans).
20. Care that is not normally provided as treatment of an Injury or Sickness.
21. Charges for therapeutic acupuncture.
22. Charges for gender reassignment surgery, sex hormones related to surgery, related preparation and follow-up treatment, care, and counseling.
23. Charges for marital, family, or other counseling or training services, religious counseling or sex therapy rendered in the absence of a significant mental disorder. Also excluded are programs to provide complete personal fulfillment. Family counseling is allowed when a family member has been recently diagnosed with a mental disorder or substance abuse and the counseling is recommended by the attending Physician as a part of the treatment plan.
24. Charges for recreational or educational therapy, or forms of non-medical self-care or self-help training, including, but not limited to, health club memberships, strength conditioning, work-hardening programs and smoking cessation programs.
25. Services or treatment for behavioral problems, learning disabilities, or developmental delays when not the result of an Injury or Sickness.
26. Charges for lenses, frames, contact lenses or other fabricated optical devices or professional services for the fitting or supply thereof; lasik, keratotomy, and keratorefractive surgeries.
27. Charges for services that are normally provided without charge, including services of the clergy.
28. Charges for autopsies.
29. Charges by a health professional for e-mail consultations.

30. Charges for major organ and bone marrow transplants, including all transplant-related follow-up treatment, exams, and drugs, except as specified in the Medical Covered Expenses section, including drug therapies.
31. Nonprescription and/or over-the-counter drugs or medicines, nutritional therapy or counseling, or appetite suppressants.
32. Any prescription drug that is not approved for marketing by United States Food and Drug Administration, by issuance of a New Drug Application or other form of formal approval; or any approved drug which is not used for the specific indication which led to its approval by the United States Food and Drug Administration, been classified as effective by the FDA, bioengineered drug therapy that has not received FDA approval for the specific use being requested, and prescription drugs that are not administered according to generally accepted standards of practice in the medical community This does not include investigational new drugs which have reached a Phase 3 clinical investigation for the treatment of HIV infection. Other prescription drugs not covered are:
    (a) Infertility drugs;
    (b) Devices or appliances (not including diabetic needles, syringes and supplies);
    (c) Nutritional supplements, cosmetic or growth hormone treatment;
    (d) Smoking cessation drugs;
    (e) Drugs or supplies associated with weight reduction;
    (f) Drugs for sexual dysfunction;
    (g) Injectables, except for treatment of migraine headaches, insulin, Glucagon and EpiPen;
    (h) Drugs dispensed while in a Hospital, Skilled Nursing Facility, etc.;
    (i) Rogaine, Monoxidl or equivalents.
33. Charges for services a Qualified Practitioner gives him/herself or to a close relative (such as Spouse, domestic partner, brother, sister, parent, or child).
34. Charges for dental or oral care, except for those specified in the Medical Covered Expenses section.
35. Charges for any appliance or service for or related to dental implants, including hospital charges.
36. Charges for personal comfort items such as telephone, television, barber, beauty services, and guest services.
37. Charges for hospital room and board expense that exceeds the Semi-private Room rate unless a private room is approved by the Claims Administrator as Medically Necessary.
38. Charges for services and supplies that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, breast pumps, exercise equipment, air purifiers, air conditioners, dehumidifiers, heat appliances, water purifiers, hypoallergenic mattresses, waterbeds, vehicle lifts, computers and related equipment, and home blood pressure kits.
39. Nonprescription and over-the-counter charges for arch supports, foot orthotics or orthopedic shoes, including biomechanical evaluation and negative foot mold impressions, except as specified in the Medical Covered Expenses section.
40. Treatment of weak or strained ankles, misability or imbalance of the feet or ankles or the treatment of flat feet.
41. Charges for travel, transportation, or living expenses.
42. Charges for services provided before coverage is effective or after your coverage terminates for the Covered Person even though the Sickness or Injury started while coverage was in force.
43. Private duty nursing while confined in a Hospital or other Qualified Treatment Facility, except as specifically described.
44. Charges for weight control or reduction including, but not limited to, nutritional supplements, vitamins, dietary or nutritional counseling, individual or behavior modification therapy, body composition or underwater weighing procedures, exercise therapy, weight control or reduction programs, or any obesity surgery including but not limited to stomach stapling, gastric bubble, intestinal or stomach bypass or suction lipectomy.
45. Charges for maintenance or Custodial Care, except as specified under Home Health Care and Hospice Care.
46. Charges for rehabilitation services, such as physical, occupational, and speech therapy that are not expected to make measurable or sustainable improvement within a reasonable period of time.
47. Charges for nursing services to administer home infusion therapy when the patient or other caregiver can be successfully trained to administer therapy.
48. Charges for services that do not involve direct patient contact, such as delivery charges and record keeping.

49. Charges for inpatient Admission to the hospital for diagnostic tests that can be performed on an outpatient basis.
50. Charges for injections which can be self-administered; however, in some cases the drug may be covered as specified in the Schedule of Benefits.
51. Charges for services for or related to systemic candidiasis, homeopathy, immunoaugmentative therapy, or chelation therapy that the Claims Administrator determines is not Medically Necessary.
52. Services for or related to functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits.
53. Services to hold or confine a person under chemical influence when no medical services are required regardless of where the services are received.
54. Charges for services for or related to growth hormone, except that replacement therapy is eligible for conditions that meet Medical Necessity criteria as determined by the Claims Administrator prior to receipt of the services.
55. Charges for reversal of sterilization.
56. Charges for long-term storage of ova or sperm.
57. Elective abortions performed by any means.
58. Massage therapy for the purpose of the comfort or convenience of a Covered Person.
59. Nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as required by law for PKU treatment.
60. Services for genetic counseling, genetic studies, genetic screening and testing, except as specifically stated in the Medical Covered Expenses section.
61. Any medical expense for a Sickness or Injury that occurred during the commission of, or attempt to commit, an illegal act, or participation in an illegal occupation, or participation in civil insurrection or riot, and any complication arising from any such Sickness or Injury.
62. Charges incurred outside the United States, if obtaining medical services, drugs or supplies was a purpose of the Covered Person's travel to such location.
63. Charges for services and supplies that are to treat Injuries for which a Covered Person is reimbursed or may be entitled to be reimbursed by another party or insurer; however the Plan may make payment on these claims if the terms of the Plan's Subrogation Provision have been satisfied.
64. Chelation (metallic ion therapy), except in the treatment of heavy metal poisoning.
65. Educational testing or training, or recreational therapy.
66. Phone consultations, completion of claim forms or forms necessary for the Covered Person to return to work or school, or for an appointment the Covered Person did not attend.
67. Any charge for holistic medicine or other programs with an objective to provide complete personal fulfillment.
68. Charges for a standby surgical team, unless surgery is actually performed.
69. Any charge for rolfing, colon therapy, homeopathy, naturopathy, reiki or visualization sessions.
70. Any human organ or tissue transplant not specifically listed, or any non-human or artificial organ or tissue transplant.
71. Charges for routine foot care such as removal of corns and calluses and trimming of toenails, except when necessary because of a peripheral-vascular disease.
72. Cognitive therapy or kinetic therapy. Cognitive therapy is defined as therapy that embraces mental activities associated with thinking, learning and memory. Kinetic therapy is defined as therapy related to motion or movement (i.e. the study of motion, acceleration or rate of change).
73. Health care services provided while held, detained or imprisoned in a local, state or federal penal or correctional institution or while in the custody of law enforcement officials.
74. Care, services or treatment required as a result of complication from a treatment not covered under the Plan.
75. Charges for services or supplies resulting from malpractice, malfeasance or misfeasance.
76. Charges for hypnotherapy, biofeedback, myo-functional therapy or sleep therapy.
77. Penile implants or prosthesis.
78. Sanataria or rest cures.
79. Milieu therapy, or any confinement in an institution primarily to change one's environment.

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

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

G. OUTLINE OF DENTAL BENEFITS

Plan Maximums:	$1,200 per Covered Person per Calendar Year for a combined total of Class A, B and C services	
	$300 Per Calendar Year and $1,200 per Covered Person per Lifetime for Class D Orthodontic services	
Deductible:	$100 per Covered Person per Calendar Year, Lifetime	
Coinsurance:	Class A (Preventative) Services:	100% (You pay 0)
	Class B (Basic) Services:	100% (You pay 0)
	Class C (Major) Services:	50% (You pay 50%)
	Class D (Orthodontic) Services:	50% (You pay 50%)

Each Calendar Year, the Plan will pay the applicable percentage shown for Covered Expenses, subject to Plan maximums.

Refer to the **Dental Covered Expense** section and the **Exclusions and Limitations** sections for additional information.

NOTE: No benefits are payable for Class C Services in the first 12 months of coverage under the Plan.

H. GENERAL PLAN INFORMATION

Pretreatment Review - When the expected cost of a proposed course of treatment is $300.00 or more, You must send a treatment plan in an acceptable format to 3PA for approval before treatment starts. The treatment plan must include:

(a) A list of the services to be done, using the American Dental Association Nomenclature and codes;
(b) The itemized cost of each service; and
(c) The estimated length of treatment.

You must also provide dental x-rays, study models and whatever else the Plan requests to evaluate the treatment plan.

The Plan will review the treatment plan and estimate what it will pay. The Plan will send the estimate to the Covered Person's Dentist. If the Plan does not agree with a treatment plan, or if one is not sent in, the Plan will base its payments on treatment the Plan determines is suited to the Covered Person's condition based on accepted standards of dental practice. Pre-treatment review is not a guarantee of what the Plan will pay. The estimate states in advance to the Covered Person and his Dentist what the Plan will pay for the covered dental services delineated in the treatment plan. However, payment is conditioned on:

(a) The work being done as proposed and while the Covered Person is insured; and
(b) The deductible and payment limit provisions and all of the other terms of this Plan.

Emergency treatment, oral examinations, dental X-rays and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

Integration with Medical Benefits. - In the event benefits are available for the same expenses under both the medical and dental provisions of this Plan, such charges will first be considered for payment as a medical expense. The charges will be considered as a dental expense only if the amount normally paid

under the dental provision exceeds the amount paid under the medical provision, and only up to the excess amount.

Expenses are Incurred - An expense is incurred when the service is performed, except that it is deemed to be incurred:

(a) When preparation of the tooth is begun for a crown;
(b) When the final impressions are taken for dentures or fixed bridgework; and
(c) When the pulp chamber is opened for root canal treatment.

No benefits will be paid for any type of work not listed above that is completed after this coverage under this Plan ends.

If this Plan Replaces Another Plan. - This Plan may be replacing another plan the Employer maintained. If so, this Plan starts immediately after the prior plan ends will pay for certain charges incurred for a Covered Person before this Plan starts, if:

(a) The Covered Person is covered under this Plan on the date it begins,
(b) The Covered Person was covered under the prior plan on the date the prior plan terminated, and
(c) The prior plan would have paid such charges. The Plan will pay the lesser of:

- What the old plan would have paid; or
- What we would otherwise pay.

This Plan will deduct any benefits actually paid by the old plan under any extension provision from benefits paid under this Plan.

I. DENTAL COVERED EXPENSES

The services covered by this Plan are named in this list. Any procedure not listed is excluded. All covered dental services must be furnished by or under the direct supervision of a Dentist. They must be usual and necessary treatment for a dental condition. The Plan will reimburse the service provider directly for eligible expenses unless You submit a receipt.

Preventive Dental Services
Routine oral examinations are limited to every six (6) months.

Prophylaxis is limited to once every six (6) months.

Topical fluoride treatment for Your Eligible Child under the age of 19 and limited to once every twelve (12) months. A prophylaxis performed in conjunction with a fluoride treatment is a separate dental service.

Full mouth series or panoramic x-rays are limited to once every twenty four (24) months.

Bitewing x-rays are limited to once every six (6) months.

Periapical x-rays.

Sealants and sealant repair for Your Eligible child under the age of 14. Limited to molar teeth and not ore than one per tooth, per Lifetime and not on primary teeth.

Space maintainers. Fixed Appliances to maintain a space created by the premature loss of a primary tooth or teeth.

Emergency palliative treatment and other non-routine, unscheduled visits. We pay for this only if no other service (except x-rays) is rendered during the visit.

Basic Services

Restorative Services

- Fillings: amalgam, acrylic and synthetic.
- Crowns: stainless steel.
- Posterior resins are payable at the amalgam rate.

Endodontic Services. Endodontic treatment, including root canal therapy.

Periodontic Services. Services necessary for the treatment of diseases of the tissues supporting the teeth Perioprophylaxis only covered for one (1) year after active treatment, otherwise subject to same frequency as regular prophylaxis. Periodontal splinting is not a Covered Expense.

Oral Surgery

- Extractions.
- Preparation of the mouth for dentures.
- Removal of tooth-generated cysts of less than ¼ inch.
- General anesthesia in connection with covered oral surgery only.

General Anesthesia, upon demonstration of medical necessity.

Re-cementing bridges, crowns or inlays.

Injections of antibiotic drugs by the Dentist.

Major Services

Restorative Services

- Crowns
- Inlays
- On lays
- Gold foils

The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic are only eligible when the teeth must be restored with gold.

Prosthodontic Services. Initial installation of, or addition to, full or partial dentures or fixed bridgework. Dentures and bridgework will be considered to be initially installed only if the dentures or bridgework do not replace existing dentures or bridgework. Such denture or bridgework includes the replacement of any extracted teeth and must be completed within 12 months of when the work is started. There is coverage for replacement or alteration of full or partial dentures or fixed bridgework, if more than 5 years after the last installation. Such expenses must have occurred on or after the effective date of coverage and must be completed within 12 months.

Repair of crowns, bridgework and removable dentures.

Rebasing or relining of removable dentures.

Orthodontic Services

Charges are eligible only to the extent that they are made in connection with an orthodontic procedure, including.

- Cephalometric x-rays
- Diagnostic casts in connection with Orthodontic Treatment
- Surgical exposure of impacted teeth in connection with Orthodontic Treatment
- Orthodontic Appliances for tooth guidance
- Fixed or removable Appliances to correct harmful habits

Eligible expenses include those for preliminary study and treatment plan. Also covered under this benefit are extractions for the purposes of Orthodontic Treatment. The first month of active treatment includes all

active and retention Appliances. Payments will be made in equal installments for the duration of covered treatment, until no longer covered, or until the maximum benefit has been paid, whichever occurs first.

J. SPECIAL LIMITATIONS

Alternate Treatment. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

Waiting Period for Major Services. Benefits will be limited to Preventive and Diagnostic and Basic Restorative Services only until You have been covered under this Plan for 12 consecutive months. After You have been covered under this Plan for 12 consecutive months, You will be eligible for Major Restorative and Prosthodontic Services. Charges that are not covered due to this provision are not considered covered dental services and cannot be used to satisfy Your deductible under this Plan.

Teeth Lost Before A Covered Person Became Covered under this Plan. This Plan will not pay for charges or services for a Prosthetic Device that replaces one or more teeth lost before a Covered Person became covered under this Plan if You declined to enroll when You were initially eligible to enroll.

If this Plan Replaces Another Plan. If this Plan replaces another plan the Employer maintained, this Plan will pay for certain charges incurred before this Plan became effective if the person who incurred the expense was covered at that time under the prior Employer plan and the prior Employer plan would have paid the expense. In such circumstances, the Plan will limit the amount it will pay to the lesser of what would have been paid under the prior Employer plan or what would be paid under this Plan after deducting any benefits paid for such expenses under the prior Employer plan.

K. GENERAL EXCLUSIONS AND LIMITATIONS – DENTAL

No payment will be eligible under any portion of this Plan for Dental Expenses incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited under this Plan, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits. Any such payment does not waive the written exclusions, limitations or other terms of the Plan.

This plan does not provide dental benefits for:

1. Expenses incurred prior to the effective date of coverage, or after the termination date of coverage.
2. Services or supplies
   (a) For which no charge is made, or for which You would not be legally obligated to pay if You did not have coverage under this Plan.
   (b) Furnished or payable under any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid).
   (c) Furnished in the treatment of any service-related Injury or Sickness (past or present) while You were confined in a Hospital or institution owned or operated by the United States Government or any of its agencies.
3. Expenses which do not meet the standards of dental practices accepted by the American Dental Association, or for services not prescribed as necessary by a Physician or Dentist.
4. For any Injury or Sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain.
5. For any Injury or Sickness for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, employer liability law, or any similar law, regardless of whether a claim was filed for such benefits.
6. Paid, or payable under any medical payment, personal injury protection, automobile, or other coverage that is payable without regard to fault.
7. Furnished while the Covered Person was not under the regular care of a Qualified Practitioner;
8. Not authorized or prescribed by a Qualified Practitioner.

9. Any loss to a Covered Person who is not a member of the armed forces which was caused or contributed to by:
    (a) War or any act of war, whether declared or not, or
    (b) Any act of international armed conflict, or
    (c) Any conflict involving armed forces or any international authority.
10. Completion of forms or failure to keep an appointment with the Dentist, or telephone or email consultations.
11. Replacement or lost, missing, broken or stolen appliances or duplicate appliances.
12. Cosmetic Dentistry, including personalization or characterization of dentures and facing on crowns, abutments or pontics posterior to the second bicuspid, or labial veneer laminates.
13. Expenses for Hospital expenses or for services of any anesthesiologist.
14. Expenses for installation, replacement or alteration of, or addition to, dentures and fixed bridgework, except as specified in Dental Covered Expenses.
15. Expenses for tooth implants and any related services.
16. Expenses for mouth guards, night guards, or take home items.
17. Expenses for preventive control program including oral hygiene, plaque control, dietary planning, or other educational programs, lab tests, anaerobic culture except in connection with periodontal disease, sensitivity training and bite registration.
18. Expenses for a temporary full Prosthetic Device or for adjustment or relining of a Prosthetic Device within 6 months after the Prosthetic Device are initially furnished.
19. Expenses for treatment by other than a Dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist under the supervision and direction of a Dentist consistent with generally accepted dental standards.
20. Treatment by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister.
21. Appliances or restorations for: increasing vertical dimension, restoring occlusion, replacing tooth structure lost by attrition, correction or congenital malformation.
22. Precision or semi-precision attachments.
23. Dental services which do not have uniform professional endorsement.
24. Major Restorative and Prosthodontic expenses incurred before a Covered Employee or Dependent has been covered under the Plan for 12 consecutive months.
25. Expenses for procedures or restorations other than those listed in the Dental Covered Expenses section.
26. For expenses where there are alternate courses of treatment available carrying different fees, the Plan will provide benefits only for the treatment carrying the lesser fee.
27. Periodontal splinting.
28. Expenses incurred for Appliances or restorations in connection with temporomandibular joint dysfunction (TMJ) or myofunctional therapy.
29. Expenses in excess of the Customary, Usual and Reasonable charges.
30. Care and treatment for which there would not have been a charge if no coverage were in force.
31. Orthognathic surgery.
32. Charges excluded or limited by the Plan as stated in this document.

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

7 PRE-ADMISSION CERTIFICATION AND UTILIZATION REVIEW

Delphi of Florida, Inc. is a Utilization Management, Cost Containment Program that works together with MAP (Medical Advocate Program) to assure You receive quality care with the most qualified healthcare providers . They understand the importance of minimizing the intrusion into the Qualified Practitioner/patient relationship and rely on their ability to promote health care alternatives that are acceptable to everyone: patients, Qualified Practitioners and Plan Administrators.

A. PRE-CERTIFICATION REQUIREMENTS AND HOW THE PROGRAM WORKS

"Pre-admission Certification" means approval by Delphi of the Medical Necessity and the appropriate length of stay for a proposed Confinement in a Qualified Treatment Facility. When a Qualified Practitioner recommends an inpatient Confinement for a Covered Person, the Covered Person must contact Delphi at their toll-free number 1-888-289-0700. Pre-certification of non-emergency services should be called in 7 days prior to the admission. Special rules apply to Emergency admissions, explained further in this section. The following information is needed for certification:

Group name and number;
Name of Employee and Employee's Identification Number;
Name of patient;
Patient's birthday;
Patient's address;
Admitting Hospital;
Phone number of admitting Hospital;
Qualified Practitioner's name and phone number;
Reason for admission;
Admission date.

Pre-admission certification is not required for maternity admissions when the length of stay is within federal guidelines (2 days for vaginal delivery; 4 days for cesarean section). Admissions to a mental health or substance abuse facility do not require pre-admission certification.

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

If You have any questions regarding pre-certification requirements or procedures, please call the Administrative Services Manager (3PAdministrators) at 1-888-540-0094.

The Qualified Practitioner, the Qualified Treatment Facility or any other person who can provide the necessary information may contact Delphi; however the Covered Person is responsible for making sure that Delphi has provided Pre-admission Certification. Upon notification, Delphi will contact Your Qualified Practitioner for all pertinent details concerning the admission. This is only the first step in the certification procedure, Delphi will request the following information when contacted for Pre-admission Certification:

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

A Pre-admission Certification is valid for 30 days from the scheduled date of admission. If the patient does not enter the Qualified Treatment Facility within 30 days or enters for a different reason, another Pre-admission Certification must be obtained.

B. EMERGENCY ADMISSIONS

Do not delay seeking medical care for any Covered Person who has a serious condition that may jeopardize his life or health because of the requirements of this Plan. You may contact Delphi after admission as described below.

If a Covered Person must be admitted on an Emergency basis, follow the physician's instructions carefully and contact Delphi by telephone within 48 hours or the first business day after the admission date. The Plan does not require a Covered Person to obtain approval of a medical service prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. In an urgent care or Emergency situation, a Covered Person simply follows the Plan's procedures after receipt of treatment, and files the claim as a Post-service Claim. The Plan Administrator may, in its discretion, request satisfactory proof that an Emergency or acute condition did exist.

C. WEEKEND ADMISSIONS

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

D. EXTENSION OF A CERTIFIED ADMISSION

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

E. CASE MANAGEMENT

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

Case management services are also provided by Delphi. The case management staff at Delphi consists of licensed, professional nurses who have many years of experience in health care. They understand the importance of minimizing intrusion into the Qualified Practitioner-patient relationship. The case management staff relies on its ability to promote health care alternatives that are acceptable to everyone: patients, Qualified Practitioners and Plan Administrators.

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

F. REDUCTION IN BENEFITS

If You fail to notify Delphi of a Confinement or when receiving any of the outpatient services listed within the time limits specified, the benefits payable under this Plan will be reduced by 20% up to a $300 penalty per occurrence. The penalty may be taken from either the Qualified Treatment Facility or the Qualified Practitioner charges, but not both. The penalty is not applied to the coinsurance or out-of-pocket limits shown on the Schedule of Benefits.

8 WOMENS' HEALTH AND CANCER RIGHTS ACT

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;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

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

If you would like more information on WHCRA benefits, call Your Plan Administrator or the Administrative Services Manager at 888-540-0090 or 608-779-3000.

9 QUALIFIED MEDICAL CHILD SUPPORT ORDERS AND NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Qualified Medical Child Support Order
The Plan will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Newborns' and Mothers' Health Protection Act of 1996
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

10 COORDINATION OF BENEFITS

Benefits described in this Plan are coordinated with benefits provided by other plans under which the Covered Person is covered. This section applies when the Covered Person has health care coverage under more than one plan, as defined below. Benefits will be reduced under certain circumstances when the Covered Person is covered both under this Plan and any other plan defined below which also provide coverage for Covered Expenses. Reimbursement under this Plan and any other plans included under this provision will not exceed 100% of the total Allowable Expenses Incurred under this Plan. Benefits under this Plan will be coordinated with benefits paid or payable under another plan, as defined, whether or not a claim is filed with such other plan.

A. DEFINITION OF OTHER PLANS

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

1. Group or franchise insurance coverage, whether insured or self-insured;
2. Hospital or medical service organizations on a group basis and other group pre-payment plans;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage sponsored or provided by or through an educational institution;
5. Any governmental program or a program mandated by state statute;
6. Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of injuries arising out of a motor vehicle Accident, and any other medical and liability benefits received under any automobile policy; or
7. Any coverage sponsored or provided by or through an employer, trustee, union, employee benefit, or other association.

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

B. HOW COORDINATION OF BENEFITS WORKS

One of the plans involved will pay benefits first, without considering the benefits available under the other plans. This is called the "primary plan". The other plans will then make up the difference, up to the total Allowable Expense. "Primary plan/secondary plan" is determined by the Order of Benefits Rules. When this Plan is a primary plan, its benefits are determined before any other plan and without considering the other plan's benefits. When this Plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When you are covered under more than two plans, this Plan may be a primary plan to some plans and may be a secondary plan to other plans.

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

C. "ALLOWABLE EXPENSES"

"Allowable Expenses" means any Medically Necessary, Customary, Usual and Reasonable item of expense, at least a portion of which is covered under this Plan. Benefits payable under any other plan include the benefits that would have been payable had a claim been properly made. In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider. "Allowable expense" does not include:

1. an item or expense that exceeds benefits that are limited by statute or this Plan; or
2. the difference between the cost of a private and a semi-private hospital room, unless admission to a private hospital room is Medically Necessary under generally accepted medical practice or as defined under this Plan.

D. ORDER OF BENEFITS DETERMINATION RULES

1. A plan will be the primary plan and pay benefits first if it meets one of the following conditions:
   (a) The plan has no coordination provision;
   (b) The plan covers the person as an Employee;
   (c) The plan covering a laid off or retired person, or a person on COBRA or any other form of continuation, will pay benefits after the plan covering such persons as an active Employee.
   (d) The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons as an active Employee.

2. **Dependent child of parents not separated or divorced.** When this Plan and another plan cover the same child as a Dependent of different persons, called "parents":
   (a) The plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but
   (b) If both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time. However, if the other plan does not have this rule for children of married parents and instead has a rule based on the gender of the parent, and, if as a result the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

3. **Dependent child of parents divorced or separated.** If two or more plans cover a Dependent child of divorced or separated parents, the plan determines benefits in this order:
   (a) First, the plan of the parent with custody of the child;
   (b) Then, the plan that covers the spouse of the parent with custody of the child;
   (c) Finally, the plan that covers the parent not having custody of the child.

However, if the court decree requires one of the parents to be responsible for the health care expenses of the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has that actual knowledge.

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

E. EFFECT ON BENEFITS OF THIS PLAN

When Order of Benefits Determination Rules requires this Plan to be a secondary plan, this section applies. Benefits of this Plan will be reduced when the sum of: a) the benefits payable for allowable expenses under this Plan, without applying coordination of benefits, and b) the benefits payable for allowable expenses under the other plans, without applying coordination of benefits or a similar provision, whether or not claim is made exceeds those allowable expenses in a claim determination period. "Claim determination period" means a Plan Year, except any part of a year the person is not covered under this Plan, or any part of a year before the date this section takes effect. In that case, the benefits of the medical portion of this Plan are reduced so that benefits payable under all plans do not exceed allowable expenses. For the prescription drug portion, benefits payable under this Plan are reduced so that benefits do not exceed allowable expenses less any prescription co-pays. When benefits of this plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of this Plan.

F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these Coordination of Benefits rules. The Plan has the right to decide which facts are needed. The Plan may get needed facts from, or give them to, any other organization or person. The Claims Administrator does not need to tell, or get the consent of, any person to do this unless applicable federal or state law prevents disclosures of information without the consent of the patient or patient's representative. Each person claiming benefits under this plan must provide any facts needed to pay the claim.

G. FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Plan. If this happens, the Claims Administrator may pay that amount to the organization that made that payment. That amount will then be considered a benefit paid under this Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

H. RIGHT OF RECOVERY

If the Plan pays more than it should have paid under these Coordination of Benefits rules, it may recover the excess from any of the following:

1. The persons it paid or for whom it has paid, or such person's legal representative
2. Any Insurance companies; and
3. Other organizations the amount paid includes the reasonable cash value of any benefits provided in the form of services.

I. COORDINATION OF BENEFITS WITH MEDICARE

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

Disabled individuals entitled to Medicare can remain on the Plan as secondary coverage to Medicare. If any Covered Person is eligible for Medicare benefits because of End Stage Renal Disease ("ESRD"), the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement (with respect to charges Incurred on or after February 1, 1991 and before August 5, 1997), and for the first 30 months of Medicare entitlement (with respect to charges Incurred on or after August 5, 1997), unless applicable federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law. For any other Medicare condition, Federal Statutes and Regulations will govern the coordination of benefits.

11 HOW TO FILE A CLAIM

A. SUBMITTING CLAIMS

You or the provider must submit claim to the address shown on Your ID card. 3PA does not require a special form to submit claims. You must, however, submit claims in a format acceptable to 3PA and comply with any applicable legal requirements. The Plan will not accept submitted claims that do not comply with the requirements of applicable Federal law respecting privacy of protected health information and/or electronic claims standards.

You must submit claims directly to 3PA at the address shown below if the provider who provided the services does not file the claim. You may submit your written claim to 3PAdministrators by mail (postage prepaid), by fax or by e-mail as indicated below:

Attention: Claim Department
3PAdministrators
P.O. Box 247
1113 Riders Club Road
Onalaska, WI 54650-2400

Phone: 608-779-3000 or 888-540-0094
Fax: 608-779-3009
Email info@3pa.com

You must include the following information for claims you submit:

- The date of service;
- The name, address, telephone number and tax identification number of the provider of services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges, which reflect any applicable PPO re-pricing;
- The name of the Plan;
- The name of the Covered Employee; and
- The name of the patient

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

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

B. TIME LIMIT IN WHICH TO FILE A CLAIM

You must file a written claim for benefits with the Plan within 365 days after the claim was Incurred. Your claim will not be denied if the Plan Administrator determines it was not reasonably possible for you to file such proof of claim within 365 days. The latest you may file a claim with the Plan is 365 days after the date the claim was Incurred, except in the case of legal incapacity.

If the Employer terminates this Plan, you must file written claims for services incurred prior to the termination date with the Plan Administrator within 60 days of the Plan termination date. Any claim received by the Plan Administrator more than 60 days after this Plan is terminated will not be a Covered Expense.

C. PAYMENT OF CLAIMS

You or the provider must direct all claims and questions regarding health claims to 3PA. The Plan Administrator will be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the provisions of the Plan and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Covered Person is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to 3PA; provided, however, that 3PA is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

D. ASSIGNMENT

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

Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the provider; however, if those benefits are paid directly to You, the Plan will have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. The Plan Administrator will pay benefits that have been assigned directly to the assignee unless the Plan Administrator receives a written request not to honor the assignment, signed by the covered Employee and the assignee before receiving the invoice for payment from the assignee.

E. PRESCRIPTION DRUG CHARGES

Retail Pharmacy: Present your insurance identification card and the prescription to a participating pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the co-payment for each prescription you receive as shown on the Schedule of Benefits - Medical Expenses. Your pharmacy will handle the balance of the transaction.

For more information on participating pharmacies, please contact PartnersRx at 1-800-711-4550..

F. MAIL ORDER

The mail service program provides participants with an easy and convenient way to obtain Your maintenance medications. An order form, which explains the mail service program in greater detail, is available. Please contact PartnersRx at the number on the order form if You have any questions.

12 CLAIM PROCEDURES, PAYMENT OF CLAIMS

A. CLAIM PROCEDURES

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

Each Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Participant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions**. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Participant has the right to request a review of an adverse benefit determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final adverse benefit determination. If the Participant receives notice of a final adverse benefit determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

- Pre-service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

  A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  If the Plan does not require the Participant to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

- The Plan Administrator determines that the course of treatment should be reduced or terminated; or
- The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Post-service Claims. A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed
Post-service health claims must be filed with the Contract Administrator within 180 days of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Contract Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Contract Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Contract Administrator within 45 days from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions
The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-service Urgent Care Claims:

  - If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim.
  - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
  - The Participant will be notified of a determination of benefits as soon as possible, but not later than 24 hours, taking into account the medical exigencies, after the earliest of:
    - The Plan's receipt of the specified information; or
    - The end of the period afforded the Participant to provide the information.
  - If there is an adverse benefit determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

- Pre-service Non-urgent Care Claims:

  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be notified of a determination of benefits in a

reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

- Concurrent Claims:
  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
  - Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
  - Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).
  - Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:
    - Notification to Participant - 30 days
    - Notification of adverse benefit determination on appeal - 30 days

- Post-service Claims:
  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

- Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

B. NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION

The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the Participant. The notice will contain the following information:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;
- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and
- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes.
- In a claim involving urgent care, a description of the Plan's expedited review process.

C. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

- Participants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
- Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
- That a Participant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits in possession of the Plan Administrator or the Contract Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and
- In an urgent care claim, for an expedited review process pursuant to which:
  - A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Participant; and
  - All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Participant by telephone, facsimile or other available similarly expeditious method.

Requirements for Appeal
The Participant must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an adverse benefit determination. For pre-service urgent care claims, if the Participant chooses to orally appeal, the Participant may telephone:

3PAdministrators
1113 Riders Club Road
PO Box 247
Onalaska, WI 54650
Phone: 608-779-3000 or 888-540-0094
Fax: 608-779-3009 or 877-540-0094

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

3PAdministrators
1113 Riders Club Road
PO Box 247
Onalaska, WI 54650
Phone: 608-779-3000 or 888-540-0094
Fax: 608-779-3009 or 877-540-0094

It shall be the responsibility of the Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the employee/Participant;
- The employee/Participant's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the appeal.

- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.

- Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review
If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

D. EXTERNAL REVIEW PROCESS

Standard external review
Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   (b) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
   (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
   (d) The claimant has provided all the information and forms required to process an external review.

   Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
   (a) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
   (b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.
   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

13 FAMILY AND MEDICAL LEAVE ACT

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

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

A. EMPLOYEE ELIGIBILITY

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

1. You are an Employee who has been employed with the Employer for a total of at least 12 months;
2. You have worked at least 1,250 hours during the 12 consecutive months prior to the request for FMLA leave; and
3. You are employed at a worksite that employs at least 50 Employees within a 75-mile radius.

B. FAMILY AND MEDICAL LEAVES

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

- The birth of Your child;
- The placement of a child with You for adoption or foster care;
- You take leave to care for a Spouse, Son, Daughter or Parent who has a Serious Health Condition;
- You take leave due to a Serious Health Condition that makes You unable to perform the functions of Your position; or
- A qualifying exigency arising out of the fact that the Spouse, son daughter or parent of the Employee is on active military duty, or has been notified of an impending call to active duty status in support of a contingency operation.

Coverage under this Plan can be continued up to 26 weeks in a single 12 month period for an Employee who is the Spouse, son daughter, parent or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty.

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

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

C. NOTICE OF LEAVE

You must notify the Employer at least 30 days prior to beginning any leave under the FMLA. If Your leave was not foreseeable, You must notify the Plan Administrator of Your FMLA leave as soon as possible. The Plan Administrator has the right to require medical certification to support Your request for leave due to Your or Your family members' Serious Health Condition.

D. MAXIMUM LEAVE PERIOD

The maximum FMLA leave You may take during any 12-month period is 12 weeks. If You and Your Spouse are both employed by the Employer, FMLA leave may be limited to a combined period of 12 weeks, for both spouses, when FMLA leave is due to:

- The birth or placement for adoption of a child; or
- The need to care for a Parent.

E. TERMINATION BEFORE THE MAXIMUM LEAVE PERIOD

Your coverage under this Plan will continue until your FMLA leave ends, up to a maximum of 12 weeks from the date your FMLA leave began. Coverage may end prior to this under the following circumstances:

- Your coverage under this Plan will end if you decide not to return to work, or
- If you do not pay your portion of the cost for coverage within 30 days of its due date.

Notice of termination must be provided at least 15 days prior to the termination. If You do not return to work when coverage under the Act ends, You will be eligible for COBRA Continuation of Coverage at that time, if applicable.

F. RECOVERY OF PLAN CONTRIBUTIONS

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

G. REINSTATEMENT OF COVERAGE UPON RETURN TO WORK

The law requires that coverage be reinstated upon the Employee's return to work following an FMLA leave whether coverage under the Plan was maintained during the FMLA or not. On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA leave had not been taken. The Waiting Period and the Pre-Existing Condition limitation will be credited as if You had been continually covered under the Plan.

H. DEFINITIONS

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

1. **Serious Health Condition** is a Sickness, Injury, impairment or physical or mental condition that involves:
   - Inpatient care in a Hospital, Hospice or Qualified Treatment Facility, including any period of incapacity due to a serious health condition, or treatment of or recovery from a serious health condition;
   - Continuing treatment by a Qualified Practitioner, including any period of incapacity: For more than three consecutive calendar days, if a Qualified Practitioner is consulted two or more times during the period or if a Qualified Practitioner is consulted once and a continuing treatment program is provided;
   - Due to pregnancy or prenatal treatment, even if treatment is not provided or it does not last for more than three days;
   - Due to a chronic condition (i.e. a condition which required periodic treatments by a Qualified Practitioner and continues over an extended period of time, whether incapacity is continuous or periodic), even if treatment is not provided or it does not last for more than three days;
   - Which is permanent or long term due to a condition which requires the supervision of a Qualified Practitioner, but for which treatment is ineffective; or
   - To receive multiple treatments from a Qualified Practitioner for restorative surgery due to an Accident or Sickness or for a condition that would likely result in a period of incapacity of more than three days without such treatment.
2. **Spouse** is Your lawful husband or wife.

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

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

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

NOTE: For complete information regarding Your rights under the Family and Medical Leave Act, contact The Plan Administrator. State regulations may override provisions included in this section.

14 AMENDMENTS TO OR TERMINATION OF THE PLAN

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

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

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

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

15 RECOVERY RIGHTS – GENERAL RECOVERY RIGHTS PROVISIONS

A. APPLICABLE TO RIGHT OF SUBROGATION, RIGHT OF REIMBURSEMENT, RIGHT OF RECOVERY PROVISION, AND WORKERS' COMPENSATION

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

A Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;
2. Authorize the Plan to sue, compromise and settle in his/her name to the extent of the
3. amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan Your rights to Recovery when this provision applies;
4. Immediately Reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limit of collect-ability or responsibility, or otherwise);
5. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
6. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

By accepting any benefits paid by this Plan, a Covered Person agrees that such benefits are an advancement of Plan assets.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Sicknesses or Injuries), the Covered Person must execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Sickness. If the Plan pays any medical or other benefits for the Injury or Sickness before these papers are signed and things are done, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person must not do anything to prejudice the Plan's right to Subrogation and Reimbursement and You acknowledge that the Plan precludes operation of the made-whole and common-fund doctrines.

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

B. SUBROGATION, REIMBURSEMENT AND/OR THIRD PARTY RESPONSIBILITY

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

Covered Persons, Plan Beneficiaries, and/or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Covered Person(s)”) or a third party, where another party 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”).

Covered Person(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 Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(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 Covered Person(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts.

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

Subrogation
As a condition to participating in and receiving benefits under this Plan, the Covered Person(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 Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan’s discretion.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(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 Covered Person(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 Covered Person(s) fails to file a claim or pursue damages against:

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

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)’ and/or the Plan’s name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(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 attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(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 Covered Person(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 any fault or claim on the part of the Covered Person(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 Covered Person(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:

a) the responsible party, its insurer, or any other source on behalf of that party;
b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) any policy of insurance from any insurance company or guarantor of a third party;
d) worker's compensation or other liability insurance company or
e) 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 Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(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 Covered Person(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.

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

a) 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;
b) 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;
c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the Covered Person(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 Covered Person(s) will

be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

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

Offset
Failure by the Covered Person(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 Covered Person(s) may be withheld until the Covered Person(s) satisfies his or her obligation.

Minor Status
In the event the Covered Person(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 the Plan.

C. DEFINITIONS

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

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

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

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

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

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

16 NOTICE OF PRIVACY PRACTICES

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

A. PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

This notice explains how the Plan uses and discloses your protected health information and the rights that you have with respect to accessing that information and keeping it confidential. "Protected health information" means information that individually identifies you, and relates to payment for your health care, your health or condition, or health care you receive, including demographic information. The Plan creates, receives and maintains eligibility and enrollment information, information about your health care claims paid under the Plan, and other protected health information that is necessary to administer the Plan. The Plan is required by law to maintain the privacy of your protected health information and to provide this notice to you. This notice explains the Plan's legal duties and privacy practices, and your rights regarding your protected health information. The Plan is committed to protecting the privacy of your protected health information by complying with all applicable federal and state laws. While this notice is in effect, the Plan must follow the privacy practices described. This notice takes effect on the effective date of this Plan Summary shown at the top of this section, and will remain in effect until it is replaced. The Plan reserves the right to change its privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. The Plan reserves the right to make such changes effective for all protected health information that the Plan maintains, including information created or received before the changes were made. You may request a copy of the Plan's privacy notice at any time. For more information about the Plan's privacy practices, or for additional copies of this notice, please contact the Plan using the information listed at the end of this notice.

B. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe the different ways that the Plan uses and discloses your protected health information. Not every use or disclosure within a category is listed, but all uses and disclosures fall into one of the following categories.

1. **Payment:** The Plan may use and disclose protected health information about you for payment purposes, such as determining your eligibility for Plan benefits, facilitating payment for treatment and health care services you receive, determining benefit responsibility under the Plan, coordinating benefits with other Plans, determining medical necessity, and so on. For example, the Plan may share protected health information with third party administrators hired to provide claims services and other administrative services to the Plan.
2. **Health Care Operations:** The Plan may use and disclose protected health information about you for health care operations. These uses and disclosures are necessary to operate the Plan. For example, the Plan uses and discloses protected health information to conduct quality assessment and improvement activities, and for cost management and business management purposes.
3. **Treatment:** The Plan may use or disclose protected health information for treatment purposes, including helping providers to coordinate your care. Only the minimum amount of information necessary will be disclosed. For example, an emergency care provider may contact the Plan to find out what other providers you use, so that he or she can contact them to get medical records necessary to your care, if you are unable to provide that information.
4. **Disclosures to the Plan Sponsor:** The Plan may disclose your protected health information to th Employer, which sponsors the Plan, but only to permit the Employer to perform Plan administration functions. These disclosures may be made only to the Employer involved in Plan administration, and will be strictly limited to disclosures necessary for Plan administration purposes.
5. **Disclosures to Other Plans:** The Plan may disclose your protected health information to another health plan to facilitate claims payment and certain health care operations of the other plan.
6. **Uses and Disclosures You Specifically Authorize:** You may give the Plan written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give the Plan an authorization, you may revoke it in writing at any time. If you revoke your permission, the Plan will stop using or disclosing your protected health information in accordance with that authorization, except to the extent the Plan has already relied on it. Without your written authorization, the Plan may not use or disclose your protected health information for any reason except those described in this notice.

7. **Plan Communications with Individuals Involved in Your Care (or Payment for Your Care):** In general, the Plan will communicate directly with you about your claims and other Plan-related matters that involve your protected health information. In some cases, however, it may be appropriate to communicate about these matters with other individuals involved in your health care or payment for that care, such as your family, relatives, or close personal friends (or anyone else, if you choose to designate them).

   If you agree, the Plan may disclose to these persons protected health information about you that is directly relevant to their involvement in these matters. The Plan may also make such disclosures to these persons if you are given the opportunity to object to the disclosures and do not do so, or if the Plan reasonably infers from the circumstances that you do not object to disclosure to these persons. The Plan would not need to obtain your written authorization. For example, if you are an employee and are attempting to resolve a claims dispute with the Plan, and you orally inform the Plan that your spouse will be calling the Plan for additional discussion of these issues, the Plan would be permitted to disclose protected health information directly relevant to that dispute to your spouse.

   The Plan also may use or disclose your name, location and general condition (or death) to notify, or help to notify, persons involved in your care about your situation. If you are incapacitated or in an emergency, the Plan may disclose your protected health information to persons involved in your care (or payment) if it determines that the disclosure is in your best interest.
8. **Communication about Benefits, Products, and Services:** The Plan may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives, or to tell you about health-related products or services (or payment or coverage for such products or services) that may be of interest to you. The Plan may use your protected health information to contact you with information about benefits under the Plan, including certain communications about health plan networks, health plan changes, and value-added health plan-related products or services. The Plan may communicate with you face-to-face regarding any benefits, products or services. The Plan may use or disclose protected health information to distribute small promotional gifts.
9. **Required by Law:** The Plan may use or disclose your protected health information when required to do so by law. For example, disclosures to the Secretary of Health & Human Services for the purpose of determining the Plan's compliance with federal privacy law.
10. **Disaster Relief:** The Plan may use or disclose your name, location and general condition (or death) to a public or private organization authorized to assist in disaster relief efforts.
11. **Public Health and Safety:** The Plan may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others (but only to someone in a position to help prevent the threat). The Plan may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes. The Plan may disclose your protected health information to appropriate authorities if it reasonably believes that you are a possible victim of abuse, neglect, domestic violence or other crimes.
12. **Lawsuits and Disputes:** The Plan may disclose your protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, in accordance with specified procedural safeguards.
13. **Law Enforcement:** Under circumstances, such as a court order, or court-issued warrant, subpoena or summons, or grand jury subpoena, the Plan may disclose your protected health information to law enforcement officials. The Plan also may disclose limited protected health information to a law enforcement official concerning a suspect, fugitive, material witness, crime victim or missing person. The Plan may disclose protected health information about the victim of a crime (under limited circumstances); about a death the Plan believes may be the result of criminal conduct; to report a crime on the premises of the Plan; or, in an emergency, information relating to a crime not on the premises. If you are an inmate of a correctional institution, the Plan may disclose protected health information to the institution or to law enforcement.
14. **Research:** The Plan may use or disclose protected health information for research purposes, provided that the researcher follows certain procedures to protect your privacy. To the extent it is required by State law, the Plan will obtain your consent for a disclosure for research purposes.

15. **Decedents (Death, Organ/Tissue Donation):** The Plan may disclose the protected health information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization, for certain limited purposes.
16. **Military and National Security**: The Plan may disclose to military authorities the protected health information of armed forces personnel under certain circumstances. The Plan may disclose to authorized federal officials, protected health information required for intelligence, counter-intelligence, and other national security activities authorized by law.
17. **Workers' Compensation:** The Plan may disclose protected health information about you for workers' compensation or similar programs established by law to provide benefits for work-related injuries or illness.
18. **De-Identified Data:** The Plan may create a collection of information that can no longer be traced back to you (i.e., does not contain individually identifying information).

C. YOUR RIGHTS

1. **Access:** You have the right to look at or get copies of protected health information maintained by the Plan that may be used to make decisions about your Plan eligibility and benefits, with limited exceptions. The Plan reserves the right to require you to make this request in writing. If you request copies, you may be charged a fee to cover the costs of copying, mailing and other supplies. If you prefer, the Plan will prepare a summary or an explanation of your protected health information for a fee.

   To request access and/or a full explanation of the fee structure, contact the Claims Administrator at the phone number on your ID card.

   The Plan may deny your request in very limited circumstances. If the Plan denies your request, you may be entitled to a review of that denial. You will be told how to obtain a review. The Plan will abide by the outcome of that review.
2. **Amendment:** If you feel that your protected health information is incorrect or incomplete, you have the right to request that the Plan amend it. The Plan reserves the right to require this request be in writing, including a reason to support your request. To submit a request, contact the Claims Administrator at the phone number on your ID card. The Plan may deny your request if the Plan did not create the information you want amended or for certain other reasons. If the Plan denies your request, the Plan will provide you a written explanation and the process to be followed for any additional action.
3. **Accounting of Disclosures:** You have the right to receive a list of disclosures the Plan has made of your protected health information. This right does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. Your request for the accounting must be in writing. To request an accounting, contact the Claims Administrator at the phone number on your Plan ID card. You are entitled to such an accounting for the six (6) years prior to your request, though not earlier than April 14, 2003. The Plan will provide you with the date on which it made a disclosure, the name of the person or entity to which it disclosed your protected health information, a description of the protected health information it disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, the Plan may charge you a reasonable, cost-based fee for responding to these additional requests. You will be notified of the cost involved and be given the opportunity to withdraw or change your request before any costs are incurred.
4. **Restriction Requests:** You have the right to request that the Plan place additional restrictions on its use or disclosure of your protected health information for treatment, payment, or health care operations. The Plan is not required to agree to these restrictions, but if it does, the Plan will abide by its agreement (except in an emergency). Any such agreement by the Plan must be in writing signed by a person authorized to make such an agreement on our behalf; without this written agreement, the Plan will not be bound by the requested restrictions. Please use the contact information at the end of this notice to get more information about how to make such a request.
5. **Confidential Communication:** You have the right to request that the Plan communicate with you about your protected health information by alternative means or to an alternative location. For example, you may ask that the Plan contact you only at work or by mail. You must make your request in writing and must specify how or where you wish to be contacted. Your request must state that the information could endanger you if it is not communicated in confidence as you request. The

Plan will accommodate all reasonable requests. Please use the contact information at the end of this notice to get more information about how to make such a request.

6. **Copy of this Notice:** You are entitled to receive a printed (paper) copy of this notice at any time. Please contact the Plan using the information listed at the end of this notice to obtain a copy of this notice in printed form.
7. **Questions and Complaints:** If you want more information about the Plan's privacy practices, have questions or concerns, or believe that the Plan may have violated your privacy rights, please contact the Plan using the information following this section. You also may submit a written complaint to the U.S. Department of Health and Human Services. The Plan will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. The Plan supports your right to protect the privacy of your health information. The Plan will not retaliate in any way if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

For more information, contact:

Family & Child Learning Centers of N.E. WI, Inc.
1860 N Stevens Street
Rhinelander, WI 54501
715-369-5688

Or:

3PAdministrators
1113 Riders Club Road
Onalaska, WI 54650-2400
888-540-0094

17 COBRA NOTICE

This notice contains important information concerning your right to COBRA continuation coverage – a temporary extension of benefit coverage under the Plan that can become available to you and other eligible members of your family in the event you later lose group coverage through the Plan. The right to COBRA continuation was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Under the Plan, COBRA coverage applies to medical and dental benefits.

Note: This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

This notice provides a summary of your COBRA continuation rights. For more information about your rights and obligations under the Plan and under federal law, you should review the Eligibility section.

A. CONTINUATION OF COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses and Dependent children may be qualified beneficiaries. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage.

B. WHO IS ENTITLED TO ELECT COBRA?

If you are an employee, you will become a qualified beneficiary if you will lose coverage under the Plan due to one of the following qualifying events:

- your hours of employment are reduced; or
- your employment is terminated for any reason other than gross misconduct.

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

- employee dies;
- employee's hours of employment are reduced;
- employee's employment ends for any reason other than his or her gross misconduct;
- employee retires at age 65 or over and enrolls in Medicare (Part A, Part B); or
- divorce or legal separation from Employee. Also, if your Spouse reduces or eliminates Your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for You even though Your coverage was reduced or eliminated before the divorce or separation.

Your Dependent children will become qualified beneficiaries if they will lose coverage under the Plan because of any of the following qualifying events:

- employee dies;
- employee's hours of employment are reduced;
- employee's employment ends for any reason other than his or her gross misconduct;
- employee retires at age 65 or over and enrolls in Medicare (Part A, Part B); or
- Dependent child is no longer eligible for coverage because he or she is no longer a "Dependent child" under the Plan; or
- employee is divorced or legally separated, or same-sex domestic partnership is terminated.

Certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within six months after Plan coverage is lost). If you are an employee or former employee and you qualify for TAA or ATAA, **CONTACT THE PLAN SPONSOR PROMPTLY AFTER QUALIFYING FOR TAA OR ATAA OR YOU WILL LOSE ANY RIGHT THAT YOU MAY HAVE TO ELECT COBRA DURING A SPECIAL SECOND ELECTION PERIOD.** Contact the Plan Sponsor or the Administrative Services Manager for more information about the special second election period.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Employee Benefits has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, or reduction of hours of employment Your coverage will terminate at the end of the month in which a qualifying event has occurred unless you elect COBRA continuation coverage. You have 60 days from the date of loss of coverage to elect COBRA continuation coverage.

Note: For other qualifying events – divorce or legal separation, or a Dependent child losing eligibility for coverage – you must notify the Plan Administrator within 60 days after the qualifying event occurs or a COBRA election will not be available to you. You must either send a letter of notification to the Plan Administrator or 3PAdministrators (3PA) at P.O. Box 247, Onalaska, WI 54650 or call 1-888-540-0094. The Plan Administrator will send you the appropriate form to complete. This form must then be completed and sent to The Plan Administrator at the address above, and postmarked within the 60-day time limitation. Your coverage will terminate at the end of the month in which the qualifying event occurs unless you elect COBRA continuation coverage. You have 60 days from the date of loss of coverage to elect COBRA continuation coverage. If You do not follow these procedures or if notice is not provided to the Plan Administrator during the 60-day notice period **ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.**

Once Employee Benefits notifies the Plan COBRA Administrator that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA, coverage will begin on the date the Plan coverage would otherwise have been lost.

C. QUALIFYING EVENTS DETERMINE LENGTH OF COVERAGE

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, divorce or legal separation, or a Dependent child losing eligibility, COBRA continuation coverage can be in effect for up to 36 months. When the qualifying event is the end of employment or a reduction in the employee's hours of employment, COBRA continuation coverage is available for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

1. Disability extension of the 18-month period of continuation coverage. If You or anyone in Your family who is currently covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first **60 days** of COBRA continuation coverage, You and Your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's (SSA) determination within **60 days** of the latest of:

    - the date of the SSA determination,
    - the date of the qualifying event,
    - the date of the loss of coverage, or
    - the date you are informed of your obligation and the procedure to provide this information,

    and before the end of the 18-month period of COBRA continuation coverage. You must send this notice to the Plan Administrator or 3PAdministrators. If you fail to notify the Plan Administrator or 3PA in writing and postmarked within the time limit, you will lose your right to extend coverage due to disability. Under this provision, you must also notify the Plan Administrator within 30 days if the SSA determination is revoked.

2. Second qualifying event extension of the 18-month period of continuation coverage. If another qualifying event occurs during COBRA continuation coverage, Your spouse and Dependent children in your family may be eligible for additional months of COBRA continuation coverage, up to a maximum of 36 months. The second qualifying event must be one that would have caused a loss of coverage if Your spouse and Dependent children in Your family were not currently receiving COBRA continuation coverage. This extension is available to the spouse and Dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), is divorced or legally separated, or has a termination of same-sex domestic partnership. The extension is also available to a Dependent child who is no longer eligible under the Plan as a Dependent child. In all of these cases, You must make sure that the Plan Administrator is notified in writing within **60 days** of the second qualifying event. You must send this notice to the Plan Administrator or 3PAdministrators. If you fail to notify the Plan Administrator or 3PA in writing and postmarked within the time limit, you will lose your right to extend coverage.

D. END OF COBRA CONTINUATION COVERAGE

Your COBRA continuation coverage may be terminated prior to the end of the continuation period for any of the following reasons:

- Employer no longer provides group insurance to any of its employees.
- The premium for your continuation coverage is not paid in a timely fashion.

Note: You will have 45 days from the date you elect COBRA continuation coverage in which to make your first premium payment to the Plan Administrator. After the first payment, there is a 30-day grace period for all future payments. For example: All regular COBRA continuation payments are due on the first day of the month. If your payment is due on January 1, your payment must be postmarked within 30 days or January 30. Payments made after the 30-day grace period will be returned to you and all coverage will be cancelled as of the end of the month in which the last regular payment was made.

- After making your COBRA election, you become covered under another group plan that does not include a pre-existing condition clause that applies to you or eligible Dependent(s).
- After making your COBRA election, you or your Dependents become covered under Medicare (Part A, Part B, or both). A final determination has been made by the Social Security Administration that you are no longer disabled. Termination of coverage is effective in the month that begins more than 30 days after the final determination.

E. KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect the rights of you and your family, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices sent by you to the Plan Administrator. You can contact the Plan Administrator as indicated below.

F. QUESTIONS ABOUT BILLING

The Administrative Services Manager (3PAdministrators) is responsible for administering COBRA continuation coverage. If you have any questions about your billing, you should contact the 3PA directly.

G. QUESTIONS ABOUT COVERAGE

If you have questions about your COBRA coverage, you should contact 3PAdministrators at P.O. Box 247, Onalaska, WI 54650 or 1-888-540-0094 or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of the Regional and District EBSA Offices are available through the EBSA Web site at www.dol.gov/ebsa.

18 Important Notice from Family & Child Learning Centers of N.E. WI, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Family & Child Learning Centers of N.E. WI, Inc. and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Family & Child Learning Centers of N.E. WI, Inc. has determined that the prescription drug coverage offered by the Family & Child Learning Centers health plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. Beneficiary's leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Family & Child Learning Centers of N.E. WI, Inc. prescription drug coverage, be aware that you and your Dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

The Family & Child Learning Centers of N.E. WI, Inc. plan offers prescription coverage of generic and brand name drugs. On retail pharmacy purchases, you will pay a $10 co-pay for generic drugs, a $20 co-pay for formulary brand name drugs and a $35 co-pay for non-formulary brand name drugs for up to a 34 day supply. When ordering prescriptions through the home delivery service,a $20 co-pay for generic drugs, a $40 co-pay for formulary brand name drugs and $70 co-pay for non-formulary brand name drugs for a 90 day supply.

You should also know that if you drop or lose your coverage with Family & Child Learning Centers of N.E. WI, Inc. and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact our office for further information or call 3PAdministrators at 1-888-540-0094. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Family & Child Learning Centers of N.E. WI, Inc. changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	July 1, 2011
Name of Entity/Sender:	Family & Child Learning Centers of N.E. WI, Inc.
Contact--Position/Office:	Plan Administrator Business Office
Address:	1860 N Stevens Street Rhinelander, WI 54501
Phone Number:	715-369-5688

19 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

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

- They were Covered Persons in the Plan immediately prior to the Employee's leave of absence for Uniformed Service; and
- The reason for the Employee's leave of absence is service in the Uniformed Service of coverage during military leave.

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

- For leaves of 30 days or less, the same as the Employee contribution required for similarly-situated Employees;
- For leaves of 31 days or more, up to 102% of the full Plan contribution.

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

A. MAXIMUM PERIOD OF COVERAGE DURING USERRA LEAVE

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

- The date You fail to return as an Employee following completion of Your leave. Employees must return to the Employer within:
    - The first full business day of completing Uniformed Service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such Uniformed Service;
    - 14 days of completing Uniformed Service, for leaves of 31 to 180 days;
    - 90 days of completing Uniformed Service, for leaves of more than 180 days; or
- 24 months from the date Your leave began.

B. REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

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

- The first full business day of completing Your Uniformed Service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such Uniformed Service;
- 14 days of completing Uniformed Service, for leaves of 31 to 180 days;
- 90 days of completing Uniformed Service, for leaves of more than 180 days.

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

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

NOTE: Contact the Plan Administrator for complete information regarding Your rights under the Uniformed Services Employment and Reemployment Rights Act.

20 STATEMENT OF ERISA RIGHTS

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

A. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

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

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

B. CONTINUE GROUP HEALTH PLAN COVERAGE

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

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

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Covered Persons and beneficiaries. No one, including the Plan Administrator, 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.

D. 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 that is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against

for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

E. ASSISTANCE WITH YOUR QUESTIONS

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administration, You should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA).

21 GENERAL PROVISIONS

A. APPOINTMENT OF AUTHORIZED REPRESENTATIVE

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

B. AUTOPSY

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

C. CLERICAL ERROR/DELAY

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

D. CONFORMITY WITH APPLICABLE LAWS

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

E. FAILURE TO ENFORCE PLAN PROVISIONS

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

F. FREE CHOICE PROVIDER

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

G. HEADINGS

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

H. LIMITATION ON ACTIONS

No action at law or in equity will be instituted to recover under this Plan prior to the expiration of 90 days after a claim for benefits has been filed in accordance with the requirements of this Plan. Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within one year after the

expenses due to Injury or Sickness are incurred or are alleged to have been incurred. Any limitation on actions regarding claims for benefits will be as provided in Section "Claims Procedures; Payment of Claims", heading "Decision on Review to be Final".

I. MEDICAID COVERAGE

A Covered Person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the state Medicaid program; and the Plan will honor any Subrogation rights the state may have with respect to benefits which are payable under the Plan.

J. NO WAIVER OR ESTOPPEL

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

K. NON-U.S. PROVIDERS

Medical expenses for care, supplies, or services which are rendered by a Qualified Practitioner whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

- Benefits may not be assigned to a Non-U.S. Provider;
- The Covered Person is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
- Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
- The Non-U.S. Provider will be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
- Claims for benefits must be submitted to the Plan in English.

L. NOT A CONTRACT

This Plan Document and Summary Plan Description, as well as any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document will not constitute a contract of any type between the Plan Administrator and any person. Nothing in this Plan Document and Summary Plan Description gives 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.

M. PHYSICAL EXAMINATION

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose condition, Sickness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

N. PLAN CONTRIBUTIONS

The Employer will, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) by each Covered Person.

The Plan Sponsor will fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as will be applicable to the end that the Plan will be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator will be free to determine the manner and means of funding the Plan. The amount of the Covered Person's contribution (if any) will be determined from time-to-time by the Employer.

O. PRONOUNS

All personal pronouns used in the Plan will include either gender unless the context clearly indicates otherwise.

P. PROTECTION AGAINST CREDITORS

Benefit payments under the Plan are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind. Any attempt to accomplish these will not be recognized. The Plan Administrator may, at its sole discretion, terminate Your interest in the benefits payable under this Plan, in which event the Plan will then apply the amount of the payment to the benefit of an adult child, guardian of a minor child, brother or sister, or other relative of the Covered Person. Such payment will fully discharge the Plan's liability to the extent of the payment.

Q. RIGHT OF RECOVERY PROVISION

Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Covered Person on whose behalf the payment was made.

A Covered Person, Provider, another benefit plan, insurer, or any other person or entity who receives a payment for expenses exceeding the amount of benefits available under the terms of the Plan or on whose behalf such payment to the Plan was made, will return the amount of such erroneous payment to the Plan Sponsor within 30 days of discovery or demand. The Plan Administrator will 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 will have the sole discretion to choose who will repay the Plan Sponsor for an erroneous payment and such payment will be reimbursed in lump sum or deducted from future claims presented for processing.

Health care providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. Any payments made on claims for reimbursement not in accordance with the above provisions will be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the Plan will be entitled to recover its litigation cost and actual attorney's fees incurred.

R. RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for benefits from this Plan. In so acting, the Plan Administrator will be free from any liability that may arise with regard to such action. Any Covered Person claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement this provision.

S. 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 will be interpreted to conform to the minimum requirements of such law.