

SUMMARY PLAN DESCRIPTION

Frantz Manufacturing Company

EMPLOYEE HEALTH CARE PLAN

This booklet is your Summary Plan Description. Its purpose is to summarize the provisions of the Plan, which provides and/or affects payment or reimbursement. The Plan Document takes precedence over this booklet. This Summary Plan Description supersedes any and all previous Summary Plan Descriptions issued to you by Frantz Manufacturing Company.

The Plan is funded by Frantz Manufacturing Company and employee contributions. The benefits and principal provisions of the group Plan are described in this booklet. They are effective only if you are eligible for coverage, become covered, and remain covered in accordance with the provisions of the group Plan.

The purpose of providing a comprehensive health plan is to protect you and your family from serious financial loss resulting from necessary health care. However, we must recognize and deal with escalating costs. Being fully informed about the specific provisions of your Plan will help both you and the Company to maintain reasonable rates in the future. We have prepared the following pages as a general guide for you to become a “good consumer” of your health care. It will take a joint effort between hospitals, physicians, you and us – the Company – to make our Plan work, both now and in future years.

We believe that each participant has the responsibility to: read and understand the benefit plan and comply with the rules and limitations stated therein; carry and present his or her identification card prior to receiving services; notify the Plan of any eligibility or address changes for any covered person(s); supply health care providers with any information needed for provision of health care services; notify health care providers in a timely manner of appointment cancellations; and follow the health care provider’s instructions and guideline.

We strongly encourage each person insured under this plan to enroll with Medicare upon attaining eligibility, which is generally at age 65. You are entitled to Medicare benefits even if you are still actively working and/or are covered by another health care plan.

All health benefits described herein are being provided and maintained for you and your covered dependents by Frantz Manufacturing Company, hereinafter referred to as the “Company.” Butler Benefit Service, Inc. will process all benefit payments.

Claims should be submitted to:

Butler Benefit Service, Inc.
P.O. Box 3310
Davenport, Iowa 52808-3310
(563) 327-2280
(866) 927-2200 Ext. 280

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NOTE: Any term used in this document that is denoted in SMALL CAPITAL LETTERS is described in the Definitions section of this document.

PLAN DESCRIPTION

PURPOSE

The PLAN DOCUMENT details the BENEFITS, rights, and privileges of COVERED INDIVIDUALS (as later defined), in a fund established by Frantz Manufacturing Company and referred to as the "Plan." The PLAN DOCUMENT explains the times when the Plan will pay or reimburse all or a portion of COVERED EXPENSES.

EFFECTIVE DATE

The effective date of the Plan is January 1, 1987.

The Plan is restated effective January 1, 2009.

The Plan is amended effective January 1, 2009.

NAME OF PLAN	Frantz Manufacturing Company Employee Group Health Benefit Plan
NAME, ADDRESS AND PHONE NUMBER OF PLAN SPONSOR	Frantz Manufacturing Company P.O. Box 497, 603 1st Avenue Sterling, Illinois 61081 (815) 625-7063
NAME, ADDRESS AND PHONE NUMBER OF CLAIMS PROCESSOR	Butler Benefit Service, Inc. (BBSI) P.O. Box 3310 Davenport, Iowa 52808-3310 (563) 327-2280 (866) 927-2200 ext 280
EMPLOYER IDENTIFICATION NUMBER	36-1102120
GROUP NUMBER	BBS0151
PLAN NUMBER	506
TYPE OF BENEFIT PROVIDED	Medical, Prescription Drug and Dental Expense Coverage
PLAN ADMINISTRATOR AND AGENT FOR LEGAL SERVICE	Secretary/Treasurer Frantz Manufacturing Company P.O. Box 497, 603 1st Avenue Sterling, Illinois 61081 (815) 625-7063
FUNDING OF THE PLAN	Contributions are made to the Plan by Frantz Manufacturing Company and/or COVERED SERVICES. Plan BENEFITS are provided directly from the Plan through the CLAIMS PROCESSOR.
FISCAL YEAR OF THE PLAN	Begins January 1 st and ends December 31 st .
BENEFIT YEAR OF THE PLAN	CALENDAR YEAR (January 1 st through December 31 st)
MEDIUM FOR PROVIDING BENEFITS	The CLAIMS PROCESSOR processes claims in accordance with the PLAN DOCUMENT.

Named Fiduciary and Plan Administrator

The NAMED FIDUCIARY and PLAN ADMINISTRATOR is Frantz Manufacturing Company, who will have the authority to control and manage the operation and administration of the Plan. The PLAN ADMINISTRATOR (or similar decision making body) has the sole authority and discretion to interpret and construe the terms of the Plan and to determine any and all questions in relation to the administration, interpretation or operation of the Plan, including, but not limited to, eligibility under the Plan, payment of BENEFITS or claims under the Plan and any and all other matters arising under the Plan.

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Claims Processor is Not a Fiduciary

A CLAIMS PROCESSOR is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the PLAN ADMINISTRATOR.

Contributions to the Plan

The amounts of contributions to the Plan are to be made on the following basis:

The COMPANY will from time to time evaluate the costs of the Plan and determine the amount to be contributed by the COMPANY and the amount to be contributed (if any) by each covered EMPLOYEE. Notwithstanding any other provision of the Plan, the COMPANY'S obligation to pay claims otherwise allowable under the terms of the Plan will be limited to its obligation to make contributions to the Plan as set forth in the preceding sentence. Payment of said claims in accordance with these procedures will discharge completely the COMPANY'S obligation with respect to such payments. In the event that the COMPANY terminates the Plan, then as of the effective date of termination, the COMPANY and Covered EMPLOYEES will have no further obligation to make additional contributions to the Plan.

Plan Modifications and Amendments

Subject to any NEGOTIATED agreements, the COMPANY may modify, amend, or discontinue the Plan without the consent of or notice to EMPLOYEES. Any changes made shall be binding on each EMPLOYEE and on any other COVERED INDIVIDUALS. This right to make AMENDMENTS shall extend to amending the coverage (if any) granted to RETIREES covered under the Plan, including the right to terminate such coverage (if any) entirely.

Termination of Plan

The COMPANY reserves the right at any time to terminate the Plan by a written instrument to that effect. All previous contributions by the COMPANY will continue to be issued for the purpose of paying BENEFITS under the provisions of this Plan with respect to claims arising before such termination, or will be used for the purpose of providing similar health BENEFITS to Covered EMPLOYEES, until all contributions are exhausted.

Plan Is Not a Contract

The PLAN DOCUMENT constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any EMPLOYEE of the COMPANY the right to be retained in the service of the COMPANY or to interfere with the right of the COMPANY to discharge or otherwise terminate the employment of any EMPLOYEE.

Claim Procedure

The COMPANY will provide adequate notice in writing to any Covered EMPLOYEES whose claim for BENEFITS under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the EMPLOYEE. Further, the COMPANY will afford a reasonable opportunity to any EMPLOYEE, whose claim for BENEFITS has been denied, for a full and fair review of the decision denying the claim by the person designated by the COMPANY for that purpose.

Protection against Creditors

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the COMPANY will find that such an attempt has been made with respect to any payment due or to become due to any Covered EMPLOYEE, the COMPANY in its sole discretion may terminate the interest of such Covered EMPLOYEE or former Covered EMPLOYEE in such payment, and in such case will apply the amount of such payment to or for the benefit of such Covered EMPLOYEE or former Covered EMPLOYEE, his SPOUSE, parent, adult CHILD, guardian of a minor CHILD, brother or sister, or other relative of a DEPENDENT of such Covered EMPLOYEE or former Covered EMPLOYEE, as the COMPANY may determine, and any such application will be a complete discharge of all liability with respect to such benefit payment.

Indemnification of Employees

No director, officer, or EMPLOYEE of the COMPANY or of the CLAIMS PROCESSOR will incur any personal liability for the breach of any responsibility, obligation, or duty in connection with any act done or omitted to be done in good faith in the administration or management of the Plan and will be indemnified and held harmless by the COMPANY from and against any such personal liability, including all expenses reasonably INCURRED in his defense if the COMPANY fails to provide such defense. The COMPANY and the Plan may each purchase fiduciary liability insurance consistent with applicable law.

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Clerical Error

Any clerical error by the PLAN ADMINISTRATOR or an agent of the PLAN ADMINISTRATOR in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a COVERED INDIVIDUAL, if it is requested, the amount of overpayment will be deducted from future BENEFITS payable.

PRIOR WRITTEN APPROVAL

Before you receive certain services, supplies or procedures, you should have written authorization. This procedure is called Prior Written Approval. This program helps determine if a proposed TREATMENT PLAN is MEDICALLY NECESSARY and is a benefit of this Plan. It is in your best interest to receive Prior Written Approval before you receive any of the services listed below. Without Prior Written Approval for any of the following services, the Plan cannot confirm BENEFITS:

- Communication System (Touch Talker).
- COSMETIC procedure, including but not limited to: scar revisions, reconstruction of nose (rhinoplasty), port wine stain surgery, surgery on eyelids (blepharoplasty), surgery to correct overbite or underbite (orthognathic surgery) and breast surgery (including reconstruction, reduction or gynecomastia).
- Charges for dental services not specifically included in BENEFITS described in this Plan; or for HOSPITAL charges in relation to dental care, except those services which are certified by a medical doctor to be MEDICALLY NECESSARY to safeguard the life and health of the COVERED INDIVIDUAL due to the existence of a non-dental physical condition.
- Electrical stimulation of the spine (dorsal column stimulator).
- Electronic Limbs (myo-electric and other electronic prosthetic devices).
- Bone Growth Stimulator.
- Growth Hormones; please note – growth hormones will not be covered for any male over 5 feet 6 inches and females over 5 feet 2 inches.
- Insulin infusion pump.
- Motorized wheelchair including chairs with three or four wheels.
- Reduction mammoplasty.
- Replacement of prosthetic appliance.
- Surgery to correct funneled or hollowed chest (pectus excavatum surgery).
- All transplants and joint replacements, including but not limited to cornea, artery or vein, bone marrow, heart, heart and lung, lung, valve, kidney, implantable prosthetic lenses in connection with cataracts, joint replacement, liver, prosthetic bypass or replacement vessels.
- Uvulopalatopharyngoplasty to reduce sleep apnea.

This is not meant to be an all-inclusive list. Always consult with Butler Benefit Service, Inc. when purchasing health care services, supplies or equipment if you are in any doubt of eligible charges.

Certain factors may alter or impact the Prior Written Approval decision by the Plan, including Plan coverage, the date services are INCURRED, the amount approved for payment and the provider of such services.

Written request for authorization should be sent to the Plan care of:

Butler Benefit Service, Inc.
P.O. Box 3310
Davenport, Iowa 52808-3310
Phone: (563) 327-2280 or (866) 927-2200 ext. 280
Fax: (563) 327-2250 or (866) 927-2250

Once the Plan reviews the request, written notice of the decision will be mailed to the COVERED INDIVIDUAL and the provider to the most current address on record for each.

Please note: Even if you receive written prior approval for a service, certain services are still subject to pre-certification; please refer to the "Pre-Certification" provision on page 6.

PREFERRED PROVIDER NETWORK

This Plan is a plan which contains a Preferred Provider Organization. This Plan has entered into an agreement with certain HOSPITALS, PHYSICIANS and other health care providers, which are called PARTICIPATING PROVIDERS, or In-Network Providers. Because these PARTICIPATING PROVIDERS have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a COVERED INDIVIDUAL uses a PARTICIPATING PROVIDER, that COVERED INDIVIDUAL will receive a higher BENEFIT PERCENTAGE from the Plan than when a Non-Participating, or Out-of-Network, Provider is used. It is the COVERED INDIVIDUAL'S choice as to which Provider to use.

The PPO which is applicable to each COVERED INDIVIDUAL is shown on the COVERED INDIVIDUAL'S health plan identification card. Information about the PPO network(s) available to this Plan's COVERED INDIVIDUALS, including instructions on how to access the directory of PARTICIPATING PROVIDERS, will be provided to COVERED INDIVIDUALS and updated as needed.

All services under this Plan must be provided by PARTICIPATING PROVIDERS in order to be covered at the In-Network benefit level. **It is the Covered Individual's responsibility to ensure that services are rendered by In-Network providers.** Services received elsewhere will be paid at the Out-of-Network level of BENEFITS. However, if any of the following circumstances apply, BENEFITS will be payable at the In-Network level of BENEFITS:

- The COVERED INDIVIDUAL receives Anesthesia services by an Out-of-Network Provider at an In-Network facility.
- During a scheduled IN-PATIENT admission at an In-Network facility, the COVERED INDIVIDUAL receives consulting services from an Out-of-Network PHYSICIAN provided the admitting PHYSICIAN is In-Network.
- The service was not available through the PPO.
- The PATIENT has obtained an Approved Referral **prior to the service being rendered;** such referral must be:
 1. Written by a Participating PHYSICIAN for specific services; and
 2. Reviewed by the UTILIZATION REVIEW AGENT for MEDICAL NECESSITY and appropriateness; and
 3. Approved by the PLAN ADMINISTRATOR.An Approved Referral will remain in force through a course of treatment or twelve (12) consecutive months, whichever is less.
- EMERGENCY care when an In-Network provider is not available.
- Services for COVERED INDIVIDUALS who travel and receive services outside the area served by the Network, provided that the travel is for other than the purpose of obtaining medical care.
- Ancillary services when the primary service is rendered by an In-Network HOSPITAL.

Wrap Network

Also known as a "vacation" network; this is a PREFERRED PROVIDER ORGANIZATION the Plan utilizes when a COVERED INDIVIDUAL incurs expenses for EMERGENCY or urgent care services outside of their home area. There is no need to locate a PARTICIPATING PROVIDER when emergency or urgent care is necessary.

Tertiary/Catastrophic Network

A PREFERRED PROVIDER ORGANIZATION the Plan utilizes when a COVERED INDIVIDUAL suffers a catastrophic ILLNESS or INJURY. Some instances when a tertiary network may be accessed include, but are not limited to:

Organ Transplants, Cardiovascular/Heart Disease Procedures, High Risk Maternity/ Neonatal Cases, Cancer, Severe Burns, Severe Trauma, High-risk Medical/ Surgical Cases.

Please contact BBSI for assistance in locating appropriate providers.

MANAGED CARE

Utilization Review

Utilization review is a program designed to help insure that all COVERED INDIVIDUALS receive necessary and appropriate health care while providing the most cost-effective alternatives and avoiding unnecessary expenses. The program consists of:

- Pre-certification of certain non-emergency services before such services are provided (at least two (2) business days in advance, whenever possible). A list of services which require pre-certification is provided later in this section.
- Retrospective review of the MEDICAL NECESSITY of IN-PATIENT facility admissions which commence on an EMERGENCY basis.
- Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending PHYSICIAN; and
- Certification of services and planning for discharge from a MEDICAL CARE FACILITY or cessation of medical treatment.

These services are described in greater detail below. The phone number for Pre-Certification (which is managed by the UTILIZATION REVIEW AGENT) is listed on the reverse side of your health plan identification card.

Pre-Certification

CAREFULLY REVIEW THE FOLLOWING PRE-CERTIFICATION REQUIREMENTS AND PROCEDURES; FAILURE TO FOLLOW PRE-CERTIFICATION PROCEDURES MAY INCREASE YOUR FINANCIAL RESPONSIBILITY. Pre-Certification is intended to confirm that any IN-PATIENT admission is MEDICALLY NECESSARY, the stay is only as long as the PATIENT'S condition requires, and that discharge planning is adequate to meet the PATIENT'S needs. Note: If this Plan is secondary to another medical plan that also covers the Covered Individual, pre-certification will not be required.

The Plan requires that all IN-PATIENT HOSPITAL admissions be pre-certified by the UTILIZATION REVIEW AGENT:

- All non-emergency IN-PATIENT admissions must be reported **prior** to the admission (at least two (2) business days in advance, whenever possible);
- All EMERGENCY IN-PATIENT HOSPITAL admissions must be reported within two (2) business days of admission.

Additionally, the Plan strongly recommends Pre-Certification of the following services:

- All non-emergency, scheduled SURGICAL PROCEDURES.
- All non-emergency, scheduled MRIs, MRAs, CT scans, and PET scans.
- DURABLE MEDICAL EQUIPMENT purchases in excess of \$300 and **any** rental of DURABLE MEDICAL EQUIPMENT.
- Any course of radiation therapy, chemotherapy, home health care or dialysis.

Pre-Certification of In-Patient Admission creates Pre-Service Claim

A Pre-service Claim is considered to be filed when the request for approval of an IN-PATIENT admission is made and received by the UTILIZATION REVIEW AGENT in accordance with the Plan's procedures. The UTILIZATION REVIEW AGENT shall notify the COVERED INDIVIDUAL of determination of MEDICAL NECESSITY for an IN-PATIENT admission in a reasonable period of time appropriate to the medical circumstances, according to the time limits set forth for Pre-Service Claims in the Claims Procedures section of this PLAN DOCUMENT.

When the UTILIZATION REVIEW AGENT provides pre-certification of an IN-PATIENT admission to the COVERED INDIVIDUAL, the UTILIZATION REVIEW AGENT will assign a certain number of IN-PATIENT HOSPITAL days for the stay. If any days are not MEDICALLY NECESSARY, and the COVERED INDIVIDUAL chooses to remain beyond the MEDICALLY NECESSARY length of stay, the COVERED INDIVIDUAL shall be liable for all HOSPITAL charges beyond the MEDICALLY NECESSARY length of stay.

How to Pre-Certify Services

The COVERED INDIVIDUAL must inform the provider that he participates in a program which has pre-certification requirements. The COVERED INDIVIDUAL must notify the appropriate UTILIZATION REVIEW AGENT of the upcoming non-emergency service prior to the admission to the HOSPITAL or Facility (at least two (2) business days in advance, whenever possible). For EMERGENCY services, the UTILIZATION REVIEW AGENT must be notified within two (2) business days after the admission. If there is any question as to whether or not a service should be pre-certified, please call Butler Benefit Service, Inc. or simply go ahead and call the UTILIZATION REVIEW AGENT and pre-certify the service; it is better to call and not need to have the service pre-certified than to not pre-certified a service for which it is required, and suffer the Penalty for Non-Pre-certification.

Notice can be given by the COVERED INDIVIDUAL or a FAMILY member of the COVERED INDIVIDUAL, by the HOSPITAL or by the Admitting PHYSICIAN, but it is ultimately the responsibility of the COVERED INDIVIDUAL to make sure a HOSPITAL admission, surgery, procedure, service, supply or equipment has been pre-certified. The following information will be requested by the UTILIZATION REVIEW AGENT for pre-certification:

- EMPLOYER: Frantz Manufacturing Company;
- Group Number: BBS0151;
- Covered EMPLOYEE'S Name, Address and health plan identification number;
- Patient's Name, Date of Birth, Gender and relationship to Covered EMPLOYEE;
- Admitting HOSPITAL Name, Address and Phone Number;
- Admitting Diagnosis and Procedure, if known;
- Date of Admission and/or Surgery;
- Admitting PHYSICIAN'S Name, Address and Phone Number.

Penalty for Non-Certification

Failure to pre-certify IN-PATIENT HOSPITAL admissions with the UTILIZATION REVIEW AGENT as required will result in the **eligible expenses for those services to be reduced by 100% to a maximum penalty of \$200** per COVERED INDIVIDUAL per incident. The additional penalty does not apply toward the OUT-OF-POCKET EXPENSE Limit, and will be figured before the DEDUCTIBLE and COINSURANCE are applied. The penalty is not considered a covered expense. PRE-CERTIFICATION DOES NOT GUARANTEE BENEFITS. ALL CHARGES ARE SUBJECT TO REVIEW AND ELIGIBILITY.

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 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).

Continued Stay Review

If the UTILIZATION REVIEW AGENT determines at any time during an admission, home health care treatment program, HOSPICE care program or other course of treatment, that care or treatment is no longer MEDICALLY NECESSARY, there will be no coverage for expenses INCURRED thereafter because the PATIENT elects to remain IN-PATIENT or continue with care. Notification of termination of BENEFITS for such continued care will be given to a COVERED INDIVIDUAL within 24 hours of the termination. If the Attending PHYSICIAN feels that it is MEDICALLY NECESSARY for a COVERED INDIVIDUAL to receive additional services or to stay in the MEDICAL CARE FACILITY for a greater length of time than has been pre-certified, the Attending PHYSICIAN must request the additional services or days.

Additional Surgical Opinion Provision

Certain SURGICAL PROCEDURES are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition. In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's COVERED INDIVIDUALS and protecting the financial integrity of the Plan.

BENEFITS will be provided for a second (and third, if necessary) opinion consultation, to determine the MEDICAL NECESSITY of an elective SURGICAL PROCEDURE. An elective SURGICAL PROCEDURE is one that can be scheduled in advance; that is, it is not an EMERGENCY or of a life-threatening nature. The PATIENT may choose any board-certified specialist who is not an associate of the Attending PHYSICIAN and who is affiliated in the appropriate specialty.

The Plan will not pay for expenses for an opinion on a proposed SURGICAL PROCEDURE that is not a covered procedure under this Plan. While any covered surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available:

- Appendectomy
- Hemorrhoid surgery
- Knee, shoulder, elbow or toe surgery
- Prostate surgery
- Spinal surgery
- Cataract surgery
- Hernia surgery
- Mastectomy
- Removal of fallopian tubes and/or ovaries
- Tonsillectomy, Adenoidectomy
- Surgery of ear
- Hysterectomy
- Nasal surgery
- Varicose vein ligation
- Gall bladder surgery

Case Management - MANDATORY

When a catastrophic condition, such as spinal cord INJURY, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps LIFETIME care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting – even to his or her home.

Case Management is a program whereby a case manager monitors these PATIENTS and explores, discusses and recommends coordinated and/or alternative types of appropriate MEDICALLY NECESSARY care. The case manager consults with the PATIENT, the family and the Attending PHYSICIAN in order to develop a plan of care for approval by the PATIENT'S Attending PHYSICIAN and the PATIENT. The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate TREATMENT PLAN. This plan of care may include some or all of the following:

- Personal support to the PATIENT;
- Contacting the family to offer assistance and support;
- Monitoring HOSPITAL or SKILLED NURSING FACILITY;
- Determining alternative care options; and
- Assisting in obtaining any necessary equipment and services.

Note: Case Management is a mandatory service. If you are invited to join Case Management you must accept. Case Management may be offered to diagnoses including but not limited to: Heart Disease, Respiratory Disease, Traumatic Injury, Diabetes, Asthma, Depression, Gastrointestinal Disorders, Cancer, and High Risk Pregnancy. If a plan participant is offered Case Management and they reject the service, eligible expenses will be reduced by 100% to a maximum penalty of \$3,000 per plan participant per Calendar Year.

Alternative Treatment Benefit

If there is more than one type of service or supply which can be used for the treatment of an INJURY or ILLNESS, the PLAN ADMINISTRATOR shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of PATIENT care. This alternative benefit may be beneficial to both the PATIENT and the Plan. The PLAN ADMINISTRATOR, Attending PHYSICIAN, PATIENT and PATIENT'S family must all agree to the alternate TREATMENT PLAN. Once agreement has been reached, the PLAN ADMINISTRATOR will direct the Plan to reimburse for MEDICALLY NECESSARY expenses as stated in the TREATMENT PLAN, even if these expenses normally would not be paid by the Plan. Each TREATMENT PLAN is individually tailored to a specific PATIENT and should not be seen as appropriate or recommended for any other PATIENT, even one with the same diagnosis.

If a proposed plan of treatment is offered by a COVERED INDIVIDUAL'S PHYSICIAN and accepted by the PLAN ADMINISTRATOR, the proposed TREATMENT PLAN will be considered as an ELIGIBLE EXPENSE. Services and supplies, otherwise ineligible, that are suggested and used according to the proposed TREATMENT PLAN, will be paid as an Eligible Alternative Treatment Benefit.

PLAN SUMMARY

Frantz Manufacturing Company Employee Group Health Benefit Plan

Eligibility Provisions

*Please refer to the following sections for additional information:
ELIGIBILITY FOR COVERAGE (page 38)
ENROLLMENT (page 41)*

ACTIVE EMPLOYEES

Eligibility Requirements:

- All Active Full-Time EMPLOYEES who work for the COMPANY at least thirty (30) hours per week on a regular basis.

Required Period of Service (Waiting Period):

- An EMPLOYEE will be eligible for coverage on the first day following ninety (90) calendar days of continuous employment with the COMPANY.

MAJORITY OWNERS, SURVIVING SPOUSES OF MAJORITY OWNERS

Eligibility Requirements:

- All Majority Owners of the COMPANY, and surviving spouses of Majority Owners.

Required Period of Service (Waiting Period):

- A Majority Owner will be eligible for coverage on the first day of majority ownership of the COMPANY.
- A Surviving Spouse of a Majority Owner will be eligible to continue coverage as of the date of the Majority Owner's death.

Contributions

The Plan may be evaluated from time to time to determine the amount of EMPLOYEE contribution (if any) required.

Verification of Eligibility

Call the Claims Processor to verify benefits BEFORE a charge is incurred!

Butler Benefit Service, Inc. (BBSI)
(563) 327-2280 or (866) 927-2200 ext 280

Medical Expense Benefit Summaries

*Please refer to the **COMPREHENSIVE MEDICAL EXPENSE BENEFITS** section (page 18) and the **GENERAL EXCLUSIONS** section (page 32) for additional information.*

The Frantz Manufacturing Company Employee Group Health Benefit Plan offers eligible employees and their covered dependents two different options for medical coverage. An Individual may be covered under Option 2 (the Value Plan), while other Individuals in the same family are covered under Option 1 (the Comprehensive Medical Benefit Plan). **Note:** The Prescription Drug Expense Benefit is identical for both plan options.

Option 1, Comprehensive Medical Benefit Plan

Option 1 may only be selected by an eligible person at his/her initial enrollment; this enrollment option may not be changed, except when the Covered Individual becomes eligible for enrollment under the Special Enrollment provision of this Plan – please refer to the ENROLLMENT section (page 41) for additional information.

Option 2, Value Plan

Option 2 may be selected by an eligible person at his/her initial enrollment, or at any time while covered under Option 1. Please note: an eligible person may switch from Option 1 to Option 2 at any time while covered under this Plan, but may only switch from Option 2 to Option 1 during a Special Enrollment Period.

Option 1: Comprehensive Medical Expense Benefit Summary

Deductible		
<ul style="list-style-type: none"> ➢ Accrues on CALENDAR YEAR basis. ➢ Common Accident Deductible Provision applies. ➢ In-Network and Out-of-Network DEDUCTIBLE expenses are combined. 		
	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Individual DEDUCTIBLE	\$200	\$400
DEDUCTIBLE Limit for EMPLOYEE plus one (1) DEPENDENT enrollment	\$400	\$800
DEDUCTIBLE Limit for EMPLOYEE plus two (2) or more DEPENDENTS enrollment	\$600	\$1,200

Out-of-Pocket Expense Limit		
<ul style="list-style-type: none"> ➢ Accrues on CALENDAR YEAR basis. ➢ Includes DEDUCTIBLE and COINSURANCE expenses. ➢ In-Network and Out-of-Network OUT-OF-POCKET expenses are combined. ➢ The following expenses do not accrue toward the OUT-OF-POCKET EXPENSE Limit and are never paid at 100%: <ul style="list-style-type: none"> • Amounts exceeding either (1) the UCR, or (2) the amount allowed by the PPO network contract, whichever is applicable; • Amounts exceeding Plan limitations; • Cost containment penalties; • CO-PAYMENTS (Emergency Room, Office Visit, Prescription Drug, etc.); • Ineligible charges; • Services covered under the Dental benefit of this Plan; 		
	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Family Out-of-Pocket Limit	\$3,000	\$6,000

Pre-Certification

➢ IN-PATIENT HOSPITAL and SKILLED NURSING FACILITY admissions MUST be pre-certified with the UTILIZATION REVIEW AGENT. Failure to pre-certify and admission will result in application of a *Cost Containment Penalty* to expenses INCURRED during that admission. Please refer to the “PRE-CERTIFICATION” provision on page 6.

Medical Expense Benefit Limitations and Maximums

➢ Maximums listed below are the total for In-Network and Out-of-Network expenses combined.

LIFETIME Benefit Maximum for All Covered Expenses, combined

\$1,000,000

➢ Includes all LIFETIME Benefit Limitations.

Allowable Charge

All charges are subject to the rate contracted by the PPO Network with the Provider or, in absence of PPO, the usual, customary, and reasonable (UCR) fee for the area in which the service or supply is received.

Chiropractic Services

\$500 per CALENDAR YEAR
(includes x-rays)

Durable Medical Equipment

Rental limited to purchase price.

Home Health Care

120 VISITS per CALENDAR YEAR

Hospital Room and Board

SEMI-PRIVATE rate; if a facility has only private rooms, the maximum eligible charge will be the average semi-private room rate for the area. If a private room is MEDICALLY NECESSARY, the NEGOTIATED private room rate will be allowed

Mental Health and/or Substance Abuse Treatment

In-Patient: 15 Days per CALENDAR YEAR
Out-Patient: 15 visits per CALENDAR YEAR

Orthotic Foot Devices

\$300 per LIFETIME

Rehabilitative Therapies, Out-patient

➢ Does not include IN-PATIENT therapies.

Occupational Therapy: 60 VISITS per CALENDAR YEAR
Physical Therapy: 60 VISITS per CALENDAR YEAR
Speech Therapy: 60 VISITS per CALENDAR YEAR

Skilled Nursing Facility

60 Days per CALENDAR YEAR;
ROOM AND BOARD limited to SEMI-PRIVATE rate.

Temporomandibular Joint (TMJ) Treatment

Limited to Surgical Treatment only

Transplant Services

Services provided by Out-of-Network Providers are not covered.

Benefit Percentages		
<ul style="list-style-type: none"> ➢ All services are subject to the DEDUCTIBLE unless otherwise specified. 		
	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Ambulance Services <ul style="list-style-type: none"> ➢ Subject to In-Network Deductible only. 	80%	
Anesthesia Services	80%	60%
Chemotherapy and Radiation Therapy <ul style="list-style-type: none"> ➢ <i>Pre-Certification of Chemotherapy and Radiation Therapy is strongly recommended.</i> 	80%	60%
Chiropractic Services <ul style="list-style-type: none"> ➢ Subject to In-Network Deductible only. ➢ Limited to maximum benefit of \$500 per CALENDAR YEAR, which includes x-rays. 	80%	
Diagnostic X-ray, Laboratory and Testing <ul style="list-style-type: none"> ➢ Laboratory Services performed through the DirectHealth Lab Program are not subject to CO-PAY or DEDUCTIBLE and are covered at 100%. ➢ <i>Pre-Certification of any MRI, CT Scan or PET Scan is strongly recommended.</i> 	DirectHealth Lab Program providers: 100% All other In-Network providers: 80%	60%
Dialysis <ul style="list-style-type: none"> ➢ <i>Pre-Certification of any dialysis is strongly recommended</i> 	80%	60%
Durable Medical Equipment <ul style="list-style-type: none"> ➢ Rental limited to purchase price. ➢ <i>Pre-Certification of Durable Medical Equipment is strongly recommended.</i> 	80%	60%
Healthplace Benefit™ <ul style="list-style-type: none"> ➢ Deductible is waived for Healthplace Network providers. ➢ Refer to the Healthplace Benefit™ provision in the Comprehensive Medical Expense Benefits section (page 19) for details. ➢ Pre-Certification is mandatory for medical procedures covered under this provision. 	Healthplace Network providers only: 100%, Deductible waived	Not applicable.
Home Health Care <ul style="list-style-type: none"> ➢ Limited to 120 VISITS per CALENDAR YEAR. ➢ <i>Pre-Certification of Home Health Care is strongly recommended.</i> 	80%	60%
Hospice Care	80%	60%

Benefit Percentages <i>(continued)</i>		
	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
<p>Hospital Services</p> <ul style="list-style-type: none"> ➢ Includes IN-PATIENT and OUT-PATIENT services, Emergency Room services, Ancillary services and all other ELIGIBLE EXPENSES. ➢ Emergency Room Co-Pay is waived if Covered Individual is admitted to hospital as in-patient directly from the Emergency Room. ➢ ROOM AND BOARD is limited to the SEMI-PRIVATE rate. ➢ IN-PATIENT admissions must be pre-certified; <u>failure to pre-certify an in-patient admission will result in a reduction of benefits.</u> 	<p>Emergency Room: \$100 Co-Pay, then 80% (after Deductible)</p> <p>All other eligible Hospital expenses: 80%</p>	<p>Emergency Room: \$100 Co-Pay, then 60% (after Deductible)</p> <p>All other eligible Hospital expenses: 60%</p>
<p>Maternity Care</p> <ul style="list-style-type: none"> ➢ Limited to Covered EMPLOYEES and SPOUSES. 	80%	60%
<p>Mental Health and/or Substance Abuse Treatment</p> <ul style="list-style-type: none"> ➢ IN-PATIENT CARE limited to 15 Days per CALENDAR YEAR; ➢ OUT-PATIENT care limited to 15 VISITS per CALENDAR YEAR; ➢ IN-PATIENT admissions must be pre-certified; <u>failure to pre-certify an in-patient admission will result in a reduction of benefits.</u> 	<p>In-Patient: 80%</p> <p>Out-Patient: 70%</p>	<p>In-Patient: 60%</p> <p>Out-Patient: 50%</p>
<p>Orthotic Foot Devices</p> <ul style="list-style-type: none"> ➢ Limited to custom molded devices prescribed by a PHYSICIAN. ➢ Limited to \$300 per LIFETIME. 	80%	60%
<p>Physician Services</p> <ul style="list-style-type: none"> ➢ Includes office VISITS and consultations, diagnostic x-ray and lab, injections, allergy testing and treatment, IN-PATIENT HOSPITAL VISITS, surgical services (IN-PATIENT and OUT-PATIENT), emergency room care, ADDITIONAL SURGICAL OPINION and all other eligible PHYSICIAN services. ➢ <i>Pre-Certification of any surgical procedure is strongly recommended.</i> 	<p>Office Visit: \$10 Co-Pay, then 80% (after Deductible)</p> <p>All other eligible Physician expenses: 80%</p>	<p>Office Visit: \$10 Co-Pay, then 60% (after Deductible)</p> <p>All other eligible Physician expenses: 60%</p>

Benefit Percentages <i>(continued)</i>		
	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
<p>Preventative Care</p> <ul style="list-style-type: none"> ➢ Includes office visits, routine physical examination, gynecological examination, pap smear, mammogram, prostate screening, well child care, developmental assessments, x-rays and laboratory blood tests, bone mass measurement, CA-125 serum marker testing, immunizations (except mass immunizations or those required for travel) and routine colorectal cancer screenings. 	<p>Office Visit: \$25 Co-Pay, Then 100% All Other Eligible Preventative Care Expenses: First \$1,000 of submitted eligible expenses payable at 100%, annual deductible is waived; Submitted ELIGIBLE EXPENSES over the first \$1,000 paid under this provision will be subject to the ANNUAL DEDUCTIBLE and payable at 80%.</p>	<p>Office Visit: \$50 Co-Pay, Then 100% All Other Eligible Preventative Care Expenses: First \$500 of submitted eligible expenses payable at 100%, annual deductible is waived; Submitted ELIGIBLE EXPENSES over the first \$500 paid under this provision will be subject to the ANNUAL DEDUCTIBLE and payable at 60%.</p>
<p>Out-patient Rehabilitative Therapies</p> <ul style="list-style-type: none"> ➢ Does not include In-Patient Therapy. ➢ Occupational Therapy limited to 60 VISITS per CALENDAR YEAR; ➢ Physical Therapy limited to 60 VISITS per CALENDAR YEAR; ➢ Speech Therapy limited to 60 VISITS per CALENDAR YEAR. 	80%	60%
<p>Skilled Nursing Facility</p> <ul style="list-style-type: none"> ➢ Limited to 60 Days per CALENDAR YEAR; ➢ ROOM AND BOARD limited to SEMI-PRIVATE rate; ➢ IN-PATIENT admissions must be pre-certified; <u>failure to pre-certify an in-patient admission will result in a reduction of benefits.</u> 	80%	60%
<p>Specialty Medications</p> <ul style="list-style-type: none"> ➢ Must be reviewed and approved by the Pharmacy Benefit Manager <u>prior to purchase</u>; ➢ Refer to page 22 for further information. 	90%	Not covered
<p>Temporomandibular Joint (TMJ) Treatment</p> <ul style="list-style-type: none"> ➢ Limited to Surgical Treatment only 	80%	60%
<p>Transplant Services</p> <ul style="list-style-type: none"> ➢ IN-PATIENT admissions must be pre-certified; <u>failure to pre-certify an in-patient admission will result in a reduction of benefits.</u> 	80%	Not covered
<p>Well Newborn Care</p> <ul style="list-style-type: none"> ➢ Be sure to notify the Plan in writing within 31 days of the CHILD'S birth to be eligible for timely coverage. 	80%	60%
<p>All Other Covered Expenses</p>	80%	60%

Option 2: Value Plan Benefit Summary

Out-of-Pocket Expense Limitations – Option 2

Deductible	\$0
Out-of-Pocket Expense Limit	\$0

Medical Expense Benefit Limitations and Maximums – Option 2

LIFETIME Benefit Maximum for All Covered Expenses, combined > Includes Prescription Drug expenses.	\$250,000
Benefit Maximum for In-Patient Hospital Expenses	\$1,100 per admission
ANNUAL Benefit Maximum for All Other Eligible Medical Expenses > Accrues on a Calendar Year basis. > Does not include expenses covered under Prescription Drug Expense Benefit of this Plan.	\$3,000

Medical Benefit Percentages – Option 2

	IN-NETWORK AND OUT-OF-NETWORK SERVICES
In-Patient Hospital Expenses	100%, up to the per admission and lifetime benefit limits
All Other Eligible Medical Expenses	100%, up to the annual and lifetime benefit limits

Prescription Drug Expense Benefit Summary

Please refer to the PRESCRIPTION DRUG EXPENSE BENEFITS section (page 27) for additional information.

Prescription Drug Co-Pays

- Limited to Pharmacies that participate in the Pharmacy Benefit Manager's network.
- Out-of-Network Pharmacies (non-participating) are not covered.
- One (1) CO-PAY applies to each prescription and each refill of a prescription.
- Fills at Retail pharmacies are limited to 30-day supply or 100 unit dose.
- Fills at Mail Order pharmacy are limited to 90-day supply or 300 unit dose.
- Mail order is highly recommended for medications that are taken on a continual basis.
- For the purposes of this Plan, the formulary brand name medications will be determined based upon the Pharmacy Benefit Manager's Formulary list.

		Co-Pay	Minimum	Maximum
Retail Pharmacy (In-Network only)	Generic Drug	15%	\$5	\$25
	Preferred Brand Drug	30%	\$10	\$50
	Non-preferred Brand Drug	45%	\$25	\$75
Mail Order Pharmacy (In-Network only)	Generic Drug	15%	\$15	\$75
	Preferred Brand Drug	30%	\$30	\$150
	Non-preferred Brand Drug	45%	\$75	\$225

Certain PRESCRIPTION DRUGS must be reviewed for MEDICAL NECESSITY and appropriateness and approved by the PLAN ADMINISTRATOR to be considered for coverage under this Plan – such approval should be obtained **prior to purchase**. Please refer to the COMPREHENSIVE MEDICAL EXPENSE BENEFITS section (page 19) for detailed information.

Comprehensive Dental Expense Benefit Summary

*Please refer to the **COMPREHENSIVE DENTAL EXPENSE BENEFITS** section (page 29) for additional information.*

Annual Dental Deductible	
➤ Accrues on CALENDAR YEAR basis.	
Individual	Class II Services: \$50 Class III Services: \$100 Class IV Services: \$50

Dental Benefit Percentages	
➤ All services are subject to the DEDUCTIBLE unless otherwise specified.	
Class I Services: Diagnostic and Preventative Care	100%, ANNUAL DEDUCTIBLE does not apply
Class II Services: Basic Restorative Services	80%
Class III Services: Major Restorative Services	50%
Class IV Services: Orthodontic Services	50%

Dental Limitations and Maximums	
Maximum ANNUAL Benefit for all Class I, II and III Expenses, combined	➤ \$1,000 per CALENDAR YEAR
MAXIMUM LIFETIME BENEFIT for Class IV Expenses	➤ \$1,000 per LIFETIME
Routine Exams and Dental Cleaning (PROPHYLAXIS)	➤ Twice per CALENDAR YEAR
Periodontal PROPHYLAXIS (may be substituted for Routine Dental Cleaning)	➤ Twice per CALENDAR YEAR
Dental X-rays	➤ BITEWINGS: limited to two (2) per CALENDAR YEAR ➤ Full mouth (single or multiple films): limited to once in any three (3) year period
SEALANTS	➤ Once per tooth per CALENDAR YEAR ➤ DEPENDENT CHILDREN under age sixteen (16)
Topical FLUORIDE	➤ Once per CALENDAR YEAR ➤ DEPENDENT CHILDREN under age eighteen (18)

COMPREHENSIVE MEDICAL EXPENSE BENEFITS

Upon receipt of proof of loss, the Plan will pay the BENEFIT PERCENTAGE listed in the Plan Summary for ELIGIBLE EXPENSES INCURRED in each BENEFIT PERIOD. The amount payable in no event shall exceed the MAXIMUM LIFETIME BENEFIT stated in the Plan Summary. All BENEFITS described in the Plan Summary are subject to the exclusions and limitations described more fully herein including, but not limited to, the PLAN ADMINISTRATOR'S determination that: care and treatment is MEDICALLY NECESSARY; that charges do not exceed the PPO contracted rate or, in absence of PPO contract, are USUAL, CUSTOMARY AND REASONABLE; that services, supplies and care are not EXPERIMENTAL and/or INVESTIGATIONAL.

The Deductible

The DEDUCTIBLE is the amount of covered medical expenses which must be INCURRED before Comprehensive Medical Expense BENEFITS are payable. The amount of the DEDUCTIBLE is shown in the Plan Summary. Each FAMILY member is subject to the DEDUCTIBLE up to the FAMILY maximum as shown in the Plan Summary. This amount accrues toward the ANNUAL Out-of-Pocket Limit. Deductible Expenses for both In-Network and Out-of-Network services are combined.

The Family Deductible Limit

When DEDUCTIBLE expenses for any combination of covered FAMILY members reaches the FAMILY DEDUCTIBLE limit during the CALENDAR YEAR, as shown in the Plan Summary, no further DEDUCTIBLES will be required on any FAMILY member for the remainder of that CALENDAR YEAR.

Common Accident Deductible Provision

If two or more covered members of a family sustain bodily injuries in the same accident, only one applicable annual individual medical deductible amount will be applied for all expenses resulting from that Accident during that year.

Benefit Percentage

The BENEFIT PERCENTAGE is the percentage paid by the Plan for COVERED EXPENSES that are in excess of the DEDUCTIBLE and any COINSURANCE or CO-PAYMENTS.

Coinsurance

COINSURANCE is the percentage of COVERED EXPENSES a COVERED INDIVIDUAL is responsible for each time he receives certain COVERED SERVICES. The COINSURANCE for most services accrues toward the OUT-OF-POCKET EXPENSE Limit.

Co-Payment

A CO-PAYMENT (CO-PAY) is the fixed dollar amount a COVERED INDIVIDUAL is responsible for each time he receives certain COVERED SERVICES. The CO-PAYMENT does not apply toward the COVERED INDIVIDUAL'S Out-of-Pocket Limit and continues to be taken after the Out-of-Pocket Limit is met.

Out-of-Pocket Limit

COVERED CHARGES are payable at the percentages shown in the Plan Summary each CALENDAR YEAR until the Out-of-Pocket Limit shown in the Plan Summary is reached. Then, COVERED CHARGES INCURRED by a COVERED INDIVIDUAL, or FAMILY unit, will be payable at 100% (except for charges excluded) for the rest of the CALENDAR YEAR. The ANNUAL Out-of-Pocket Limit includes DEDUCTIBLE and COINSURANCE expenses. Out-of-Pocket Expenses for both In-Network and Out-of-Network services are combined. See the Plan Summary for a list of expenses that are not applied to the OUT-OF-POCKET EXPENSE Limit, and are never paid at 100%.

Benefit Payment

Each CALENDAR YEAR, BENEFITS will be paid for the COVERED CHARGES of a COVERED INDIVIDUAL that are in excess of the DEDUCTIBLE and any COINSURANCE or CO-PAYMENTS. Payment will be made at the rate shown in the Plan Summary. No BENEFITS will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

Maximum Benefit Amount

The Maximum Benefit Amount is shown in the Plan Summary. It is the total amount of BENEFITS that will be paid under the medical and PRESCRIPTION DRUG portion of the Plan for all COVERED CHARGES INCURRED by a COVERED INDIVIDUAL. The Maximum Benefit Amount includes all medical benefit maximums listed in this Plan.

Allocation and Apportionment of Benefits

The COMPANY reserves the right to allocate the DEDUCTIBLE amount to any eligible charges and to apportion the BENEFITS to the COVERED INDIVIDUAL and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the COVERED INDIVIDUAL and all assignees.

Eligible Medical Expenses

Eligible medical expenses are the following expenses that are INCURRED while coverage is in force for the COVERED INDIVIDUAL. If, however, any of the listed expenses are excluded from coverage because of a reason described in the General Limitations section, those expenses will not be considered Eligible Medical Expenses. A charge is INCURRED on the date that the service or supply is performed or furnished.

The Plan will allow charges for medical care according to the amount allowed by the PPO network contract (or, in absence of such contract, the usual, customary, and reasonable (UCR) guidelines) for such medical care. The Plan will make payment for eligible medical expenses subject to the COINSURANCE percentage and maximum amounts shown in the Plan Summary.

DirectHealth Lab Benefits

Laboratory Services performed through the DirectHealth Lab Program are not subject to co-payment or DEDUCTIBLE and are covered at 100%.

Healthplace Benefit™

The Healthplace Benefit™ is an option for Plan Members and their Covered Dependents (collectively "Covered Individuals") whose treating physicians recommend certain covered medical procedures ("Covered Services") and elect to receive treatment at certain medical providers participating in the Healthplace Network™ ("Providers").

In addition to covered medical costs related to the procedure defined in this Plan, covered medical costs incurred under the Healthplace Benefit™ are defined to include necessary Travel Services for the Covered Individual and one companion, a fee for the Administrator, and a Recovery Benefit. Travel Services include (a) round trip transportation between the Plan Member's home location and the location of the Provider where treatment is to be performed; (b) hotel accommodations near the Provider; and (c) necessary local transportation among the airport, hotel, and Provider. All Travel Services must be reserved and scheduled through Healthplace America. An Administrative Fee, if any, may also be included as compensation for the Claims Administrator. The Recovery Benefit includes a payment which recognizes the potential financial savings and is meant as compensation for incidental and "out of pocket" expenses related to the procedure and is paid upon completion of the procedure.

Certain examinations, tests, treatments or other medical services may be required prior to or following travel for care under the Healthplace Benefit™. Any medical services performed by anyone not a Provider, including such pre and post care, shall be subject to the coverage limits and other terms of the Health Plan.

All other provisions of this Agreement and its Exhibits notwithstanding, the Healthplace Benefit™ is included toward and subject to the standard in-network provisions and Lifetime Maximum for Covered Services under the Health Plan.

The Plan shall remain responsible for Healthplace Benefit™ costs if a change is required once travel and other accommodations have been made. The Plan will also pay for any emergency or life-saving health services required as a result of any medical procedures or health services received by the Plan Member.

Limitations and Disclosures:

1. Healthplace America is the trade name of Optamin Medical Services, LLC, a Delaware limited liability company which has arranged a network of participating medical service providers to communicate the availability of medical and surgical diagnostic, treatment, and care services and coordinate the delivery of such services with travel, communication and other non-medical aspects of the interaction with the service providers to institutional healthcare purchasers and their Plan Members.
2. Healthplace America does not provide any medical care or medical advice and does not evaluate or recommend any medical provider, including Providers.
3. The non-medical benefits provided under the Healthplace Benefit™ program will be subject to taxation as income to the Covered Individual; particularly (without limitation) any amounts paid to a Covered Individual as a "Recovery Benefit." Healthplace America will provide appropriate documentation for benefits paid under the Healthplace Benefit™.

Home Health Care Expenses

Home health care expenses are the charges made by a HOME HEALTH CARE AGENCY, for the following services and supplies which are ordered by a PHYSICIAN and furnished to a COVERED INDIVIDUAL in his home in accordance with a HOME HEALTH CARE PLAN:

- Part-time or intermittent nursing care provided by a REGISTERED NURSE (RN), or by a LICENSED PRACTICAL NURSE (LPN), a vocational nurse, or a public health nurse who is under the direct supervision of a REGISTERED NURSE.
- Part-time or intermittent home health aide services which consist primarily of caring for the PATIENT, and is under the supervision of an RN or LPN.
- Medical supplies, drugs, and medicines prescribed by a PHYSICIAN, and laboratory services provided by or on behalf of a HOSPITAL, but only to the extent that such charges would have been covered if the COVERED INDIVIDUAL had remained in the HOSPITAL or a SKILLED NURSING FACILITY.
- Charges for physical, speech or occupational therapy.
- Charges for parenteral or enteral nutrition.
- Charges for inhalation therapy
- Medical social services.

Home Health Care Expenses will not be covered if they are for:

- CUSTODIAL CARE, housekeeping services, or meals or nutritional services.
- Services by a member of the EMPLOYEE'S or DEPENDENT'S FAMILY or household.
- Services of a non-medical SOCIAL WORKER.
- Services for a period during which an EMPLOYEE or DEPENDENT is not under the continuing care of a PHYSICIAN.
- Transportation services.

Each Home Health Care VISIT, up to four (4) hours, by a REGISTERED NURSE (RN) or LICENSED PRACTICAL NURSE (LPN) to provide nursing care, by a therapist to provide physical, occupational or speech therapy, and each VISIT of up to four (4) hours by a home health aide shall be considered as one (1) home health care VISIT.

Pre-Certification of any Home Health Care is strongly recommended.

Hospice Expenses

A HOSPICE means a health care program providing services to TERMINALLY ILL PATIENTS. The following services and supplies provided by a HOSPICE are covered:

- HOSPICE care in a free-standing HOSPICE facility, HOSPITAL -based HOSPICE, extended care HOSPICE facility, or nursing home HOSPICE;
- Nursing care by a REGISTERED NURSE (RN), or by a LICENSED PRACTICAL NURSE (LPN), a vocational nurse, or a public health nurse who is under the direct supervision of a REGISTERED NURSE.
- Physical therapy, occupational therapy and speech therapy, when rendered by a licensed therapist.
- Medical supplies, including drugs and biologicals, and the use of medical appliances.
- PHYSICIAN services.
- Services, supplies, and treatments deemed MEDICALLY NECESSARY and ordered by a licensed PHYSICIAN.

COMPREHENSIVE MEDICAL EXPENSE BENEFITS

The Plan will not pay for:

- Expenses or services of a person who resides in the PATIENT'S home or is a CLOSE RELATIVE of the PATIENT.
- Expenses solely in connection with research.
- Expenses for services that do not meet medically acceptable standards of quality and sound principles of health care.
- Expenses related to the organization or dispensation of non-medical personal, legal or financial affairs, such as preparation of a will, liquidation of an estate, or other similar activities.
- Expenses excluded by any general limitation or provision set forth in this Plan.

Hospital Expenses

HOSPITAL expenses are the charges made by a HOSPITAL in its own behalf. *In-patient admissions must be pre-certified.* Such charges include:

- SEMI-PRIVATE ROOM AND BOARD rate. If a facility only has private rooms available, the room rate will be limited to the average SEMI-PRIVATE room rate for the area. If a private room is MEDICALLY NECESSARY, the NEGOTIATED private room rate will be allowed. After 23 observation hours, a CONFINEMENT will be considered an IN-PATIENT CONFINEMENT.
- Necessary ancillary HOSPITAL services other than ROOM AND BOARD as furnished by the HOSPITAL.
- SPECIAL CARE UNITS, including burn care units, cardiac care units, delivery rooms, INTENSIVE CARE UNITS, isolation rooms, operating rooms and recovery rooms.
- OUT-PATIENT HOSPITAL services.
- Emergency room services for treatment of a condition which is of an urgent or EMERGENCY nature.

Mental Health/Substance Abuse Treatment Expenses

The Plan will allow PHYSICIAN and Facility charges according to usual, customary, and reasonable (UCR) or the amount allowed by the PPO network contract, whichever is applicable for Mental Health and/or SUBSTANCE ABUSE treatments, including office or home VISITS, HOSPITAL IN-PATIENT or OUT-PATIENT care and clinic care. *In-patient admissions must be pre-certified.* Eligible Mental Health/ SUBSTANCE ABUSE expenses under this benefit will be limited to the maximums listed in the Plan Summary. The Mental Health Parity Act applies to all persons covered under this Plan.

Multiple Surgical Procedures

Payment for services provided by physicians and/or stand-alone surgical centers for multiple SURGICAL PROCEDURES (not including the primary SURGICAL PROCEDURE) performed at the same time may be reduced to 50% of the amount allowed.

- If the multiple SURGICAL PROCEDURE is determined incidental, BENEFITS will be denied.
- If multiple unrelated SURGICAL PROCEDURES are performed by two (2) or more surgeons on separate operative fields, BENEFITS will be based on the amount allowed for each surgeon's primary procedure.
- If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, BENEFITS for all procedures will not exceed the percentage of the allowed amount for that procedure.
- An assistant surgeon's services will only be covered if MEDICALLY NECESSARY and only up to the allowed charge.

Surgical procedures should be pre-certified.

Physician Services

The Plan will allow PHYSICIAN charges according to the amount allowed by the PPO network contract (or, in absence of such contract, the usual, customary, and reasonable (UCR) guidelines) for medical care and/or surgical treatments, including office or home VISITS, HOSPITAL IN-PATIENT or OUT-PATIENT care, clinic care, and surgical opinion consultations.

Skilled Nursing/Extended Care Facility Expenses

Eligible SKILLED NURSING/EXTENDED CARE FACILITY expenses will be payable if and when:

1. The PATIENT is confined as a bed PATIENT in the facility; and
2. The Attending PHYSICIAN certifies that the CONFINEMENT is needed for care of a condition that would otherwise cause a HOSPITAL CONFINEMENT; and
3. The Attending PHYSICIAN completes a TREATMENT PLAN which includes the diagnosis, the proposed course of treatment and the projected date of discharge from the SKILLED NURSING FACILITY.

Eligible SKILLED NURSING/EXTENDED CARE FACILITY expenses under this benefit will be limited up to the maximums listed in the Plan Summary and will include:

1. ROOM AND BOARD, including any charges made by the facility as a condition of occupancy or on a regular daily or weekly basis, such as general nursing services. The daily ROOM AND BOARD charges allowed will not exceed the average SEMI-PRIVATE rate.
2. Medical services customarily provided by the SKILLED NURSING FACILITY, with the exception of private-duty or special nursing services and PHYSICIAN fees.
3. Drugs, biologicals, solutions, dressings and casts furnished for use during the convalescent period, but no other supplies.

Skilled Nursing Facility admissions must be pre-certified.

Specialty Medications

This Plan provides coverage for certain "Specialty Medications" under the Comprehensive Medical Expense Benefit. Specialty Medications are drugs which require a physician's prescription, but which are not covered under the Prescription Drug Benefit of this Plan. Specialty Medications are drugs that have typically been provided by and administered in the physician office, clinic or outpatient hospital setting. Ongoing developments in drug delivery and patient education have made it possible for some of these medications to be self-administered by the patient. Many Specialty Medications may be obtained through the Plan's pharmacy benefit manager's network at a greatly reduced cost and, if properly reviewed and approved (as indicated below), will be eligible for benefits under the Comprehensive Medical Expense Benefit, instead of the Prescription Drug Expense Benefit of this Plan.

The Plan will allow the Pharmacy Benefit Manager's maximum allowable cost or the dispensing pharmacy's charge, whichever is less, for specialty medications covered under this provision. This provision does not allow coverage for experimental drugs or "off-label" use of legend drugs (drugs which are prescribed for conditions other than those approved by the U.S. Food and Drug Administration). Medications covered under this provision include, but are not limited to, immunosuppressants, antiretrovirals, cancer therapies, recombinant biological pharmaceuticals, interferons, growth hormones, drugs to treat other rare disorders, and most injectable medications (except those specifically covered under the Prescription Drug Expense Benefit provision of this Plan). Following are some examples:

Actimmune	Betaseron	Helixate	Lovenox	Proplex T
Alferon N	Calcitonin	Hemofil M	Lupron	Protropin
Alphanate	Copaxone	Humate-P	Miacalcin	Rebetron
Alphanine	Cyanocobalamin	Humira	Monarc-M	Rebif
Amicar	Cyklokapron	Hyatec	Monoclote-P	Recombinate
Aranesp	DDAVP	Infergen	Mononine	Refacto
Arava	Dihydroergotamine	Intron-A	Neumega	Remicade
Aredia	Enbrel	Kineret	Neupogen	Rituxan
Arixtra	Epogen	Koate-DVI	Novantrone	Roferon-A
Autoplex T	Feiba VH	Koate-HP	Pegasys	Sandostatin
Avonex	Forteo	Kogenate	Peg-Intron	Serostim
Bebulin VH	Fragmin	Kogenate FS	Procrit	Supprelin

To be eligible for benefits under this provision, the medication must be reviewed and approved by the Pharmacy Benefit Manager **prior to purchase**. The following information is needed to facilitate the approval process:

- Patient's name, address and date of birth;
- Diagnosis;
- Covered Employee's name, identification number and date of birth;
- Medication name, dosage, frequency and route of administration;
- Prescribing physician's name, phone number and fax number.

The Plan will advise the patient and/or covered Employee of such decision within the time limits set forth in the Claims Procedures section of this plan document.

Transplant Expenses

BENEFITS are available to a COVERED INDIVIDUAL who is a recipient or donor for MEDICALLY NECESSARY COVERED SERVICES relating to bone marrow, liver, heart, lung (single and double), combination heart/lung, pancreas, pancreas/kidney, kidney and cornea and any other non-experimental transplant. Eligible services include, but are not limited to: testing to determine transplant feasibility and donor compatibility; charges related to the transplant itself, as well as follow-up care to include: diagnostic x-ray and lab; procedures to determine rejection or success of transplant, to include: PHYSICIAN, lab, x-ray or HOSPITAL charges.

Organ transplant expenses are those charges for services and supplies in connection with non-experimental transplant procedures, subject to the following criteria:

- Except for transplant of a cornea, the recipient must be in danger of death in the event the organ transplant is not performed.
- There must be a reasonable expectation of survival if he were to receive the transplant.
- If the donor is not covered under this Plan, charges INCURRED by the donor are only payable if the donor has no other coverage available, i.e. group health plan, a government program, or a research program. In this case, charges of the donor will be considered charges of the recipient.
- If both recipient and donor are covered under this Plan, the expenses for each will be considered separately.
- Eligible charges for the procurement of an organ will be considered under the recipient's coverage, to include the following:
 - Harvesting, removal, preserving, storage and transportation of the actual organ.
 - Surgeon's fee for removing the organ.
 - Procurement of an organ from a cadaver or tissue bank.
 - HOSPITAL'S fee for storage of the organ.
- Subject to Plan maximums as stated in the Plan Summary.
- **Pre-certification is required for all transplant surgeries.**

The following will not be eligible for coverage under this benefit:

- Charges in connection with mechanical organs or a transplant involving a mechanical organ or a transplant involving an animal organ; except charges in relation to mechanical organs which may be necessary on a temporary short-term basis until a suitable donor organ is available will be eligible under the Plan.
- Services or supplies furnished in connection with the transportation of a living donor.
- Services or supplies related to donation of any organ under the coverage of a donor.
- Services or supplies related to donation of any organ if the recipient is not a Covered Individual under this Plan.

Covered Expenses In or Out of the Hospital

1. **Medically Necessary Abortion:** Charges for abortion performed to safeguard the life of the mother.
2. **Acne:** Charges for non-COSMETIC treatment of acne. Accutane and any laboratory tests specifically related to treatment with Accutane are not covered. Treatment of acne may be subject to review by the UTILIZATION REVIEW AGENT and deemed MEDICALLY NECESSARY to be eligible for BENEFITS under this Plan.
3. **Allergy Treatment:** Charges for allergy testing, allergens and allergy injections.
4. **Ambulance:** Charges for MEDICALLY NECESSARY local ground or air ambulance service to and from the nearest, local adequate HOSPITAL or nursing facility where EMERGENCY care or treatment is rendered, or to the nearest facility equipped to furnish necessary medical treatment if not available at a local HOSPITAL. This Plan will only cover ambulance transportation when:
 - a. no other method of transportation is appropriate;
 - b. the services necessary to treat the ILLNESS or INJURY are not available in the HOSPITAL or nursing facility where the COVERED INDIVIDUAL is an IN-PATIENT; and/or
 - c. the HOSPITAL or nursing facility where the ambulance takes the COVERED INDIVIDUAL is the nearest with adequate facilities.
5. **Ambulatory Surgical Center:** Charges made by an AMBULATORY SURGICAL CENTER when treatment has been rendered.
6. **Anesthesia:** Charges for the cost and administration of anesthetic in conjunction with a covered surgical or medical procedure.
7. **Blood:** Charges for the processing and administration of blood or blood components, including charges for the processing and storage of autologous blood.

COMPREHENSIVE MEDICAL EXPENSE BENEFITS

8. **Cardiac Rehabilitation Programs:** OUT-PATIENT, second phase cardiac rehabilitation programs to provide supervised monitored exercise sessions following an acute cardiac episode or surgery.
9. **Cataract and Retinal Repair Surgery:** Charges for cataract or retinal repair surgery, including the initial set of contact lenses or eyeglasses (but not both) required following cataract or retinal repair surgery. *Pre-Certification of any surgical procedure is strongly recommended.*
10. **Chemotherapy:** Charges for chemotherapy, including the services of technicians. *Pre-Certification of any Chemotherapy is strongly recommended.*
11. **Chiropractic Services:** Charges for CHIROPRACTIC SERVICES by a D.C., subject to the CHIROPRACTIC SERVICES limit shown in the Plan Summary.
12. **Dental Services, Medically Necessary:** Charges for MEDICALLY NECESSARY, emergent, non-restorative dental services provided by a DENTIST when MEDICALLY NECESSARY and limited to services provided for the repair of damage to the jaw or sound natural teeth as the direct result of an ACCIDENTAL INJURY. INJURY as a result of chewing or biting will not be considered an ACCIDENTAL INJURY. This will not in any event be deemed to include charges for treatment for the repair or replacement of a DENTURE.
13. **Diabetic Self Management Education:** Charges for Diabetic Self Management Education. Such services must:
 - Be MEDICALLY NECESSARY and prescribed by a PHYSICIAN.
 - Be instructed by a qualified health care professional, including but not limited to PHYSICIANS, nurses or licensed pharmacists.
 - Meet the standards developed by the appropriate State Department of Public Health
14. **Diagnostic Tests:** Charges for x-rays, microscopic tests, laboratory tests, electrocardiograms, electroencephalograms, pneumoencephalogram, basal metabolism tests, allergy tests, or similar well-established diagnostic tests generally approved by PHYSICIANS throughout the United States not connected with a routine physical exam, which:
 - Are performed as a result of definite symptoms of an INJURY or ILLNESS; or
 - Reveal the need for medical treatment.*Pre-Certification of any MRI, CT Scan or PET Scan is strongly recommended.*
15. **Dialysis:** Charges for dialysis as an IN-PATIENT or at a MEDICARE-approved OUT-PATIENT dialysis center. *Pre-Certification of any dialysis is strongly recommended.*
16. **Drugs and Biologicals:** Charges for drugs and biologicals which are approved by the Food and Drug Administration, including (but not limited to) globulin, serum, vaccine, antitoxin or antigen, used in the prevention or treatment of disease.
17. **Durable Medical Equipment:** Charges for the rental, up to the purchase price, of a wheelchair, hospital bed, iron lung, or other DURABLE MEDICAL EQUIPMENT required for MEDICALLY NECESSARY temporary therapeutic use, or the purchase of this equipment if economically justified, whichever is less. Maintenance and repair of DURABLE MEDICAL EQUIPMENT is the responsibility of the COVERED INDIVIDUAL and is not covered under this Plan. Replacement of DURABLE MEDICAL EQUIPMENT will only be allowed if:
 - a. The replacement is necessary due to usual wear and tear and not due to external damage of any sort; or
 - b. The replacement is necessary due COVERED INDIVIDUAL having undergone pathologic change or due to growth to the extent the equipment is no longer usable by the COVERED INDIVIDUAL; and
 - c. The UTILIZATION REVIEW AGENT certifies the equipment as not repairable or alterable, or is no longer the appropriate size for the COVERED INDIVIDUAL.
 - d. For C-pap and bi-pap machines: unit has been in continuous use by the COVERED INDIVIDUAL for five (5) years or longer.*Pre-Certification of any rental or purchase of Durable Medical Equipment is strongly recommended.*
18. **Eye Examinations, Eyeglasses or Contact Lenses, Medically Necessary:** Charges for eye examination due to a medical condition, and for eyeglasses or contact lenses for aphakic (absence of natural lens of the eye) PATIENT and for soft contact lenses or sclera shells intended for use in the treatment of disease or INJURY.
19. **Growth Development Delays:** Charges for testing and treatment of growth development delays, including growth hormones when MEDICALLY NECESSARY as determined by a PHYSICIAN (except, growth hormones will not be covered under any circumstances for males over 5 feet 6 inches and females over 5 feet 2 inches.
20. **Handling and Conveyance Fees:** Charges for handling and conveyance fees; however shipping charges are not covered.
21. **Home Infusion Therapy:** Charges for home infusion therapy, including the administration of nutrients, antibiotics, and other drugs and fluids intravenously or through a feeding tube.

22. **Insulin:** Charges for insulin, insulin supplies, syringes and blood glucose monitoring equipment and supplies.
23. **Intravenous Injections and Solutions:** Charges for intravenous injections and solutions; administration of these items is included.
24. **Mammogram, Routine:** Charges for routine mammograms, up to the limits outlined in the Plan Summary.
25. **Mammoplasty:** Charges for MEDICALLY NECESSARY mammoplasty following a MEDICALLY NECESSARY mastectomy. Services include reconstruction of the breast on which the mastectomy has been performed and reconstruction of the other breast to produce symmetrical appearance. Breast prostheses and physical complications of all stages of mastectomy, including lymphedemas, are also eligible under the Plan. This further includes removal of breast implants, including implants that involved COSMETIC procedure performed for reasons of reconstruction performed as a result of ILLNESS or INJURY. Removal of breast implants solely for COSMETIC purposes is not covered. Charges for MEDICALLY NECESSARY reduction mammoplasty will only be covered under this Plan when MEDICAL NECESSITY is established by the UTILIZATION REVIEW AGENT.
26. **Medical Supplies:** Charges for dressings, sutures, casts, splints, crutches, braces, or other necessary medical supplies, with the exception of dental braces, orthopedic shoes, arch supports, elastic stockings, trusses, lumbar braces, garter belts and similar items which can be purchased without a prescription.
27. **Mental Health/Substance Abuse Treatment:** Charges in relation to individual or group PSYCHIATRIC CARE (treatment of a psychiatric condition, alcoholism, SUBSTANCE ABUSE or drug addiction) are limited to the COINSURANCE percentage of COVERED EXPENSES in excess of the DEDUCTIBLE up to the maximums as shown in the Plan Summary. A psychiatric condition includes but is not limited to anorexia nervosa and bulimia, schizophrenia, and depressive disorders including but not limited to manic-depressive. Acute IN-PATIENT detoxification is covered if determined that OUT-PATIENT management is not medically appropriate; treatment is considered medical and does not apply to the SUBSTANCE ABUSE benefit or limitations until the PATIENT is discharged from the HOSPITAL or transferred to a Substance Abuse Unit. *Pre-Certification of any in-patient admission is required.*
28. **Minor Emergency Medical Clinic:** Charges made by a MINOR EMERGENCY MEDICAL CLINIC when treatment has been rendered.
29. **Occupational Therapy:** Charges for restorative or rehabilitative occupational therapy, up to the limits shown in the Plan Summary, due to an ILLNESS or INJURY, or due to surgery performed because of an ILLNESS or INJURY; however, occupational therapy supplies related to these services are not covered.
30. **Oral Surgery:** Charges for the following oral surgery whether performed by a DENTIST or a medical doctor will be considered as eligible medical expenses:
 - a. Correction of congenital abnormalities of the jaw.
 - b. Removal of bony growths of the jaw and hard palate (except as preparation for DENTURES or other prostheses).
 - c. SURGICAL PROCEDURES of the jaw and gums for treatment of fractures and dislocations of the jaw and facial bones or to repair the mouth or lips necessary to correct accident INJURY.
 - d. Excision of lesions of the jaws, cheeks, lips, tongue or roof and floor of the mouth.
 - e. Incision of the accessory sinuses, mouth, salivary glands or ducts.
 - f. Surgical extraction of IMPACTED TEETH.
 - g. General anesthesia for covered oral surgery.
 - h. Intra-oral x-rays in connection with covered oral surgery.
31. **Orthotic Foot Devices:** Charges for custom molded orthotic foot devices (such as special shoe inserts for arch or foot support) which are prescribed by a PHYSICIAN following an open SURGICAL PROCEDURE of the foot or which are prescribed to avoid an open SURGICAL PROCEDURE.
32. **Orthotic Appliances:** Charges for the initial purchase, fitting and repair of ORTHOTIC APPLIANCES such as braces, splints, or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an INJURY or ILLNESS. Charges for any braces or devices predominantly used for support during athletic activities are not covered.
33. **Oxygen:** Charges for oxygen and other gases, and their administration.
34. **Pap Smear:** Exam and laboratory charges in relation to a routine ANNUAL pap smear test.
35. **Podiatric Care:** Charges for non-routine podiatric care, including charges for open cutting procedures, partial or complete removal of nail roots, or for services reasonably necessary in the treatment of a metabolic or peripheral vascular disease.

COMPREHENSIVE MEDICAL EXPENSE BENEFITS

36. **Physical Therapy:** Treatment or services rendered by a licensed PHYSICAL THERAPIST in a home setting or at a facility or institution, which has the primary purpose of providing medical care for an ILLNESS or INJURY. Charges for restorative or rehabilitative physical therapy, up to the limits shown in the Plan Summary, due to an ILLNESS or INJURY, or due to surgery performed because of an ILLNESS or INJURY will be eligible.
37. **Pre-Admission Testing:** Charges for laboratory and x-ray tests performed as OUT-PATIENT. Tests must be related to the condition which is the cause of the Admission, and must be performed in place of tests while HOSPITAL -confined.
38. **Pregnancy:** Eligible PREGNANCY related expenses for a Covered EMPLOYEE or DEPENDENT SPOUSE, including MEDICALLY NECESSARY amniocentesis tests, are considered the same as any other medical condition under the Plan. For the purpose of this provision only, a BIRTHING CENTER shall be treated the same as a HOSPITAL.
39. **Prescription Drugs:** Charges for drugs requiring the written prescription of a licensed PHYSICIAN, except as specifically excluded elsewhere in this Plan.
40. **Preventative Care:** Charges for routine preventative care for COVERED INDIVIDUALS, up to the limits as stated in the Plan Summary. ELIGIBLE EXPENSES include, but are not limited to, those for routine or periodic examinations, screening examinations, evaluation procedures, preventative medical care, school, camp or school sports examinations, or treatment or services not directly related to the diagnosis or treatment of a specific INJURY, ILLNESS or PREGNANCY -related condition.
41. **Private Duty Nursing:** Charges for IN-PATIENT PRIVATE DUTY NURSING care are covered only when MEDICALLY NECESSARY and the HOSPITAL'S INTENSIVE CARE UNIT is filled or the HOSPITAL has no INTENSIVE CARE UNIT.
42. **Prostate Specific Antigen (PSA) Test:** Exam and laboratory charges in relation to a routine prostate specific antigen test.
43. **Prosthetic Appliances:** Charges for prosthetic appliances used to replace a missing natural body part, except penile prosthesis or implant, dental appliances or vision appliances (except as specifically listed as a covered expense elsewhere in this Plan). Repair or replacement of damaged, lost or stolen devices is not covered. Replacement of a prosthetic appliance will be covered when due to a pathological change or normal growth. Prior Written Approval of a replacement is recommended.
44. **Radiation Therapy:** Charges for radiation therapy or treatment, including the services of technicians. *Pre-Certification of any Radiation Therapy is strongly recommended.*
45. **Reconstructive Surgery:** Charges for reconstructive surgery to correct a condition that resulted from an INJURY or ILLNESS, or for the correction of a congenital anomaly or birth defect.
46. **Respiratory Therapy:** Charges for MEDICALLY NECESSARY respiratory (pulmonary) therapy or treatment.
47. **Speech Therapy:** Charges for restorative or rehabilitative speech therapy, up to the limits shown in the Plan Summary, by a licensed SPEECH THERAPIST due to an ILLNESS or INJURY, or due to surgery performed because of an ILLNESS or INJURY.
48. **TMJ:** Charges for treatment of TMJ (temporomandibular joint) disorder. Limited to surgical treatment only.
49. **Sterilization, Elective:** Charges in relation to an elective sterilization procedure (such as tubal ligation, Essure procedure or vasectomy), but only for the initial surgery. BENEFITS do not include the reversal of an elective sterilization.
50. **Urgent/Immediate Care Clinic:** Charges made by an urgent/immediate care clinic when treatment has been rendered.
51. **Well Newborn Care:** HOSPITAL and PHYSICIAN charges in relation to the routine WELL CARE of a NEWBORN, including circumcision.

PRESCRIPTION DRUG EXPENSE BENEFITS

The Plan will pay the usual and customary charge of PRESCRIPTION DRUGS, after the CO-PAY has been satisfied at the BENEFIT PERCENTAGE listed in the Plan Summary for each prescription and each refill of a prescription. The PRESCRIPTION DRUG CO-PAYMENT is not eligible for BENEFITS under the medical BENEFITS portion of this Plan. The Prescription Drug Program will not cover the cost of administration of any drug.

For the purposes of this Plan, the formulary brand name medications will be determined based upon the Pharmacy Benefit Manager's Formulary list.

Pharmacy Benefit Manager

The PHARMACY BENEFIT MANAGER for this Plan processes electronic claims filed by network pharmacies. The PHARMACY BENEFIT MANAGER also reviews new and current drugs for FDA compliance and Formulary status. The PHARMACY BENEFIT MANAGER'S name and customer service telephone number are listed on your health plan identification card.

Mail Order Program

The Plan provides BENEFITS for PRESCRIPTION DRUGS obtained through its specified mail order service. Please contact your Human Resources Department or BBSI for order forms.

Covered Prescription Drugs

1. All medications which, under federal or state law, require the written prescription of a licensed PHYSICIAN except as noted under Exclusions.
2. Insulin and glucagon and syringes used to administer insulin or glucagon, and diabetic diagnostic agents including test strips and lancets.
3. Epi-Pen and Imitrex.

Drugs Which Require Prior Approval

Certain PRESCRIPTION DRUGS must be reviewed for MEDICAL NECESSITY and appropriateness and approved by the PLAN ADMINISTRATOR to be considered for coverage under this Plan – such approval should be obtained **prior to purchase**. Requests for prior approval must be made to the CLAIMS PROCESSOR – such request may be made in person, by phone or in writing. Some examples include (but are not limited to):

- Prescriptions which exceed the Food and Drug Administration's dosing guidelines.
- Injectable medications (except insulin, glucagon, Epi-Pen and Imitrex) including syringes, needles and/or administration.
- Antiretrovirals, immunosuppressants, interferons, growth hormones, recombinant biological pharmaceuticals, and drugs to treat other rare disorders.

Certain approved drugs **may** be covered under the Medical Expense Benefit portion of this Plan - please refer to the COMPREHENSIVE MEDICAL EXPENSE BENEFIT section of this document (SPECIALTY MEDICATIONS subsection, page 22) for further information.

Exclusions

Under this program, the following drugs are never considered a prescription/refill, regardless of use or diagnosis:

- Any drug for which reimbursement is available under any other group program or government program.
- Drugs dispensed from or by any HOSPITAL, EXTENDED CARE FACILITY, or other institution to an IN-PATIENT or OUT-PATIENT; such drugs are covered by the medical portion of the Plan.
- Drugs dispensed by other than retail PHARMACY, except through the approved Mail Order Program.
- Drugs that do not require a written prescription of a licensed PHYSICIAN (with the exception of insulin and the syringes or needles for its administration).
- The cost of administration of any drug.

The charge for more than a ninety (90) day supply shall not be covered by the Plan.

PRESCRIPTION DRUG EXPENSE BENEFIT

Drugs or supplies excluded under the Prescription Drug benefit, but which may be covered under the Medical BENEFITS portion of this Plan:

- Allergy injections
- Anesthetic agents.
- Asthma and respiratory supplies.
- Blood components and products.
- Blood glucose monitors.
- Diagnostic agents including urine and other test strips (except blood glucose test strips).
- Dialysis supplies.
- DURABLE MEDICAL EQUIPMENT.
- IMMUNIZATION agents, vaccines, biological sera, toxoids or allergens.
- Medical or surgical supplies, such as ostomy bags and devices.
- Nutritional and diet supplements and nutritional foods (enteral and parenteral).

Also excluded are:

- Any drug not approved by the Food and Drug Administration (FDA) or for FDA-approved drugs that are prescribed for non-FDA-approved uses.
- EXPERIMENTAL or INVESTIGATIONAL drugs or medicines.
- A charge excluded under Medical Plan Limitations or Exclusions.
- Refills of a prescription that is more than one (1) year old.
- Refills of a prescription in excess of the number of times specified by a PHYSICIAN.
- Devices or appliances (except for needles and syringes necessary for the administration of insulin and other covered injectable medications, and blood glucose monitors).
- Accutane.
- Anorexic drugs or supplies (associated with weight reduction)
- Bulk chemicals.
- Chemical dependency agents.
- All contraceptives and contraceptive devices used for contraceptive purposes.
- Drugs used for COSMETIC alteration.
- COSMETIC hair products.
- Impotence drugs.
- INFERTILITY/fertility agents.
- Over-the-counter medication and equivalents (excluding chemstrips, glucostix, lancets), except as specifically listed as a covered expense elsewhere in this Plan.
- Smoking cessation drugs, except one (1) course of prescription drug treatment, not to exceed six (6) months duration.
- Vitamins, excluding prenatal vitamins.

COMPREHENSIVE DENTAL EXPENSE BENEFITS

Subject to the General Limitations and Exclusions of this Plan, reasonable charges INCURRED for the following dental expenses will be covered in accordance with the percentage of coverage, DEDUCTIBLE amounts and maximums in the Plan Summary.

The Deductible

The DEDUCTIBLE is the amount of covered dental expenses which must be paid before Comprehensive Dental Expense Benefits are payable. The amount of the DEDUCTIBLE is shown in the Plan Summary. Each FAMILY member is subject to the DEDUCTIBLE as shown in the Plan Summary.

The Family Deductible Limit

When DEDUCTIBLE expenses for any combination of covered FAMILY members reaches the FAMILY DEDUCTIBLE limit during the CALENDAR YEAR, as shown in the Plan Summary, no further DEDUCTIBLES will be required on any FAMILY member for the remainder of that CALENDAR YEAR.

Eligible Dental Expenses

The term "Covered Dental Expenses" means the expenses INCURRED by or on behalf of a COVERED INDIVIDUAL for charges made by a DENTIST for the performance of dental service provided for in the Plan Summary when the dental service is performed by or under the direction of a DENTIST, is essential for the necessary care of the teeth, and begins while the COVERED INDIVIDUAL is covered for Dental BENEFITS. If the actual performance of a dental service begins on a date other than the date the service was recommended or determined to be necessary, the dental service will be considered to begin on the date the actual performance of the service rendered or a supply furnished.

Covered dental expenses do not include any expenses that are in excess of the reasonable and customary amount.

All covered dental services are subject to the limitations as stated in the Plan Summary.

CLASS I – Diagnostic and Preventive Services

1. Oral examinations.
2. Routine cleaning (PROPHYLAXIS) of teeth.
3. Periodontal PROPHYLAXIS.
4. FLUORIDE applied to the teeth.
5. SEALANTS.
6. Bitewing x-rays.
7. Full-mouth x-rays (single or multiple films).

CLASS II – Basic Restorative Services

1. EMERGENCY oral examinations and palliative treatment to relieve pain.
2. Consultation by a specialist.
3. Dental x-rays not covered under Class I.
4. Regular CAVITY fillings, other than gold, including AMALGAM, synthetic porcelain or plastic materials.
5. Extraction of teeth. This service includes local anesthesia and routine post-operative care.
6. Oral surgery, including pre- and post-operative care, general anesthesia, local anesthetic and injectable antibiotics. Oral surgery is limited to removal of teeth, preparation of the mouth for DENTURES and removal of tooth-generated cysts of less than ¼ inch (please refer to the COMPREHENSIVE MEDICAL EXPENSE BENEFIT section, page 25 for additional details).
7. Biopsies of oral tissue, including laboratory report.
8. Space maintainers, including adjustments within six (6) months of installation.
9. Stainless steel crowns.
10. Endodontics (root canals).
11. Periodontics (gum treatments).
12. PULP vitality tests.
13. VISITS by DENTIST or PHYSICIAN to a COVERED INDIVIDUALS home when MEDICALLY NECESSARY in order to render a covered dental service.
14. Local anesthesia or analgesia in connection with a covered procedure.
15. General anesthetics, upon demonstration of MEDICAL NECESSITY.
16. Injectable antibiotic drugs administered by the attending DENTIST.

COMPREHENSIVE DENTAL EXPENSE BENEFITS

17. Appliances to treat tooth grinding and/or jaw clenching, or appliances to correct thumb-sucking or tongue thrusting.
18. Recementing BRIDGES, CROWNS or INLAYS.
19. Repair, rebasing or RELINING of DENTURES and BRIDGES.

CLASS III - Major Restorative Services

1. Gold RESTORATIONS, including INLAYS, onlays and foil fillings. The cost of gold RESTORATIONS in excess of the cost for AMALGAM, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
2. Installation of CROWNS, other than stainless steel.
3. Installing partial or full removable DENTURES to replace one or more natural teeth that have been extracted. This service also includes all adjustments made during a six-month period following the installation.
4. Addition of CLASP or rest to existing partial removable DENTURES.
5. Initial installation of fixed bridgework to replace one or more natural teeth that have been extracted.
6. Precision attachments for DENTURES.
7. Replacing an existing removable partial or full DENTURE or fixed bridgework; adding teeth to an existing removable partial DENTURE; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:
 - a. The replacement or addition of teeth is required because of one or more natural teeth being extracted after the person is covered under these BENEFITS.
 - b. Services are needed because of oral surgery.

CLASS IV – Orthodontics

This is treatment to move teeth by means of appliances to correct a handicapping MALOCCLUSION of the mouth. These services include preliminary study, including x-rays, diagnostic casts and TREATMENT PLAN, active treatments and retention appliance. Removable progression appliances (a.k.a., Invisalign braces) will be considered the same as traditional adjustable appliances by this Plan. The Plan will not pay for orthodontic charges INCURRED prior to the effective date of a COVERED INDIVIDUAL'S coverage under this Plan. Payment for orthodontic treatment which is started prior to the effective date of coverage will be limited to charges determined to be INCURRED while the COVERED INDIVIDUAL is covered by this Plan. Payments for comprehensive full-banded orthodontic treatments are made in installments.

Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of BENEFITS the Plan will pay for treatments covered under the Plan. If a PATIENT chooses a more expensive treatment than is necessary 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. For example, if a regular AMALGAM filling is sufficient to restore a tooth to health, and the PATIENT and the DENTIST decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an AMALGAM filling. The PATIENT will pay the difference in cost.

Pre-Determination of Benefits

Before starting a dental treatment for which the charge is expected to exceed \$300 or more, a pre-determination of BENEFITS form may be submitted. A regular dental claim form is used for the pre-determination of BENEFITS. The covered EMPLOYEE fills out the EMPLOYEE section of the form and then gives the form to the DENTIST. The DENTIST will itemize all recommended services and costs and attach all supporting x-rays to the form. The DENTIST should send the completed form to the CLAIMS PROCESSOR at the address listed in the Plan Description.

The CLAIMS PROCESSOR will notify the DENTIST of the BENEFITS payable under the Plan. The COVERED INDIVIDUAL and the DENTIST can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the DENTIST'S fees are not submitted in advance, the Plan reserves the right to make a determination of BENEFITS payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the BENEFITS may be for a lesser amount than would otherwise have been payable.

Dental Exclusions and Limitations

In addition to the Exclusions listed below, please refer to the General Exclusions section on page 32.

Charges for the following services are not covered:

1. **Administrative Costs:** Administrative costs of completing claim forms or reports or for providing dental records.
2. **Broken Appointments:** Charges for broken or missed dental appointments.
3. **Congenital Deformities:** Charges for services or supplies to correct congenital deformities, such as a cleft palate (these expenses are covered under the Medical Expense Benefit of this Plan).
4. **Cosmetic:** Charges for services or supplies which have the primary purpose of improving the appearance of the teeth, rather than restoring or improving dental form or function. Some examples include: Laminate and veneers.
5. **Educational Services:** Charges for educational services including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.
6. **Implants:** Charges for any implant.
7. **Infection Control:** Charges for infection control procedures (sepsis control – rubber gloves, gowns, etc.) when billed separately from actual dental treatment.
8. **Periodontal Splinting:** Charges for services or supplies for CROWNS placed for the primary purpose of periodontal splinting, altering vertical dimension, or restoring the closing of the upper and lower teeth (occlusion).
9. **Personalization:** Charges for the personalization of DENTURES.
10. **Repair or Replacement:** Charges for the repair of any damaged appliance or replacement of lost or stolen appliances, including orthodontic appliances.
11. **Services Not Rendered by Dentist:** Services not performed by a DENTIST except for those services of a licensed dental hygienist which are supervised and billed by a DENTIST and which are for:
 - a. Cleaning and scaling of teeth; or
 - b. FLUORIDE Treatments.
12. **Third Molars:** This Plan will not pay for the replacement of third molars (wisdom teeth).
13. **TMJ:** Charges for any treatment or SURGICAL PROCEDURE intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
14. **Veneers:** Charges for veneers or similar materials.

GENERAL EXCLUSIONS

The following exclusions and limitations apply to expenses INCURRED by all COVERED INDIVIDUALS:

1. **Abortion:** Charges for abortion unless MEDICALLY NECESSARY to safeguard the life of the mother; this exclusion does not include medical complications arising from and after such an abortion.
2. **Acupuncture:** Charges for acupuncture or accupressure.
3. **Administrative Fees:** Charges for completion of any form, for failure to keep a scheduled appointment or charges for medical information.
4. **Bereavement:** Charges for bereavement counseling or services of volunteers or clergy.
5. **Billed by Employee of Facility:** Charges for professional services billed by a PHYSICIAN or nurse who is an employee of a HOSPITAL or SKILLED NURSING FACILITY and paid by the HOSPITAL or facility for the service.
6. **Chelation Therapy:** Charges in relation to chelation therapy except in the treatment of heavy metal poisoning.
7. **Childbirth at Home:** Charges for scheduled delivery for childbirth at home.
8. **Close Relative, Services Rendered by:** Charges for services rendered by a PHYSICIAN, nurse, or licensed therapist if such PHYSICIAN, nurse, or licensed therapist is a CLOSE RELATIVE, including the SPOUSE, parent (including step-parent), sibling (including step-sibling), CHILD (including legally adopted and STEP-CHILD), grandparent, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law of the COVERED INDIVIDUAL, whether the relationship is by blood or exists in law, or person who resides in the same household of the COVERED INDIVIDUAL.
9. **Concurrent Services:** Charges for IN-PATIENT concurrent services of PHYSICIANS, unless there is a clinical necessity for supplemental skills and the two or more PHYSICIANS attend the PATIENT for separate conditions during the same HOSPITAL admission.
10. **Contraceptive Devices:** Charges contraceptive devices, contraceptive patches, post-coitals or intra-vaginal contraceptive rings.
11. **Convalescent or Rest Care:** Charges for hospitalization when such CONFINEMENT occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine care or tests not connected with the actual ILLNESS or INJURY.
12. **Cosmetic:** Charges in connection with the care or treatment of or surgery performed for a COSMETIC procedure. This exclusion will not apply when such treatment is rendered to correct a condition resulting from an ACCIDENTAL INJURY, or when rendered to correct a congenital anomaly or birth defect, or for breast reconstruction following a mastectomy. **Written prior approval is recommended.**
13. **Court Mandated:** Services that are provided due to a court order, except:
 - a. When determined to be MEDICALLY NECESSARY; and
 - b. No third party liability has been established.
14. **Criminal Act:** Charges INCURRED due to an ILLNESS or INJURY resulting from the COVERED INDIVIDUAL'S voluntary commission of a CRIMINAL ACT (including but not limited to burglary, robbery, assault, criminal trespass, participation in a riot or civil disturbance), or while the COVERED INDIVIDUAL is engaged in an illegal occupation. Charges may be excluded under this provision if the Plan is presented with evidence of CRIMINAL ACT, even if charges have not been filed against the COVERED INDIVIDUAL; the COVERED INDIVIDUAL may appeal the exclusion as provided for in the Claims Procedures section of this document. Such exclusion does not apply to injuries and/or ILLNESSES sustained due to a medical condition (physical or mental) or victims of domestic violence.
15. **Custodial Care:** Charges in connection with CUSTODIAL CARE.
16. **Dental Services:** Charges for dental services not specifically included in Comprehensive Medical BENEFITS described in this Plan; or for HOSPITAL charges in relation to dental care, except those services which are certified by a medical doctor to be MEDICALLY NECESSARY to safeguard the life and health of the COVERED INDIVIDUAL due to the existence of a non-dental physical condition. **Written prior approval is recommended.**
17. **Developmental or Sensory Deficits/Delays:** Charges for hearing therapy, therapy for learning disabilities, communication delays, motor development delays, perceptual disorders, sensory deficits, mental retardation and related conditions, except physical growth development delays as shown elsewhere in this Plan.

GENERAL EXCLUSIONS

18. **Educational or Vocational:** Charges for educational or vocational testing or training, except as specifically shown as a covered expense elsewhere in the Plan.
19. **Employer, Provided by:** Services provided through a medical clinic or similar facility provided or maintained by an employer.
20. **Employment Related:** No BENEFITS or expenses will be paid or reimbursed to or for any COVERED INDIVIDUAL for care or treatment of any INJURY, ILLNESS, occupational disease, or other loss that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applies to each Covered EMPLOYEE as well as to his/her covered SPOUSE and/or DEPENDENTS and includes individuals:
 - a) who may elect coverage under a workers' compensation law or similar law, but either fails to secure such coverage or voluntarily elects not to secure such coverage; or
 - b) whose employer may elect coverage under workers' compensation law or similar law, but either fails to secure such coverage or voluntarily elects not to secure workers' compensation coverage.
21. **Excess Charges:** Charges in excess of the USUAL, CUSTOMARY AND REASONABLE charge, or the PPO allowed charge, whichever applies.
22. **Exercise Programs or Equipment:** Charges for exercise programs or equipment and other such equipment, or health club memberships.
23. **Experimental:** Charges for EXPERIMENTAL procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States or not recognized by the American Medical Association, the American Dental Association or the American College of Surgeons and/or the United States Food & Drug Administration. EXPERIMENTAL or INVESTIGATIONAL services includes:
 - a) care, procedures, treatment protocol or technology which:
 - I. is not widely accepted as safe, effective and appropriate for the INJURY or SICKNESS throughout the recognized medical and dental professions and established medical and dental societies in the United States; or
 - II. is EXPERIMENTAL, in the research or INVESTIGATIONAL stage or conducted as part of research protocol, or has not been proved by statistically significant randomized clinical trials to establish increase survival or improvement in the quality of life over other conventional therapies.
 - b) drugs, tests, and technology which:
 - I. the FDA has not approved for general use;
 - II. are considered EXPERIMENTAL;
 - III. are for INVESTIGATIONAL use; or
 - IV. are approved for a specific medical or dental condition but are applied to another condition.

The Plan will rely on the Data project of the American Medical Association, the American Dental Association, the National Institute of Health, the U.S. Food and Drug Administration, The National Cancer Institute, Office of Health Technology Assessment, the Health Care Financing Administration of the U.S. Department of Health and Human Services, and Congressional Office of Technology Assessment in determining INVESTIGATIONAL or EXPERIMENTAL services.
24. **Eye Examination, Routine:** Charges for routine eye examinations (except eye examinations due to a medical condition).
25. **Foot Care, Routine:** Charges for routine foot care, such as removal of corns, calluses, or trimming of toenails, except the services necessary for the partial or complete removal of nail roots or for services reasonably necessary in the treatment of a metabolic or peripheral vascular disease when recommended by a medical doctor or doctor of osteopathy.
26. **Foreign Travel:** If a COVERED INDIVIDUAL receives medical treatment outside of the United States or its territories, BENEFITS shall be provided for those charges to the extent that the services rendered are included as COVERED EXPENSES in the Plan, and provided the COVERED INDIVIDUAL did not travel to such a location for the sole purpose of obtaining medical services, drugs, or supplies. Additionally, charges for such treatment may not exceed the limits specified herein as reasonable and customary in the area of residence of the COVERED INDIVIDUAL in the United States. Fees and charges exceeding reasonable and customary shall be disallowed as ineligible charges. Charges equal to or less than reasonable and customary shall be considered. In no event shall benefit payment exceed that actual amount charged. (For more efficient claims processing, claims should be submitted in English and converted to American dollars).

GENERAL EXCLUSIONS

27. **Gender Identification:** Charges related to transsexualism, gender dysphoria, or sexual reassignment or services or supplies related to the performance of gender transformation procedures, including medical or psychiatric treatment, medications, implants, hormone therapy and surgery.
28. **Genetic Testing:** Charges in relation to genetic testing for other than diagnostic purposes.
29. **Governmental Facility:** Care and services available at no cost to you in a veteran's or other federal HOSPITAL or any HOSPITAL maintained by any state or governmental agency.
30. **Hair Loss:** Charges for treatment of hair loss, including surgical procedures, artificial hairpieces and drugs. Exception: initial purchase of artificial hairpiece for hair loss due to chemotherapy or radiation treatment.
31. **Hazardous Hobbies:** Charges for treatment arising from participating in a Hazardous Hobby, which is defined as an unusual activity which is characterized by a constant threat of danger or risk of bodily harm, which consists of, but not limited to, the following activities: skydiving, vehicle racing, hang gliding, jet ski operation, off-road unlicensed all terrain vehicles, snowmobiles, off road driving or racing of motorbikes, mopeds, or motor scooters, competitive fighting, skateboarding or bungee jumping. Licensed motorcycle, moped, or motor scooter operation is not a Hazardous Hobby to the extent such benefits provided under the Plan are limited to \$20,000 per Lifetime.
32. **Hearing Impairments:** Charges in connection with any service, supply, testing or treatment for hearing impairments, including hearing exams, hearing aids, earmolds, cochlear implants or any such devices and the fitting thereof.
33. **Holistic Medicine:** Charges related to holistic medicine or healing, or other programs with an objective to provide personal fulfillment.
34. **Home Remodeling:** Charges for ramps or home remodeling.
35. **Hypnotherapy:** Charges for hypnotherapy.
36. **Illegal drugs or medications:** Charges for services, supplies, care or treatment for INJURY or ILLNESS resulting from voluntary intake of any controlled substance, drug, hallucinogen or narcotic not prescribed by a PHYSICIAN for that person specifically.
37. **Impotence:** Charges for care, treatment, services, supplies or prescription drugs in connection with treatment for impotence or sexual dysfunction or inadequacies.
38. **Infertility:** Charges for treatment of INFERTILITY; however, services for diagnosis of infertility will be covered by the Plan.
39. **Incurred by Other Persons:** Expenses actually INCURRED by other persons.
40. **Learning Disabilities/Disorders:** Charges related to the testing and treatment (including speech therapy) of learning disabilities, developmental disorders or functional nervous disorders. The diagnosis and treatment of attention deficit disorder will be considered ELIGIBLE EXPENSES under the Plan.
41. **Mammoplasty:** Charges for mammoplasty, including reduction mammoplasty, or purchase of breast prostheses, except as specifically shown as a covered expense elsewhere in the Plan.
42. **Marital or Family Counseling:** Charges for services or supplies for marital and/or family counseling or training services.
43. **Mass Immunizations:** Charges for unexpected mass IMMUNIZATIONS directed by federal, state or local public officials or schools for general population groups.
44. **Massage Therapy:** Charges for massage therapy.
45. **Milieu Therapy:** Charges for milieu therapy or any CONFINEMENT in an institution primarily to change or control one's environment.
46. **Motor Vehicles:** Charges for the rental or purchase of motor vehicles such as cars or vans, or for the equipment or costs associated with converting a motor vehicle to accommodate a disability.
47. **No Legal Obligation to Pay:** Charges for which the COVERED INDIVIDUAL is not (in the absence of this coverage) legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.
48. **No Physician Recommendation:** Charges for care, treatment, services or supplies not recommended and approved by a PHYSICIAN, or treatment, services or supplies when the COVERED INDIVIDUAL is not under the regular care of a PHYSICIAN. Regular care means ongoing medical supervision or treatment which is appropriate care for the INJURY or ILLNESS.
49. **Non-Covered Procedures:** Charges in relation to complications of a non-covered procedure, except for charges INCURRED due to complications of an abortion, such as excessive hemorrhaging.

GENERAL EXCLUSIONS

50. **Not Medically Necessary:** Charges INCURRED in connection with services and supplies which are not necessary for treatment of the INJURY or ILLNESS, or are in excess of reasonable and customary charges or the PPO contracted rate, or are not recommended and approved by a PHYSICIAN, or are not recognized by the American Medical Association or American Dental Association as generally accepted and medically or dentally necessary for the diagnosis and/or treatment of an active ILLNESS or INJURY; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association or American Dental Association as having no medical or dental value.
51. **Nutritional Supplements/Vitamins:** Charges for nutritional supplements or vitamins, except prenatal vitamins.
52. **Orthopedic Shoes:** Charges for orthopedic shoes even if prescribed by a PHYSICIAN.
53. **Over-the-Counter Drugs and Medications:** Drugs and medications that can be obtained without a PHYSICIAN'S prescription (except insulin and syringes), even if the PHYSICIAN provides a prescription for such drug or medication.
54. **Penile Prosthesis/Implants:** Charges for penile prostheses/implants and any charges relating thereto.
55. **Personal Comfort:** Charges for the purchase or rental of air conditioners, humidifiers, dehumidifiers, air purifiers, saunas, whirlpool bath equipment, or any non-durable medical equipment, services or supplies which constitute personal comfort or beautification items; for television or telephone use, or for any equipment that is useful in the absence of ILLNESS or INJURY.
56. **Phone Consultation:** Charges for consultation by telephone with any healthcare provider.
57. **Pregnancy of Dependent Child:** Charges related to or in connection with the PREGNANCY of a DEPENDENT CHILD.
58. **Prior to Effective Date or After Termination Date:** Charges INCURRED prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.
59. **Private Duty Nursing:** Charges for special nurses and attendants, except to the extent provided under Home Health Care Services, or as specifically provided for elsewhere in this Plan.
60. **Prohibited by Law:** Charges for services, supplies or treatment prohibited by the laws of the jurisdiction where the person resides at the time expenses are INCURRED.
61. **Radioactive Contamination:** Charges INCURRED as a result of radioactive contamination or the hazardous properties of nuclear material.
62. **Recreational or Self-Help:** Charges for services or supplies for recreational educational therapy or forms of non-medical self-help or self-cure, and any related diagnostic testing.
63. **Reversal of Sterilization:** Charges related to or in connection with the reversal of a sterilization procedure.
64. **Third Party Examination:** Charges for routine medical examinations or care, routine health checkups, health assessments, IMMUNIZATIONS, hospitalizations or preparation of reports for third party examinations such as to travel, secure insurance, meet employment requirements, obtain government licenses or examinations to comply with a court order.
65. **Self-Inflicted/Self-Induced:** Charges in relation to intentionally self-inflicted INJURY or self-induced ILLNESS, unless related to a medical condition (such as depression) as specified in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
66. **Services Not Rendered by Nurse:** Charges for professional nursing services if rendered by other than a REGISTERED NURSE (RN) or LICENSED PRACTICAL NURSE (LPN). In addition, the Plan will not cover certified REGISTERED NURSE S in independent practice (other than a nurse-anesthetist).
67. **Services Not Rendered by Physician:** PHYSICIAN'S fees for any treatment or service which is not rendered by and in the physical presence of a PHYSICIAN.
68. **Services Rendered by School:** Charges for services rendered or billed by a school or halfway house or a member of its staff.
69. **Shipping:** Charges for shipping; however, handling and conveyance fees will not be excluded.
70. **Smoking Cessation:** Charges for treatment of smoking cessation, except as specifically listed under the Prescription Drug Expense Benefit provision of this Plan.
71. **Surcharges:** Charges for excise tax, sales tax or other surcharge imposed by a government entity for medically necessary services, equipment and supplies.
72. **Surrogate Parent:** Charges for services rendered to or by a surrogate for purposes of childbirth.
73. **TMJ:** Charges for non-surgical treatment of TMJ (temporomandibular joint) disorder.
74. **Travel or Lodging:** Charges for travel or lodging costs whether or not recommended by a PHYSICIAN, except as specifically shown as a covered expense elsewhere in the Plan.

GENERAL EXCLUSIONS

75. **Visual Impairments, Surgical Correction of:** Charges for radial keratotomy, corneal modulation, refractive keratoplasty or any similar procedure.
76. **Vocational Rehabilitation:** Charges for vocational rehabilitation.
77. **War or any Act of War:** Charges as a result of active participation in war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country or international organization, or in any auxiliary or civilian noncombatant unit serving with such forces, political terrorist actions, or atomic or thermonuclear explosion or resulting radiation.
78. **Weight Loss:** Charges for services, supplies, surgical procedures or medications rendered as treatment for an overweight condition or a condition of obesity whether or not determined to be medically necessary, or for any complication of such treatment, whether or not it is, in any case, a part of the treatment plan for any other illness. Excluded expenses include, but are not limited to:
 - a. Office Visits and other Physician services; and
 - b. Hospital expenses; and
 - c. Diagnostic Testing; and
 - d. Surgical Procedures; and
 - e. Prescription Drugs.

PRE-EXISTING CONDITIONS

This Plan complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Plan cannot deny coverage based on an individual's health status. This Plan has not established eligibility rules based on any of the following health status-related factors: medical conditions (including physical and mental ILLNESSES), claim experience, receipt of health care, medical history, GENETIC INFORMATION, evidence of insurability (including conditions arising out of domestic violence) and disability. This does not prevent this Plan from establishing limitations or restrictions on the amount, level, extent, or nature of the BENEFITS offered, provided all rules are applied on a non-discriminatory basis to all COVERED INDIVIDUALS.

A PRE-EXISTING CONDITION is a condition for which medical advice, diagnosis, care or treatment was recommended or received within three (3) months prior to the COVERED INDIVIDUAL'S ENROLLMENT DATE under this Plan (which is the earlier of the first day of health coverage or the first day of any WAITING PERIOD for coverage). GENETIC INFORMATION is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic test or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a PHYSICIAN.

COVERED CHARGES INCURRED under Medical BENEFITS for PRE-EXISTING CONDITIONS are not payable unless INCURRED twelve (12) consecutive months after the COVERED INDIVIDUAL'S ENROLLMENT DATE. This time may be offset if the person has CREDITABLE COVERAGE from his or her previous health plan.

The PRE-EXISTING CONDITION Limitation will be waived wholly or in part in the event an individual was insured previously by CREDITABLE COVERAGE, and providing there was no break in such coverage of sixty-three (63) days or longer immediately prior to the COVERED INDIVIDUAL'S ENROLLMENT DATE. If, after CREDITABLE COVERAGE has been taken into account, there will still be a PRE-EXISTING CONDITIONS Limitation imposed on a COVERED INDIVIDUAL, that individual will be so notified. For the purposes of this Plan, "CREDITABLE COVERAGE" means, with respect to an individual, coverage of the individual provided under any of the following:

- a) Part A or Part B of Title XVIII of the Social Security Act (MEDICARE);
- b) A group health plan;
- c) An individual health insurance policy that provides BENEFITS similar to or exceeding BENEFITS provided under a basic health benefit plan;
- d) Title XIX of the Social Security Act, other than coverage consisting solely of BENEFITS under section 1928 (Medicaid);
- e) Chapter 55 of Title 10, United States Code (military-sponsored health care);
- f) A State health BENEFITS risk pool;
- g) A health plan offered under chapter 89 of Title 5, United States Code (FEHBP);
- h) A public health plan (as defined in the regulations); or A medical care program of the Indian Health Service or of a tribal organization; or
- i) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or
- j) A plan recognized as "creditable" under HIPAA.

An eligible person may request a CERTIFICATE OF CREDITABLE COVERAGE from his or her prior plan within twenty-four (24) months after losing coverage and the EMPLOYER will assist any eligible person in obtaining a CERTIFICATE OF CREDITABLE COVERAGE from a prior plan.

Exceptions to the Pre-Existing Condition Limitation:

The PRE-EXISTING CONDITION Limitation does not apply to PREGNANCY, to a NEWBORN CHILD who is covered under this Plan within thirty-one (31) days of birth, or to a CHILD who is adopted or placed for adoption before attaining age eighteen (18) and who, as of the last day of the thirty-one (31) day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. The prohibition on PRE-EXISTING CONDITION exclusion for NEWBORN, adopted or pre-ADOPTED CHILDREN does not apply to an individual after the end of the first sixty-three (63) day period during all of which the individual was not covered under any CREDITABLE COVERAGE.

Any CHILD of a COVERED INDIVIDUAL who is an ALTERNATE RECIPIENT under a QUALIFIED MEDICAL CHILD SUPPORT ORDER shall be considered as having a right to DEPENDENT COVERAGE under this Plan with no PRE-EXISTING CONDITIONS provisions applied.

ELIGIBILITY FOR COVERAGE

Employee Eligibility and Effective Date

An EMPLOYEE is eligible for coverage under the Plan from the first day that he or she:

1. Is employed by the COMPANY on a regular, full-time basis as specified in the Plan Summary; and
2. Is ACTIVELY AT WORK; and
3. Has satisfied the Required Period of Service as specified in the Plan Summary; and
4. Is a resident of the United States; and
5. Is within one of the classifications shown in the Plan Summary.

A "WAITING PERIOD" is the time between the first day of employment and the first day of coverage under the Plan. The WAITING PERIOD is counted in the PRE-EXISTING CONDITIONS exclusion time.

If the EMPLOYEE has met the above eligibility requirements on or before the effective date of this Plan, the date of eligibility shall be the effective date of the Plan. If the EMPLOYEE meets the above eligibility requirements after the effective date of the Plan, the date of eligibility shall be the as indicated in the Plan Summary. EMPLOYEE COVERAGE under the Plan shall become effective on the date of the EMPLOYEE'S eligibility, provided he has made written application for such coverage on or before such date. If an EMPLOYEE applies for coverage within thirty-one (31) days after his date of eligibility, his coverage shall become effective on the date he makes his written application.

All EMPLOYEE COVERAGE under the Plan shall commence at 12:01 A.M. Standard Time, on the date such coverage is effective, provided such EMPLOYEE is able to be ACTIVELY AT WORK at such time. If the EMPLOYEE is not ACTIVELY AT WORK on the date this EMPLOYEE COVERAGE would otherwise take effect, but would have been able to actively work at 12:01 A.M. Standard Time had such work commenced at that time, such EMPLOYEE shall be eligible for coverage on that date. If an eligible EMPLOYEE is not able to be ACTIVELY AT WORK on the date this EMPLOYEE COVERAGE would otherwise become effective, for reasons other than those related to a health condition, his coverage shall become effective on the day he returns to active work.

An EMPLOYEE who chooses not to keep his coverage in effect during a period of an approved leave of absence which qualifies under the Family and Medical Leave Act will be eligible to enroll for the same type of coverage (Single or FAMILY) which was in effect at the time of the leave of absence immediately upon return to work.

Each EMPLOYEE will become eligible for DEPENDENT COVERAGE on the latest of the following:

1. The date he becomes eligible for coverage.
2. The date on which he first acquires a DEPENDENT.
3. The date he first comes within the classification (if any) eligible for DEPENDENT COVERAGE, as stated in the Plan Summary.

If both husband and wife are employed by the COMPANY and both are eligible for coverage under this Plan, each may carry single coverage in lieu of FAMILY coverage. However, if either have eligible DEPENDENTS, only one may carry FAMILY coverage on the entire FAMILY unit. A person may not be covered as both an EMPLOYEE and as a DEPENDENT.

Rehiring a Terminated Employee

A terminated EMPLOYEE who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Dependent Eligibility and Effective Date

A DEPENDENT will be considered eligible for coverage on the date the EMPLOYEE becomes eligible for DEPENDENT COVERAGE, subject to all limitations and requirements of this Plan. Each EMPLOYEE who makes such written request for DEPENDENT COVERAGE on a form approved by the COMPANY, shall, subject to the further provisions of this section, become covered for DEPENDENT COVERAGE as follows:

1. If the EMPLOYEE makes such written request on or before the date he becomes eligible for DEPENDENT COVERAGE, he shall become covered, with respect to those persons who are then his DEPENDENTS, on the date he becomes eligible for DEPENDENT COVERAGE.

ELIGIBILITY FOR COVERAGE

2. A DEPENDENT is any one of the following persons:
 - a) A covered EMPLOYEE'S SPOUSE (unless legally separated) and unmarried CHILDREN from birth to the limiting age of nineteen (19) years, who is a resident of the United States.
 - b) The term "SPOUSE" shall mean the person recognized as the covered EMPLOYEE'S husband or wife under the laws of the state where the covered EMPLOYEE lives. The PLAN ADMINISTRATOR may require documentation proving a legal relationship.
 - c) The term "CHILDREN" shall include natural CHILDREN, ADOPTED CHILDREN, CHILDREN placed with a covered EMPLOYEE in anticipation of adoption or CHILDREN for whom the covered EMPLOYEE is the LEGAL GUARDIAN. STEP-CHILDREN or FOSTER CHILDREN who reside in the EMPLOYEE'S household may also be included. Grandchildren are eligible for coverage only if the EMPLOYEE or the EMPLOYEE'S SPOUSE has been appointed LEGAL GUARDIAN in an appropriate legal proceeding and the Plan has been presented with the Order Appointing Guardianship.
 - d) In no event may a Retired EMPLOYEE add any additional DEPENDENTS to coverage under this Plan after the date of retirement.
3. A NEWBORN CHILD of an EMPLOYEE will be covered from the moment of birth providing DEPENDENT COVERAGE is in effect at that time and the EMPLOYEE notifies the EMPLOYER in writing of the NEWBORN CHILD'S name and date of birth within thirty-one (31) days of the birth. If DEPENDENT COVERAGE is not in effect, the EMPLOYEE will have thirty-one (31) days from the date of the birth to make application for DEPENDENT COVERAGE and coverage will be retroactive to the date of the birth. If the EMPLOYEE does not notify the Plan of the CHILD'S birth within thirty-one (31) days after the birth, the CHILD will not be eligible for enrollment in this Plan until the next Open Enrollment Period or Special Enrollment Period, and coverage for the NEWBORN CHILD will not be effective until the date of enrollment.
4. An adoptive CHILD of an EMPLOYEE, who has not attained the age of nineteen (19), will be covered from the date the CHILD is placed in the physical custody of the EMPLOYEE and the EMPLOYEE is legally responsible for medical expenses INCURRED by said CHILD, whether or not the adoption has become final, if DEPENDENT COVERAGE is in effect on that date and the EMPLOYEE notifies the EMPLOYER in writing of the adoptive CHILD'S name and date of birth within thirty-one (31) days of the birth. If the EMPLOYEE makes notification later than thirty-one (31) days after the adoptive CHILD is placed in the physical custody of the EMPLOYEE, coverage for the adoptive CHILD will not be effective until the date of notification. If DEPENDENT COVERAGE is not in effect, the EMPLOYEE has thirty-one (31) days from this date to make application for DEPENDENT COVERAGE and coverage will be retroactive to the date of physical custody.
5. If a DEPENDENT is acquired other than at the time of his birth due to a court order, decree, or marriage, coverage for this new DEPENDENT will be effective on the date of such court order, decree, or marriage if DEPENDENT COVERAGE is in effect under the Plan at that time and the EMPLOYEE notifies the EMPLOYER in writing of the DEPENDENT'S name and date of birth within thirty-one (31) days of the acquisition. If the EMPLOYEE does not have DEPENDENT COVERAGE in effect under the Plan at the time of the court order, decree, or marriage and requests such coverage and properly enrolls this new DEPENDENT within the thirty-one (31) day period immediately following the date of the court order, decree, or marriage, DEPENDENT COVERAGE will be retroactive to the date of the court order, decree, or marriage. If the EMPLOYEE does not notify the Plan of the acquisition of the DEPENDENT CHILD within thirty-one (31) days after the acquisition, the CHILD will not be eligible for enrollment in this Plan until the next Open Enrollment Period or Special Enrollment Period, and coverage for the CHILD will not be effective until the date of enrollment.
6. As required by the Federal Omnibus Budget Reconciliation Act of 1993, any CHILD of a COVERED INDIVIDUAL who is an ALTERNATE RECIPIENT under a QUALIFIED MEDICAL CHILD SUPPORT ORDER shall be considered as having a right to DEPENDENT COVERAGE under this Plan with no PRE-EXISTING CONDITIONS provisions applied. COVERED INDIVIDUALS and beneficiaries may obtain without charge a copy of the QUALIFIED MEDICAL CHILD SUPPORT ORDER procedures from the PLAN ADMINISTRATOR.
7. These persons are excluded as DEPENDENTS: other individuals living in the covered EMPLOYEE'S home, but who are not eligible as defined; the legally separated or divorced former SPOUSE of the EMPLOYEE; any person who is on active duty in any military service of any country (except as provided elsewhere in this Plan); or any person who is covered under the Plan as an EMPLOYEE.
8. If a person covered under this Plan changes status from EMPLOYEE to DEPENDENT or DEPENDENT to EMPLOYEE, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for DEDUCTIBLES and all amounts applied to maximums.
9. If both husband and wife are EMPLOYEES, their CHILDREN will be covered as DEPENDENTS of the husband or wife, but not of both.

Qualified Medical Child Support Order

A QUALIFIED MEDICAL CHILD SUPPORT ORDER is a medical child support order which creates or recognizes an ALTERNATE RECIPIENT'S right to, or assigns to an ALTERNATE RECIPIENT the right to, receive BENEFITS for which a COVERED INDIVIDUAL is eligible, and which the PLAN ADMINISTRATOR has determined meets the requirements of this Section. A Medical Child Support Order to be qualified must clearly:

- a. Specify the name and last known mailing address (if any) of the Covered EMPLOYEE and the name and mailing address of each ALTERNATE RECIPIENT covered by the order; and
- b. Include 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; and
- c. Specify each period to which such order applies; and
- d. Specify each plan to which such order applies; and
- e. Not require the Plan to provide any type or form of BENEFITS or any option not otherwise provided under the Plan except to the extent necessary to meet the requirements described in Section 1908 of the Social Security Act (relating to the enforcement of state laws regarding child support and reimbursement of Medicaid).

Upon receipt of a Medical Child Support Order, the PLAN ADMINISTRATOR shall:

1. Promptly notify in writing the Covered EMPLOYEE, each ALTERNATE RECIPIENT covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order and these QMCSO procedures.
2. Permit the ALTERNATE RECIPIENT to designate a representative to receive copies of notices sent the ALTERNATE RECIPIENT regarding the Medical Child Support Order.
3. Within a reasonable period after receiving a Medical Child Support Order, determine whether it is a qualified order and notify the parties indicated in subsection (a) above of such determination.
4. Ensure the ALTERNATE RECIPIENT is treated by the Plan as a beneficiary for reporting and disclosure purposes, such as by distributing to the ALTERNATE RECIPIENT a copy of the Summary Plan Description and any subsequent Summaries of Material Modifications generated by a Plan AMENDMENT.

ENROLLMENT

Enrollment Requirements

An EMPLOYEE must enroll for coverage by filling out and signing an enrollment application. If the covered EMPLOYEE does not enroll in the Plan within thirty-one (31) days of his initial date of eligibility, his enrollment will be considered a Late Enrollment (see the Late Enrollment provision below).

Enrollment Requirements for Newborn Children

A NEWBORN CHILD of a covered EMPLOYEE must be enrolled in the Plan within thirty-one (31) days of the CHILD'S birth in order for coverage to take effect on the date of birth. ELIGIBLE EXPENSES will be applied toward the Plan of the NEWBORN CHILD. If the NEWBORN CHILD is not enrolled within thirty-one (31) days of birth, there will be no payment from the Plan and the covered parent will be responsible for all costs until the NEWBORN CHILD is enrolled in the Plan, and the enrollment will be considered a Late Enrollment (see the Late Enrollment provision below).

Timely Enrollment

The enrollment will be "timely" if the completed form is received by the PLAN ADMINISTRATOR no later than thirty-one (31) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period. If two EMPLOYEES (husband and wife) are covered under the Plan and the EMPLOYEE who is covering the DEPENDENT CHILDREN terminates coverage, the DEPENDENT COVERAGE may be continued by the other covered EMPLOYEE with no WAITING PERIOD as long as coverage has been continuous.

Late Enrollment

Enrollment for coverage is required within thirty-one (31) days of the date an individual would otherwise be eligible. If enrollment is not completed within that time, or if a covered EMPLOYEE'S and/or DEPENDENT'S coverage terminates because of failure to make a contribution when due, such person will be considered a LATE ENROLLEE. Some late enrollments may be made under the following Special Enrollment provision, however, if the Special Enrollment provisions do not apply, a LATE ENROLLEE will not be eligible to enroll in the Plan.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a LATE ENROLLEE.

Special Enrollment

Special Enrollment rights may be triggered upon the occurrence of two types of events – upon the loss of other health coverage and upon the addition of a new DEPENDENT. When a triggering event occurs, an eligible individual who does not enroll in the Plan within the thirty-one (31) day deadlines explained below will lose Special Enrollment rights for that event.

The ENROLLMENT DATE for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a WAITING PERIOD.

First Type of Event

- A. **Loss of Other Health Coverage.** Eligible EMPLOYEES and their DEPENDENTS who, at the time they were offered coverage under the Plan were eligible for the coverage and declined it because of other health coverage, are entitled to enroll in the Plan when the other coverage ends. If the EMPLOYEE or DEPENDENT lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.
- **Other Coverage is COBRA Coverage.** If the other coverage is COBRA coverage, the eligible EMPLOYEE or DEPENDENT must exhaust COBRA coverage to be eligible for special enrollment in the Plan. Exhaustion of COBRA coverage means that COBRA coverage ends for any reason other than failure to pay contributions on time or for cause.
 - **Other Coverage is Not COBRA Coverage.** If the other coverage is not COBRA coverage, the eligible EMPLOYEE or DEPENDENT must lose the other coverage as a result of:
 1. loss of eligibility for the coverage; or
 2. termination of employment; or
 3. employer contribution toward the other coverage terminates.
- B. **Deadline for Special Enrollment Period.** The eligible EMPLOYEE is required to request special enrollment in the Plan not later than thirty-one (31) days after the exhaustion of the other coverage, the termination of the other coverage as a result of the loss of eligibility for the other coverage, or the termination of employer contributions toward that other coverage. If the PLAN ADMINISTRATOR does not receive the eligible EMPLOYEE'S completed request for enrollment within this deadline, the eligible EMPLOYEE and his or her DEPENDENTS lose special enrollment rights for that event.
- C. **Effective Date of Enrollment.** Enrollment in the Plan under the Special Enrollment provision will be effective not later than the first day of the calendar month beginning after the date the PLAN ADMINISTRATOR receives the completed request for enrollment.

Second Type of Event

- a. **Addition of a Dependent.** An eligible EMPLOYEE'S marriage, or the birth or adoption of his or her CHILD, triggers special enrollment rights.
- b. **Non-Participating Employee May Also Enroll.** The addition of a new DEPENDENT triggers enrollment rights for an eligible EMPLOYEE even if he or she does not participate in the Plan at the time of the event. For example, upon the birth of an eligible EMPLOYEE'S CHILD, the eligible EMPLOYEE (assuming that he or she did not previously enroll), his or her SPOUSE, and his or her NEWBORN CHILD may all enroll because of the CHILD'S birth. The same rule applies to the eligible EMPLOYEE'S marriage or adoption of a CHILD if the eligible EMPLOYEE had not previously enrolled in the Plan.
- c. **Deadline for Special Enrollment Period.** An eligible EMPLOYEE must request special enrollment within thirty-one (31) days of marriage, or birth, adoption or placement for adoption of his or her CHILD. If the PLAN ADMINISTRATOR does not receive the eligible EMPLOYEE'S completed request for enrollment within this deadline, he or his DEPENDENTS lose special enrollment rights for that event.
- d. **Effective Date of Enrollment.** The date of enrollment for coverage will be the date of the event.

Pre-existing Condition Exclusion and Special Enrollees. Special Enrollees and their DEPENDENTS will not be treated as LATE ENROLLEES. The Plan will not apply a PRE-EXISTING CONDITION exclusion to PREGNANCY, or to a NEWBORN OR ADOPTED CHILD who is enrolled under the Special Enrollment provisions.

Effect of Re-Enrollment on Deductibles, Out-of-Pocket Expense Limits and Benefit Limitations

Annual Deductibles, Out-of-Pocket Expense Limits and Benefit Limitations for a Covered Individual whose coverage under this Plan terminates for any reason and who is subsequently re-enrolled in this Plan within the same Calendar Year as termination occurs will be calculated and accrued as if no termination occurred.

The Lifetime Benefit Maximum for a Covered Individual whose coverage under this Plan terminates for any reason and who is subsequently re-enrolled in this Plan will be calculated and accrued as if no termination occurred, regardless of the number of times a Covered Individual terminates coverage and re-enrolls under this Plan.

TERMINATION OF COVERAGE

When coverage under this Plan stops, COVERED INDIVIDUAL'S will receive a certificate that will show the period of coverage under this Plan. Please contact the PLAN ADMINISTRATOR for further details.

Active Employee Termination

EMPLOYEE COVERAGE will automatically terminate immediately upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

- 1) The date the Plan is terminated; or with respect to any benefit of the Plan, the date of termination of such benefit.
- 2) The date the EMPLOYEE terminates employment.
- 3) The date the EMPLOYEE is laid off for lack of work.
- 4) The date the EMPLOYEE requests termination of coverage under this Plan.
- 5) The date the EMPLOYEE ceases to be in a class of EMPLOYEES eligible for coverage.
- 6) The thirty-first (31st) day after the EMPLOYEE enters military duty on a full-time basis.
- 7) The date the EMPLOYEE ceases to be a resident of the United States.
- 8) The date FMLA leave ends, if the EMPLOYEE has not returned to work as an active, regular full-time EMPLOYEE.
- 9) The date ending the period for which the last contribution is made if the EMPLOYEE fails to make any required contributions when due, unless coverage ends earlier for other reasons.
- 10) The date of the EMPLOYEE'S death.

Dependent Termination – Dependent of Active Employee

DEPENDENT COVERAGE will automatically terminate immediately upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

- 1) The date the Plan is terminated; or with respect to any DEPENDENTS benefit of the Plan, the date of termination of such benefit.
- 2) The date of termination of the EMPLOYEE'S coverage under the Plan.
- 3) The date the EMPLOYEE ceases to be in a class of EMPLOYEES eligible for DEPENDENT COVERAGE.
- 4) The date the DEPENDENT ceases to be an eligible DEPENDENT as defined in the Plan.
- 5) The date the DEPENDENT becomes covered under this Plan as an eligible EMPLOYEE.
- 6) The date the EMPLOYEE requests termination of coverage for the DEPENDENT.
- 7) The date ending the period for which the last contribution is made if the EMPLOYEE fails to make any required contributions when due, unless coverage ends earlier for other reasons.
- 8) The thirty-first (31st) day after the DEPENDENT enters military duty on a full-time basis.
- 9) The date the DEPENDENT ceases to be a resident of the United States.
- 10) The date of the EMPLOYEE'S death.

EXTENSION OF BENEFITS

Family and Medical Leave Act Provision

All provisions under the Plan are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to the COMPANY, group health BENEFITS may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. EMPLOYEE eligibility requirements, the obligations of the EMPLOYER and EMPLOYEE concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any Plan provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. An EMPLOYEE with questions concerning any rights and/or obligations should contact the PLAN ADMINISTRATOR or his EMPLOYER.

When a qualifying leave has been taken by the EMPLOYEE, coverage will continue under the Family and Medical Leave Act of 1993, until the earliest of the following dates:

- a. The COVERED INDIVIDUAL fails to return from such leave;
- b. The COVERED INDIVIDUAL exhausts his or her leave entitlement under said Act;
- c. The COVERED INDIVIDUAL informs the COMPANY of the intent not to return from such leave; or
- d. The COVERED INDIVIDUAL fails to pay to the Plan any contribution required during the qualifying leave period within thirty-one (31) days after the due date of such contribution.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

It is the intent of the Plan to adhere to the provisions of The Uniformed Services Employment and Reemployment Rights Act (USERRA), which prohibits discrimination against persons because of their service in the Armed Forces Reserve, the National Guard, or other uniformed services. The USERRA prohibits the EMPLOYER from denying any benefit of employment on the basis of an individual's membership, application for membership, performance of service, application for service, or obligation for service in the uniformed services. USERRA also protects the right of veterans, reservists, National Guard members, and certain other members of the uniformed services to reclaim their civilian employment after being absent due to military service or training. An individual who would like complete information regarding his rights under USERRA should contact the COMPANY, or visit the Department of Labor's website at <http://www.dol.gov/vets/welcome.html>.

EMPLOYEES going into or returning from military service may elect to continue Plan coverage as mandated by the USERRA under the following circumstances. EMPLOYEES performing military duty of more than thirty-one (31) days may elect to continue EMPLOYER sponsored health care for up to twenty-four (24) months. For military service of less than thirty-one (31) days, health care coverage is provided as if the service member had remained employed, provided that the individual makes the required contributions, if any. These rights apply only to EMPLOYEES and their DEPENDENTS covered under the Plan before leaving for military service. The maximum period of coverage of a person under such an election shall be the lesser of:

- The twenty-four (24) month period beginning on the thirty-first day following the date on which the person's absence begins, or
- The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty-one (31) days or less cannot be required to pay more than the EMPLOYEE'S share, if any, for the coverage. Failure to pay the required monthly contribution within thirty-one (31) days of the due date will result in termination of coverage under this Plan.

Continuing coverage under this health plan will be terminated for a person serving military duty for more than thirty-one (31) days but who fails to elect continuation coverage under this provision within sixty (60) days following the last day of active employment prior to entering military service.

In order to be eligible for coverage under this Plan upon return to work after military leave, the period of time a service member has to make application for reemployment or report back to work after military service is based on time spent on military duty:

- For service of less than thirty-one (31) days, the service member must return at the beginning of the next regularly scheduled work period on the first full day after release from service, taking into account safe travel home plus and eight (8) hour rest period.

EXTENSION OF BENEFITS

- For service of more than thirty (30) days but less than one hundred eighty-one (181) days, the service member must submit an application for reemployment within fourteen (14) days of release from service.
- For service of more than one hundred eighty (180) days, an application for reemployment must be submitted within ninety (90) days of release from service.

An exclusion or WAITING PERIOD may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or WAITING PERIOD may be imposed for coverage of any ILLNESS or INJURY determined by the Secretary of Veterans Affairs to have been INCURRED in, or aggravated during, the performance of uniformed service.

Continuation during Periods of Employer-Certified Disability or Leave of Absence

A person may remain eligible for a limited time if active, regular full-time or part-time work ceases due to disability, leave of absence or layoff, but not beyond the periods defined in the COMPANY'S policies.

Coverage may be continued as follows:

- For EMPLOYER-certified disability leave: an EMPLOYEE may continue coverage under this Plan for a maximum of twenty-six (26) weeks, provided that the EMPLOYEE pays the required premium. If the EMPLOYEE is unable to return to work at the end of the twenty-six week continuation period, he may be eligible for COBRA continuation coverage (see COBRA Extension of Benefits provision, which follows later in this section).
- For EMPLOYER-certified leave of absence (non-disability): an EMPLOYEE on non-disability leave of absence may only continue coverage under this Plan under the COBRA Extension of Benefits provision.
- For layoff: an EMPLOYEE who has been laid off may only continue coverage under this Plan under the COBRA Extension of Benefits provision.

COBRA Extension of Benefits

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan offer EMPLOYEES and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform COVERED INDIVIDUALS and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the PLAN ADMINISTRATOR to COVERED INDIVIDUAL who become QUALIFIED BENEFICIARIES under COBRA.

What is COBRA continuation coverage?

COBRA continuation coverage is group health plan coverage that an employer must offer to certain COVERED INDIVIDUALS and their eligible FAMILY members (called "QUALIFIED BENEFICIARIES") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the EMPLOYER'S Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the QUALIFIED BENEFICIARY had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active EMPLOYEES who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who is a Qualified Beneficiary?

In general, a QUALIFIED BENEFICIARY is:

- Any individual who, on the day before a Qualifying Event, is covered under a plan by virtue of being on that day either a covered EMPLOYEE, the SPOUSE of a covered EMPLOYEE, or a DEPENDENT CHILD of a covered EMPLOYEE. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a QUALIFIED BENEFICIARY if that individual experiences a Qualifying Event.
- Any CHILD who is born to or placed for adoption with a covered EMPLOYEE during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a QUALIFIED BENEFICIARY if that individual experiences a Qualifying Event.

The term “covered EMPLOYEE” includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the EMPLOYER sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a QUALIFIED BENEFICIARY if the individual’s status as a covered EMPLOYEE is attributable to a period in which the individual was a non-resident alien who received from the individual’s EMPLOYER no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a QUALIFIED BENEFICIARY, then a SPOUSE or DEPENDENT CHILD of the individual is not considered a QUALIFIED BENEFICIARY by virtue of the relationship to the individual.

Each QUALIFIED BENEFICIARY (including a CHILD who is born to or placed for adoption with a covered EMPLOYEE during a period of COBRA continuation coverage) must be offered the opportunity to make an INDEPENDENT election to receive COBRA continuation coverage.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provides that the COVERED INDIVIDUAL would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before a Qualifying Event) in the absence of COBRA continuation coverage:

- The death of a covered EMPLOYEE.
- The termination (other than by reason of the EMPLOYEE’S gross misconduct), or reduction of hours, of a covered EMPLOYEE’S employment.
- The divorce or legal separation of a covered EMPLOYEE from the EMPLOYEE’S SPOUSE.
- A covered EMPLOYEE’S enrollment in the MEDICARE program.
- A DEPENDENT CHILD’S ceasing to satisfy the Plan’s requirements for a DEPENDENT CHILD (e.g., attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered EMPLOYEE, or the SPOUSE or a DEPENDENT CHILD of the covered EMPLOYEE, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become QUALIFIED BENEFICIARIES under COBRA if all the other conditions of the COBRA law are also met.

The taking of leave under the Family and Medical Leave Act of 1993 (“FMLA”) does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an EMPLOYEE does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered EMPLOYEE and FAMILY members will be entitled to COBRA continuation coverage even if they failed to pay the EMPLOYEE portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last?

An election period is the time period within which the QUALIFIED BENEFICIARY can elect COBRA continuation coverage under the EMPLOYER'S Plan. A plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the QUALIFIED BENEFICIARY would lose coverage on account of the Qualifying Event and must not end before the date that is sixty (60) days after the later of the date the QUALIFIED BENEFICIARY would lose coverage on account of the Qualifying Event or the date notice is provided to the QUALIFIED BENEFICIARY of her or his right to elect COBRA continuation coverage.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

In the event the Qualifying Event is the termination of employment (for reasons other than gross misconduct) or reduction in hours of employment, the death of the EMPLOYEE or the EMPLOYEE'S becoming entitled to MEDICARE BENEFITS (under Part A, Part B, or both), the EMPLOYER is responsible for notifying the PLAN ADMINISTRATOR that a Qualifying Event has occurred.

However, under the law, the QUALIFIED BENEFICIARY has the responsibility to inform the PLAN ADMINISTRATOR of a divorce, legal separation, or a CHILD losing DEPENDENT status under the Plan. These events cause SPOUSES and DEPENDENTS to lose coverage under the Plan. The Plan will offer COBRA continuation coverage to QUALIFIED BENEFICIARIES only after the PLAN ADMINISTRATOR has been notified that a Qualifying Event has occurred. Notice must be given to the PLAN ADMINISTRATOR **in writing** (along with any other documentation required by the PLAN ADMINISTRATOR, e.g., divorce papers, benefits determination letter from the Social Security Administration) within sixty (60) days after the later of:

1. The date of the Qualifying Event, or
2. The date the QUALIFIED BENEFICIARY would lose coverage on account of the Qualifying Event.

The Qualifying Beneficiary must provide such written notice to:

Director of Human Resources
Frantz Manufacturing Company
P.O. Box 497, 603 1st Avenue
Sterling, Illinois 61081
(815) 625-7063

Once the PLAN ADMINISTRATOR receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the QUALIFIED BENEFICIARIES. Each QUALIFIED BENEFICIARY will have an independent right to elect COBRA continuation coverage. Covered EMPLOYEES may elect COBRA continuation coverage on behalf of their SPOUSES, and parents may elect COBRA continuation coverage on behalf of their CHILDREN.

Failure to Notify the PLAN ADMINISTRATOR as described above will cause the QUALIFIED BENEFICIARY (and any COVERED INDIVIDUAL) to lose their rights to COBRA continuation coverage.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a QUALIFIED BENEFICIARY waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the EMPLOYER or PLAN ADMINISTRATOR, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a QUALIFIED BENEFICIARY may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a QUALIFIED BENEFICIARY must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- The last day of the applicable maximum coverage period.
- The first day for which timely payment is not made to the Plan with respect to the QUALIFIED BENEFICIARY.
- The date upon which the EMPLOYER ceases to provide any group health plan (including successor plans) to any EMPLOYEE.
- The date, after the date of the election, that the QUALIFIED BENEFICIARY first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any PRE-EXISTING CONDITION, other than such an exclusion or limitation that does not apply to, or is satisfied by, the QUALIFIED BENEFICIARY.
- The date, after the date of the election, which the QUALIFIED BENEFICIARY first enrolls in the MEDICARE program (either Part A or Part B, whichever occurs earlier).

In the case of a QUALIFIED BENEFICIARY entitled to a disability extension, the later of:

- Twenty-nine (29) months after the date of the Qualifying Event; or
- The first day of the month that is more than thirty-one (31) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled QUALIFIED BENEFICIARY whose disability resulted in the QUALIFIED BENEFICIARY'S entitlement to the disability extension is no longer disabled, whichever is earlier; or
- The end of the maximum coverage period that applies to the QUALIFIED BENEFICIARY without regard to the disability extension.

The Plan can terminate for cause the coverage of a QUALIFIED BENEFICIARY on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a QUALIFIED BENEFICIARY and who is receiving coverage under the Plan solely because of the individual's relationship to a QUALIFIED BENEFICIARY, if the Plan's obligation to make COBRA continuation coverage available to the QUALIFIED BENEFICIARY ceases, the Plan is not obligated to make coverage available to the individual who is not a QUALIFIED BENEFICIARY.

What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of Qualifying Event and the status of the QUALIFIED BENEFICIARY, as shown below.

- In the case of a Qualifying Event that is a termination of employment (for reasons other than gross misconduct) or reduction of hours of employment, the maximum coverage period ends eighteen (18) months after the Qualifying Event if there is not a disability extension and twenty-nine (29) months after the Qualifying Event if there is a disability extension.
- In the case of a covered EMPLOYEE'S enrollment in the MEDICARE program before experiencing a Qualifying Event that is a termination of employment (for reasons other than gross misconduct) or reduction of hours of employment, the maximum coverage period for QUALIFIED BENEFICIARIES other than the covered EMPLOYEE ends on the later of:
 - 1) Thirty-six (36) months after the date the covered EMPLOYEE becomes enrolled in the MEDICARE program; or
 - 2) Eighteen (18) months (or twenty-nine (29) months, if there is a disability extension) after the date of the covered EMPLOYEE'S termination of employment (for reasons other than gross misconduct) or reduction of hours of employment.
- In the case of a QUALIFIED BENEFICIARY who is a CHILD born to or placed for adoption with a covered EMPLOYEE during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the CHILD was born or placed for adoption.
- In the case of any other Qualifying Event than that described above, the maximum coverage period ends thirty-six (36) months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded?

If a QUALIFIED BENEFICIARY'S FAMILY experiences another Qualifying Event while receiving eighteen (18) months of COBRA continuation coverage, the SPOUSE and DEPENDENT CHILDREN the QUALIFIED BENEFICIARY'S FAMILY can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available to the SPOUSE and any DEPENDENT CHILDREN receiving continuation coverage if the EMPLOYEE or former EMPLOYEE dies, becomes entitled to MEDICARE benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the DEPENDENT CHILD stops being eligible under the Plan as a DEPENDENT CHILD, but only if the event that caused the SPOUSE or DEPENDENT CHILD to lose coverage under the Plan had the first Qualifying Event not occurred. In no circumstances can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event or the MEDICARE ENROLLMENT DATE. Failure to Notify the PLAN ADMINISTRATOR as described above will cause the QUALIFIED BENEFICIARY (and any COVERED INDIVIDUAL) to lose their rights to COBRA continuation coverage.

How does a Qualified Beneficiary become entitled to a disability extension?

If a QUALIFIED BENEFICIARY is determined to be disabled by the Social Security Administration at any time within the first sixty (60) days of COBRA continuation coverage, the QUALIFIED BENEFICIARY must notify the PLAN ADMINISTRATOR and provide the PLAN ADMINISTRATOR with a copy of the BENEFITS determination letter within sixty (60) days of the receipt of the determination (but not after the expiration of the eighteen (18) month maximum coverage period) in order to be eligible for the eleven (11) month extension described above in the Maximum Period of Coverage section. The disability extension also will be granted to any non-disabled FAMILY member who is a QUALIFIED BENEFICIARY. The disability would have to have started at some time before the sixtieth (60th) day of COBRA continuation coverage and must last at least until the end of the eighteen (18) month period of continuation coverage. Under the law, you must notify the PLAN ADMINISTRATOR within thirty-one (31) days of any final determination that the individual is no longer disabled (for Social Security disability purposes). Failure to Notify the PLAN ADMINISTRATOR as described above will cause the QUALIFIED BENEFICIARY (and any COVERED INDIVIDUAL) to lose their rights to COBRA continuation coverage.

Second COBRA Election Period for Certain Individuals Eligible for Trade Adjustment Assistance

If your employment is adversely affected by international trade, such as increased imports or a shift in production to another country, you may become eligible for federal trade adjustment assistance (TAA) under the Trade Act of 1974. Part of this assistance is a 65 percent federal tax credit toward the purchase of COBRA continuation coverage if loss of health coverage is trade-related. If you become eligible for TAA after a termination of employment (for any reason other than gross misconduct) or a reduction of hours with the COMPANY, and if you are eligible to, but do not elect COBRA continuation coverage under the Welfare Benefit Plan during the initial 60-day COBRA election period that is a direct consequence of the TAA-related loss of coverage (for example, loss of Welfare Benefit Plan coverage due to loss of employment with the COMPANY caused by a shift of production to another country), you will be eligible for a second COBRA election period during which you may elect COBRA continuation coverage for both yourself and your DEPENDENTS who are eligible for COBRA continuation coverage. This second COBRA election period begins on the first day of the month in which you are determined to be a TAA-eligible individual, provided your election of COBRA continuation coverage is made within six months after the date of the TAA-related loss of coverage under the Welfare Benefit Plan. If you elect COBRA continuation coverage during this second election period, COBRA continuation coverage is effective on the first day of the second election period and not on the date Welfare Benefit Plan coverage originally ended.

Can a Plan require payment for COBRA continuation coverage?

Yes. For any period of COBRA continuation coverage, a plan can require the payment of an amount that does not exceed one hundred two percent (102%) of the applicable premium except the Plan may require the payment of an amount that does not exceed one hundred fifty percent (150%) of the applicable premium for any period of COBRA continuation coverage covering a disabled QUALIFIED BENEFICIARY that would not be required to be made available in the absence of disability extension. A group health plan can terminate a QUALIFIED BENEFICIARY'S COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that QUALIFIED BENEFICIARY.

EXTENSION OF BENEFITS

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage?

Timely Payment means payment that is made to the Plan by the date that is thirty-one (31) days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered EMPLOYEES or QUALIFIED BENEFICIARIES are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the EMPLOYER and the entity that provides Plan BENEFITS on the EMPLOYER'S behalf, the EMPLOYER is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a plan cannot require payment for any period of COBRA continuation coverage for a QUALIFIED BENEFICIARY earlier than forty-five (45) days after the date on which the election of COBRA continuation coverage is made for that QUALIFIED BENEFICIARY. Payment is considered made on the date on which it is sent to the Plan.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a QUALIFIED BENEFICIARY'S COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the one hundred eighty (180) day period that ends on that expiration date, provide the QUALIFIED BENEFICIARY with the option of enrolling under a conversion health plan, if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to QUALIFIED BENEFICIARIES.

Questions concerning this Plan or COBRA continuation coverage rights should be addressed to:

Director of Human Resources
Frantz Manufacturing Company
P.O. Box 497, 603 1st Avenue
Sterling, Illinois 61081
(815) 625-7063

For more information about a COVERED INDIVIDUAL'S rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Plan informed of address changes

In order to protect their rights, COVERED INDIVIDUALS should keep the PLAN ADMINISTRATOR informed of any changes in the addresses for themselves and covered FAMILY members. COVERED INDIVIDUAL should always keep a copy, for their records, of any notices they send to the PLAN ADMINISTRATOR.

PRIVACY STANDARDS

Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued pursuant to The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

The Frantz Manufacturing Company Employee Group Health Benefit Plan (the "Plan") PLAN DOCUMENT and Summary Plan Description (the "PLAN DOCUMENT s") are hereby stated to comply with HIPAA's Privacy Standards, as follows:

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the PLAN SPONSOR, if the PLAN SPONSOR requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the PLAN SPONSOR may receive and use PHI for Plan Administration purposes, the PLAN SPONSOR agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the PLAN DOCUMENT s or as Required by Law (as defined in the Privacy Standards);
- b. Ensure that any agents, including a subcontractor, to whom the PLAN SPONSOR provides PHI received from the Plan agree to the same restrictions and conditions that apply to the PLAN SPONSOR with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the PLAN SPONSOR, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the PLAN SPONSOR becomes aware;
- e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- f. Make available PHI for AMENDMENT and incorporate any AMENDMENTS to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
- i. If feasible, return or destroy all PHI received from the Plan that the PLAN SPONSOR still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

- j. Ensure that adequate separation between the Plan and the PLAN SPONSOR, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
- i. The following EMPLOYEES, or classes of EMPLOYEES, or other persons under control of the PLAN SPONSOR, shall be given access to the PHI to be disclosed:
 - Director of Human Resources
 - Payroll Service Manager
 - Secretary/Treasurer
 - ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the PLAN SPONSOR performs for the Plan.
 - iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the PLAN DOCUMENTS relating to use and disclosure of PHI, the PLAN ADMINISTRATOR shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the PLAN SPONSOR only upon receipt of a certification by the PLAN SPONSOR that (a) the PLAN DOCUMENTS have been amended to incorporate the above provisions and (b) the PLAN SPONSOR agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the PLAN SPONSOR information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the PLAN SPONSOR.

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

The PLAN SPONSOR hereby authorizes and directs the Plan, through the PLAN ADMINISTRATOR or the Butler Benefit Service, Inc., to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

6. Provisions for Security in Transmission of PHI

This Plan will adhere to the national security standards, as defined by HIPAA, for safeguards to protect the confidentiality, integrity, and availability of electronic protected health information that is collected, maintained, used, or transmitted by the Plan. These standards require measures to be taken to secure this information while in the custody of entities covered by HIPAA (covered entities) as well as in transit between covered entities and from covered entities to others.

NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices ("Notice") is made in compliance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). The Frantz Manufacturing Company Employee Group Health Benefit Plan (the "Plan") is required by law to take reasonable steps to ensure the privacy of your Protected Health Information ("PHI"), as defined below, and to inform you about:

- (1) the Plan's uses and disclosures of PHI;
- (2) your privacy rights with respect to your PHI;
- (3) the Plan's duties with respect to your PHI;
- (4) your right to file a complaint with the Plan and with the Secretary of HHS; and
- (5) the person or office to contact for further information about the Plan's privacy practices.

The term "**Protected Health Information**" (PHI) includes all "Individually Identifiable Health Information" transmitted or maintained by the Plan, regardless of form (oral, written or electronic).

The term "**Individually Identifiable Health Information**" means information that:

- Is created or received by a health care provider, health plan, employer or health care clearinghouse;
- Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Notice of PHI Uses and Disclosures

Required PHI Disclosures

Upon your request, the Plan is required to give you access to certain PHI to inspect and copy it and to provide you with an accounting of disclosures of PHI made by the Plan. For further information pertaining to your rights in this regard, see Section 2 of this Notice.

The Plan must disclose your PHI when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards.

Permitted uses and disclosures to carry out treatment, payment and health care operations

The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose PHI without your consent, authorization or opportunity to agree or object, to carry out treatment, payment and health care operations. The Plan will disclose PHI to a business associate only if the Plan receives satisfactory assurance that the business associate will appropriately safeguard the information.

In addition, the Plan may contact you to provide information about treatment alternatives or other health-related BENEFITS and services that may be of interest to you. The Plan will disclose PHI to Frantz Manufacturing Company ("PLAN SPONSOR ") for purposes related to treatment, payment and health care operations. The PLAN SPONSOR has amended its PLAN DOCUMENTS to protect your PHI as required by the Privacy Standards. The PLAN SPONSOR will obtain an authorization from you if it intends to use or disclose your PHI for purposes unrelated to treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services by one or more health care providers. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating DENTIST so that the orthodontist may ask for your dental X-rays from the treating DENTIST.

Payment means activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of BENEFITS under the Plan, or to obtain or provide reimbursement for the provision of health care. Payment includes, but is not limited to, actions to make eligibility or coverage determinations, billing, claims management, collection activities, subrogation, reviews for MEDICAL NECESSITY and appropriateness of care, utilization review and pre-authorizations.

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill might be paid by the Plan.

Health care operations means conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, contacting health care providers and PATIENTS with information about treatment alternatives, reviewing the competence or qualifications of health care professionals, evaluating health plan performance, underwriting, premium rating and other insurance activities relating to creating, renewing or replacing health insurance contracts or health BENEFITS. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require your written authorization

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes without authorization when needed by the Plan to defend against litigation filed by you.

Disclosures that require that you be given an opportunity to agree or disagree prior to the disclosure

The Plan may disclose to a family member, other relative, close personal friend of yours or any other person identified by you PHI directly relevant to such person's involvement with your care or payment for your health care when you are present for, or otherwise available prior to, a disclosure and you are able to make health care decisions, if:

- The Plan obtains your agreement;
- The Plan provides you with the opportunity to object to the disclosure and you fail to do so; or
- The Plan infers from the circumstances, based upon professional judgment, that you do not object to the disclosure.

The Plan may obtain your oral agreement or disagreement to a disclosure.

However, if you are not present, or the opportunity to agree or object to the disclosure cannot practicably be provided because of your incapacity or an EMERGENCY circumstance, the Plan may, in the exercise of professional judgment, determine whether the disclosure is in your best interests, and, if so, disclose only PHI that is directly relevant to the person's involvement with your health care.

Uses and disclosures for which authorization or opportunity to agree or object is not required

Use and disclosure of your PHI is allowed without your authorization or opportunity to agree or object under the following circumstances:

- a) When required by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.

NOTICE OF PRIVACY PRACTICES

- b) When permitted for purposes of public health activities, including disclosures to (i) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect and (ii) a person subject to the jurisdiction of the Food and Drug Administration (FDA) regarding an FDA-regulated product or activity for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity, including to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI also may be disclosed to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.
- c) Except for reports of child abuse or neglect permitted by part (b) above, when required or authorized by law, or with your agreement, the Plan may disclose PHI about you to a government authority, including a social service or protective services agency, if the Plan reasonably believes you to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless (i) the Plan believes that informing you would place you at risk of serious harm or (ii) the Plan would be informing your personal representative, and the Plan believes that your personal representative is responsible for the abuse, neglect or other INJURY, and that informing such person would not be in your best interests. For the purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure generally may be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
- d) The Plan may disclose your PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of: (i) the health care system, (ii) government benefit programs for which health information is relevant to beneficiary eligibility, (iii) entities subject to government regulatory programs for which health information is needed to determine compliance with program standards, or (iv) entities subject to civil rights laws for which health information is needed to determine compliance.
- e) The Plan may disclose your PHI in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the Plan discloses only the PHI expressly authorized by such order, or in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court of administrative tribunal if certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection, and the time to object has expired and either no objections were raised or any objections were resolved in favor of disclosure by the court or tribunal.
- f) The Plan may disclose your PHI to a law enforcement official when required for law enforcement purposes. The Plan may disclose PHI as required by law, including laws that require the reporting of certain types of wounds. Also, the Plan may disclose PHI in compliance with (i) a court order, court-ordered warrant, or a subpoena or summons issued by a judicial officer, (ii) a grand jury subpoena, or (iii) an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, provided certain conditions are satisfied. PHI may be disclosed for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose your PHI in response to a law enforcement official's request if you are, or are suspected to be, a victim of a crime. Further, the Plan may disclose your PHI if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Plan's premises.
- g) The Plan may disclose PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- h) The Plan may use or disclose PHI for research, subject to certain conditions.
- i) When consistent with applicable law and standards of ethical conduct, the Plan may use or disclose PHI if the Plan, in good faith, believes the use or disclosure: (i) is necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public and is to person(s) able to prevent or lessen the threat, including the target of the threat, or (ii) is needed for law enforcement authorities to identify or apprehend an individual, provided certain requirements are met.

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- j) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke an authorization at any time, provided your revocation is done in writing, except to the extent that the Plan has taken action in reliance upon the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your requested restriction.

If the Plan agrees to a requested restriction, the Plan may not use or disclose PHI in violation of such restriction, except that, if you requested a restriction and later are in need of EMERGENCY treatment and the restricted PHI is needed to provide the EMERGENCY treatment, the Plan may use the restricted PHI, or it may disclose such information to a health care provider, to provide such treatment to you. If restricted PHI is disclosed to a health care provider for EMERGENCY treatment, the Plan must request that such health care provider not further use or disclose the information.

A restriction agreed to by the Plan is not effective to prevent uses or disclosures when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards or uses or disclosures that are otherwise required by law.

The Plan may terminate its agreement to a restriction, if:

- You agree to or request the termination in writing;
- You orally agree to the termination and the oral agreement is documented; or
- The Plan informs you that it is terminating its agreement to a restriction, except that such termination is only effective with respect to PHI created or received after the Plan has informed you of the termination.

If the Plan agrees to a restriction, it will document the restriction by maintaining a written or electronic record of the restriction. The record of the restriction will be retained for six years from the date of its creation or the date when it last was in effect, whichever is later.

You or your personal representative will be required to request restrictions on uses and disclosures of your PHI in writing. Such requests should be addressed to the following individual: Benefit Claims Manager, Butler Benefit Service, Inc., P.O. Box 3310, Davenport, Iowa, 52808-3310.

Right to Request Confidential Communications of PHI

You may request to receive communications of PHI from the Plan by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information to which the request pertains could endanger you. The Plan will accommodate all such reasonable requests. However, the Plan may condition the provision of a reasonable accommodation on:

- When appropriate, information as to how payment, if any, will be handled; and
- Specification by you of an alternative address or other method of contact.

You or your personal representative will be required to request confidential communications of your PHI in writing. Such requests should be addressed to the following individual: Benefit Claims Manager, Butler Benefit Service, Inc., P.O. Box 3310, Davenport, Iowa, 52808-3310.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains PHI in the designated record set.

"Designated Record Set" means a group of records maintained by or for a health plan that is enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or used in whole or in part by or for the health plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The Plan will act on a request for access no later than 30 days after receipt of the request. However, if the request for access is for PHI that is not maintained or accessible to the Plan on-site, the Plan must take action no later than 60 days from the receipt of such request. The Plan must take action as follows: if the Plan grants the request, in whole or in part, the Plan must inform you of the acceptance and provide the access requested. However, if the Plan denies the request, in whole or in part, the Plan must provide you with a written denial. If the Plan cannot take action within the required time, the Plan may extend the time for such action by no more than 30 days if the Plan, within the applicable time limit, provides you with a written statement of the reasons for the delay and the date by which it will complete its action on the request.

If the Plan provides access to PHI, it will provide the access requested, including inspection or obtaining a copy, or both, of your PHI in a designated record set. The Plan will provide you with access to the PHI in the form or format requested if it is readily producible in such form or format; or, if it is not, in a readable hard copy form or such other form or format as agreed to between you and the Plan. The Plan may provide you with a summary of the PHI requested, in lieu of providing access to the PHI or may provide an explanation of the PHI to which access has been provided in certain circumstances. The Plan will arrange with you for a convenient time and place to inspect or obtain a copy of the PHI, or mail a copy of the PHI at your request. If you request a copy of PHI or agree to a summary or explanation of PHI, the Plan may impose a reasonable, cost-based fee.

If the Plan denies access to PHI in whole or in part, the Plan will, to the extent possible, give you access to any other PHI requested, after excluding PHI as to which the Plan has grounds to deny access. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, if applicable, a statement of your review rights, including a description of how you may exercise those review rights and a description of how you may complain to the Plan or to the Secretary of the HHS. If you request review of a decision to deny access, the Plan will refer the request to a designated licensed health care professional for review. The reviewing official will determine, within a reasonable period of time, whether to deny the access requested. The Plan will promptly provide you with written notice of that determination.

If the Plan does not maintain the PHI that is the subject of your request for access, and the Plan knows where the requested information is maintained, the Plan will inform you where to direct the request for access.

You or your personal representative will be required to request access to your PHI in writing. Such requests should be addressed to the following individual: Benefit Claims Manager, Butler Benefit Service, Inc., P.O. Box 3310, Davenport, Iowa, 52808-3310.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan may deny your request for AMENDMENT if it determines that the PHI or record that is the subject of the request:

- Was not created by the Plan, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested AMENDMENT;
- Is not part of the designated record set;
- Would not be available for your inspection under the Privacy Standards; or
- Is accurate and complete.

NOTICE OF PRIVACY PRACTICES

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply within that deadline provided that the Plan, within the original 60-day time period, gives you a written statement of the reasons for the delay and the date by which it will complete its action on the request. If the Plan accepts the requested AMENDMENT, the Plan will make the appropriate AMENDMENT to the PHI or record that is the subject of the request by, at a minimum, identifying the records in the designated record set that are affected by the AMENDMENT and appending or otherwise providing a link to the location of the AMENDMENT. The Plan will timely inform you that the AMENDMENT is accepted and obtain your identification of and agreement to have the Plan notify the relevant persons with which the AMENDMENT needs to be shared as provided in the Privacy Standards.

If the request is denied in whole or part, the Plan must provide you with a written denial that (i) explains the basis for the denial, (ii) sets forth your right to submit a written statement disagreeing with the denial and how to file such a statement, (iii) states that, if you do not submit a statement of disagreement, you may request that the Plan provide your request for AMENDMENT and the denial with any future disclosures of the PHI that is the subject of the AMENDMENT, and (iv) includes a description of how you may complain to the Plan or to the Secretary of HHS. The Plan may reasonably limit the length of a statement of disagreement. Further, the Plan may prepare a written rebuttal to a statement of disagreement, which will be provided to you. The Plan must, as appropriate, identify the record or PHI in the designated record set that is the subject of the disputed AMENDMENT and append or otherwise link your request for an AMENDMENT, the Plan's denial of the request, your statement of disagreement, if any, and the Plan's rebuttal, if any, to the designated record set. If a statement of disagreement has been submitted, the Plan will include the above-referenced material, or, at the Plan's election, an accurate summary of such information, with any subsequent disclosure of the PHI to which the disagreement relates. If you do not submit a written statement of disagreement, the Plan must include your request for AMENDMENT and its denial, or an accurate summary of such information with any subsequent disclosure of the PHI only if requested by you.

You or your personal representative will be required to request AMENDMENT to your PHI in a designated record set in writing. Such requests should be addressed to the following individual: Benefit Claims Manager, Butler Benefit Service, Inc., P.O. Box 3310, Davenport, Iowa, 52808-3310. All requests for AMENDMENT of PHI must include a reason to support the requested AMENDMENT.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date on which the accounting is requested. However, such accounting need not include PHI disclosures made: (a) to carry out treatment, payment or health care operations; (b) to individuals about their own PHI; (c) incident to a use or disclosure otherwise permitted or required by the Privacy Standards; (d) pursuant to an authorization; (e) to certain persons involved in your care or payment for your care; (f) to notify certain persons of your location, general condition or death; (g) as part of a "Limited Data Set" (as defined in the Privacy Standards), which largely relates to research purposes; or (h) prior to the compliance date of April 14, 2003. You may request an accounting of disclosures for a period of time less than six years from the date of the request.

The accounting will include disclosures of PHI that occurred during the six years (or such shorter time period, if applicable) prior to the date of the request for an accounting, including disclosures to or by business associates of the Plan. Except as otherwise provided below, for each disclosure, the accounting will include:

- The date of the disclosure;
- The name of the entity or person who received the PHI and, if known, the address of such entity or person;
- A brief description of the PHI disclosed; and
- A brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure, or, in lieu of such statement, a copy of a written request for disclosure.

If during the period covered by the accounting, the Plan has made multiple disclosures of PHI to the same person or entity for a single purpose, the accounting may, with respect to such multiple disclosures, provide the above-referenced information for the first disclosure; the frequency, periodicity or number of the disclosures made during the accounting period; and the date of the last disclosure.

NOTICE OF PRIVACY PRACTICES

If during the period covered by the accounting, the Plan has made disclosures of PHI for a particular research purpose for 50 or more individuals, the accounting may, with respect to such disclosures for which your PHI may have been included, provide certain information as permitted by the Privacy Standards. If the Plan provides an accounting for such research disclosures, and if it is reasonably likely that your PHI was disclosed for such research activity, the Plan shall, at your request, assist in contacting the entity that sponsored the research and the researcher.

If the accounting cannot be provided within 60 days after receipt of the request, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You or your personal representative will be required to request an accounting of your PHI disclosures in writing. Such requests should be addressed to the following individual: Benefit Claims Manager, Butler Benefit Service, Inc., P.O. Box 3310, Davenport, Iowa, 52808-3310.

The Right to Receive a Paper Copy of This Notice upon Request

You have a right to obtain a paper copy of this Notice upon request. To request a paper copy of this Notice, contact the following individual: Director of Human Resources, Frantz Manufacturing Company, P.O. Box 497, 603 1st Avenue, Sterling, Illinois, 61081.

A Note about Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may include, but is not limited to, the following:

- (a) a power of attorney for health care purposes, notarized by a notary public;
- (b) a court order of appointment of the person as the conservator or guardian of the individual; or
- (c) an individual who is the parent of a minor CHILD.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan's Duties

Notice

The Plan is required by law to maintain the privacy of PHI and to provide individuals (COVERED INDIVIDUAL and beneficiaries) with notice of its legal duties and privacy practices with respect to PHI.

This Notice is effective beginning on the effective date set forth on the first page of this Notice, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change the terms of this Notice and to make the new revised notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by the Plan prior to the date of the revised notice. If a privacy practice is changed, a revised version of this Notice will be provided to all individuals then covered by the Plan. If agreed upon between the Plan and you, the Plan will provide you with a revised Notice electronically. Otherwise, the Plan will deliver a paper copy to you personally or mail a paper copy of the revised Notice to your home address. In addition, the revised Notice will be maintained on any web site maintained by the Plan to provide information about its BENEFITS.

Any revised version of this Notice will be distributed within 60 days of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice. Except when required by law, a material change to any term of this Notice may not be implemented prior to the effective date of the revised notice in which such material change is reflected.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- a) disclosures to or requests by a health care provider for treatment;
- b) uses or disclosures made to the individual;
- c) disclosures made to the Secretary of HHS.
- d) uses or disclosures that are required by law;
- e) uses or disclosures that are required for the Plan's compliance with the Privacy Standards; and
- f) uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the PLAN SPONSOR for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a PLAN SPONSOR has provided health BENEFITS under a group health plan, and from which identifying information has been deleted in accordance with the Privacy Standards.

Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the following individual: Director of Human Resources, Frantz Manufacturing Company, P.O. Box 497, 603 1st Avenue, Sterling, Illinois, 61081.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services, by writing to him at the following address: The Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the following individual: Director of Human Resources, Frantz Manufacturing Company, P.O. Box 497, 603 1st Avenue, Sterling, Illinois, 61081.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the Privacy Standards. The Privacy Standards will supersede any discrepancy between the information in this Notice and the Privacy Standards.

RIGHTS UNDER ERISA

As a COVERED INDIVIDUAL in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all COVERED INDIVIDUALS shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the PLAN ADMINISTRATOR'S office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the PLAN ADMINISTRATOR, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The PLAN ADMINISTRATOR may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case Frantz Manufacturing Company, as PLAN ADMINISTRATOR, is required by law to furnish each COVERED INDIVIDUAL with a copy of this summary annual report.

COBRA and HIPAA Rights

- Continue health care coverage for yourself, your SPOUSE, or your DEPENDENTS if there is a loss of coverage under the Plan as a result of a qualifying event. You or your DEPENDENTS may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for PRE-EXISTING CONDITIONS under your group health plan, if you have CREDITABLE COVERAGE from another plan. You should be provided with a CERTIFICATE OF CREDITABLE COVERAGE, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of CREDITABLE COVERAGE, you may be subject to a PRE-EXISTING CONDITION exclusion for 12 months (18 months for LATE ENROLLEES) after your ENROLLMENT DATE in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for COVERED INDIVIDUALS, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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 INDIVIDUALS and beneficiaries. No one, including your EMPLOYER or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of PLAN DOCUMENTS or the latest annual report (Form 5500), if any, 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 Frantz Manufacturing Company, as PLAN ADMINISTRATOR, to provide the materials and pay you up to \$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for BENEFITS which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

If it should happen that PLAN FIDUCIARIES misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the PLAN ADMINISTRATOR. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the PLAN ADMINISTRATOR, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact 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.

COORDINATION OF BENEFITS

If you are covered by more than one group health plan, it is important to understand Coordination of Benefits (COB). COB ensures that COVERED INDIVIDUALS who are covered by more than one group health plan receive the proper BENEFITS while avoiding overpayment by either health plan. This Plan will always pay either its BENEFITS in full, or a reduced amount which when added to the benefits payable by the other plan(s) will not exceed 100% of ALLOWABLE EXPENSES. Only the amount paid by this Plan will be charged against this Plan's maximums. The Coordination of Benefits provision applies whether or not a claim is filed under the other plan(s). If needed, authorization must be given this Plan to obtain information as to benefits or services available from the other plan(s), or to recover overpayment. All BENEFITS contained in the Plan are subject to this provision.

Effect of Medicare

Each plan makes its claim payment according to where it falls in the order explained below, if MEDICARE is not involved. It is the intent of the Plan to adhere to the laws of DEFRA, TEFRA, and COBRA as currently constituted and as amended from time to time. The Plan will pay claims in accordance with the MEDICARE Secondary Payer rules set forth by the U.S. Department of Health and Human Services and the Centers for MEDICARE and Medicaid Services.

Any EMPLOYEE or DEPENDENT eligible for MEDICARE should contact the CLAIMS PROCESSOR for current rulings. If any COVERED INDIVIDUAL eligible for MEDICARE fails to enroll therefore, BENEFITS will be paid by the Plan as though he had enrolled.

Order of Benefit Determination

When a COVERED INDIVIDUAL is covered under two different group health plans, one is considered 'Primary' and the other is considered 'Secondary.' The PRIMARY PLAN is usually responsible for the majority of the claim and provides reimbursement according to plan allowances. The Secondary plan often (but not always) provides reimbursement covering the remaining ALLOWABLE EXPENSES.

If a person is covered by this health Plan and another group health plan, and . . .

- The other plan does not have a COB provision:
 - The other plan (without COB) is Primary; and
 - This Plan (which has COB) is Secondary.
- The person is covered as the "Insured" by one plan and as a DEPENDENT by the other plan:
 - The plan which covers the person as the "Insured" is Primary; and
 - The plan which covers the person as a DEPENDENT is Secondary.
- The person is covered as the "Insured" by both plans:
 - The plan that has been in effect longer is Primary; and
 - The plan that has been in effect for a shorter period of time is Secondary.
- The person is covered under one plan as an active EMPLOYEE or DEPENDENT of an active EMPLOYEE, and covered under another plan as a COBRA enrollee or DEPENDENT of a COBRA enrollee:
 - The plan which covers the active EMPLOYEE is Primary; and
 - The COBRA plan is Secondary.
- If the person is a DEPENDENT CHILD and his/her parents are not divorced or legally separated:
 - The plan of the parent whose birthday occurs earlier in the CALENDAR YEAR is Primary; and
 - The plan of the parent whose birthday occurs later in the CALENDAR YEAR is Secondary; but
 - If both parents have the same birthday, the plan that has been in effect longer is Primary.
- However, if a DEPENDENT CHILD'S parents ARE divorced or legally separated, and:
 - * Health coverage is stipulated in a court decree, then:
 - The plan of the parent deemed primarily responsible for health coverage under the court decree is Primary; and
 - The plan of the step-parent married to the custodial parent (if applicable) is Secondary; and
 - The plan of the other parent pays next; and
 - The plan of the step-parent married to the non-custodial parent (if applicable) pays last.

COORDINATION OF BENEFITS

- * Health coverage is NOT stipulated in a court decree, then:
 - The plan of the parent with custody is Primary; and
 - The plan of the step-parent married to the custodial parent (if applicable) is Secondary; and
 - The non-custodial parent's plan pays next; and
 - The plan of the step-parent married to the non-custodial parent (if applicable) pays last.
- * If the parents share joint custody and are equally responsible for health expenses, then:
 - The plan of the parent whose birthday occurs earlier in the CALENDAR YEAR is Primary; and
 - The plan of the parent whose birthday occurs later in the CALENDAR YEAR is Secondary; but
 - If both parents have the same birthday, the plan that has been in effect longer is Primary and the plan that has been in effect for the shorter period of time is Secondary; and
 - The plan of the step-parent married to the parent whose plan is Primary (if applicable) pays next; and
 - The plan of the step-parent married to the parent whose plan is Secondary (if applicable) pays last.

If the order set out above does not apply in a particular case, then the plan which has covered the CLAIMANT for the longest period of time will be Primary.

The above information is designed to help identify the primary and secondary plans in various situations. If clarification on coverage is needed related to COB, call BBSI at (563) 327-2280, or toll-free at (866) 927-2200, extension 280.

The COMPANY has the right:

1. To obtain or share information with an insurance company or other organization regarding Coordination of Benefits without the CLAIMANT'S consent.
2. To require that the CLAIMANT provide the COMPANY with information on such other plans so that this provision may be implemented.
3. To pay the amount due under this Plan to an insurer or other organization if this is necessary, in the COMPANY'S opinion, to satisfy the terms of this provision.

Coordination Procedures

Notwithstanding the other provisions of this Plan, BENEFITS that would be payable under this Plan will be reduced so that the sum of BENEFITS and all BENEFITS payable under all other plans will not exceed 100% of ALLOWABLE EXPENSES INCURRED during any CLAIM DETERMINATION PERIOD with respect to a COVERED INDIVIDUAL eligible for:

1. BENEFITS either as an insured person or as a DEPENDENT under any other plan which has no provision similar in effect to this provision, or
2. DEPENDENT BENEFITS under this Plan for a COVERED INDIVIDUAL who is also eligible for BENEFITS:
 - a. As an insured person under any other plan; or
 - b. As a DEPENDENT covered under another group plan; or
3. EMPLOYEE BENEFITS under this Plan for an EMPLOYEE who is also eligible for BENEFITS as an insured person under any other plan and has been covered continuously for a longer period of time under such other plan.

Definitions

The term "plan" as used herein will mean any plan providing BENEFITS or services for or by reason of medical or dental treatment, and such BENEFITS or services are provided by:

1. Group insurance or any other arrangement for coverage for COVERED INDIVIDUAL in a group whether on an insured or uninsured basis, including but not limited to:
 - a. HOSPITAL indemnity BENEFITS.
 - b. HOSPITAL reimbursement-type plans which permit the COVERED INDIVIDUALS to elect indemnity at the time of claims.
2. HOSPITAL or medical service organizations on a group basis, group practice, and other group pre-payment plans.
3. HOSPITAL or medical service organizations on an individual basis having a provision similar in effect to this provision.
4. A licensed Health Maintenance Organization (HMO).
5. Any coverage for students which is sponsored by or provided through a school or other EDUCATIONAL INSTITUTION.

COORDINATION OF BENEFITS

6. Any coverage under a governmental program and any coverage required or provided by any statute.
7. Group automobile insurance.
8. Individual automobile insurance coverage on an automobile leased or owned by the COMPANY.
9. Individual automobile insurance coverage based upon the principles of "NO-FAULT" coverage.

The term "plan" will be construed separately with respect to each policy, contract, or other arrangement for BENEFITS or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the BENEFITS or services of other plans into consideration in determining its BENEFITS and that portion which does not.

The term "ALLOWABLE EXPENSES" means any necessary item of expense, the charge for which is reasonable, regular, and customary, at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides BENEFITS in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

The term "CLAIM DETERMINATION PERIOD" means a CALENDAR YEAR or that portion of a CALENDAR YEAR during which the COVERED INDIVIDUAL for whom claim is made has been covered under this Plan.

Automobile Limitations

When medical or dental payments are available under vehicle insurance, the Plan shall pay excess BENEFITS only, without reimbursement for vehicle plan DEDUCTIBLES. This Plan shall always be considered the secondary carrier regardless of the individual's election under Personal Injury Protection coverage with the auto carrier.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the COMPANY will have the right, exercisable alone and in its sole discretion, to pay to any insurance COMPANY or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be BENEFITS paid under this Plan and to the extent of such payments, the COMPANY will be fully discharged from liability under this Plan.

The BENEFITS that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this provision of the Plan or any similar provision of any other plans, the COMPANY may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the COMPANY deems to be necessary for such purposes. Any person claiming BENEFITS under this Plan shall furnish to the COMPANY such information as may be necessary to implement this provision.

SUBROGATION AND REIMBURSEMENT

As used herein, "Covered Individual" means any Plan beneficiary covered under this Agreement and includes the eligible Employee, Retiree, COBRA Qualified Beneficiary, covered Dependent beneficiaries, Spouses, guardian(s) of minor beneficiaries, the Covered Individual's heirs, guardians, executors, administrators or other representatives.

As used herein, "Third-Party" means any person, insurance company or other entity that is not a party to this Agreement and is in any way responsible for the injury or illness, or for payment of any medical expenses or other expenses incurred as a result of the injury or illness, under any law, policy of insurance or accident benefit plan providing coverage, including no fault, medical payments coverage, personal injury protection or financial responsibility coverage. This expressly includes the Covered Individual's own underinsured or uninsured automobile insurance.

In the event any benefit is provided or paid by the Plan for a Covered Individual, the Covered Individual shall immediately notify the Plan or its authorized agents in writing of any accident, injury, illness or other condition in any way arising out of acts or omissions of others, for which benefits are sought as paid.

In the event any benefits or services of any kind are furnished to a Covered Individual, or payment made or credit extended to or on behalf of any Covered Individual for a physical condition, illness, or injury caused by a Third Party or for which a Third Party may be liable, the Plan shall be and is subrogated and shall succeed to individual rights of recovery against any such Third Party to the full extent of the value of any such benefits or services furnished or payments made or credit extended without reduction for the Covered Individual's attorney's fees, or application of the "common fund" doctrine, "make whole" doctrine, "Rimes" doctrine, or any other similar legal theory. The Covered Individual shall immediately upon recovery of any funds or other property reimburse the Plan out of the proceeds of any recovery no less than one hundred percent (100%) of the benefits provided under the Plan, as described above. The Covered Individual agrees to pay all of his own legal fees and expenses incurred in litigation against such third parties, and to hold the Plan harmless against any claims made against the Plan by the attorneys retained by the Covered Individual.

The Covered Individual shall, at the Plan's request, take such action, furnish such information and assistance, and execute such documents as the Plan may require to facilitate enforcement of its rights hereunder. In the event that the Plan would have a subrogation interest upon payment of benefits, the Plan may, prior to such payment, require the Covered Individual in writing to:

- (a) reimburse the Plan one hundred percent (100%) of the benefits actually provided without reduction for, or application of, the "common fund" doctrine, "make whole" doctrine, "Rimes" doctrine, or any other similar legal theory, immediately upon collection of damages by him, whether obtained by action at law, settlement, or otherwise; and
- (b) provide the Plan with a first lien to the extent of benefits provided by the Plan. Said lien may be filed with any person or organization liable, or potentially liable, to the Covered Individual for indemnification, the Covered Individual's attorney, or the court.

In the event of the Covered Individual's failure to comply with any such request made prior to or after payment of benefits, the Plan shall be entitled to withhold benefits, services, payments or credits due under the Plan, or to initiate or maintain any legal proceedings it deems necessary to protect the rights of the Plan, as provided herein. The Covered Individual shall do nothing prior to or following acceptance of benefits hereunder to prejudice the subrogation rights, or potential subrogation rights, of the Plan.

In the event the Covered Individual or his personal representative fails to institute a proceeding against a Third Party at any time prior to three (3) months before such action would be barred, the Plan may in its own name or in the name of the Covered Individual or their personal representative commence a proceeding against such Third Party for the recovery of all damages in the full extent of the value of any such benefits or services furnished or payments made or credit extended by the Plan. Out of any amount recovered, the Plan shall pay over to the Covered Individual or their personal representative all sums collected from such Third Party by judgment or otherwise in excess of (a) the amount of such services, payments, or credit extended or paid by the Plan on behalf of the Covered Individual; plus (b) the costs, attorneys' fees and reasonable expenses as may be incurred by the Plan in making such in collection or enforcing such liability.

This notice of subrogation and reimbursement is the only notice required, and by accepting payment of Benefits, the Covered Individual acknowledges and agrees to comply with these subrogation and reimbursement provisions and is duly notified that coverage and payment of claims or expenses is dependent upon it.

CLAIMS PROCEDURES

The procedures outlined below must be followed by COVERED INDIVIDUALS ("CLAIMANTS") to obtain payment of health BENEFITS under this Plan.

Health Claims

All claims and questions regarding health claims should be directed to Butler Benefit Service, Inc. 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. BENEFITS under the Plan will be paid only if the PLAN ADMINISTRATOR decides in its discretion that the CLAIMANT is entitled to them. The responsibility to process claims in accordance with the PLAN DOCUMENT and Summary Plan Description may be delegated to Butler Benefit Service, Inc.; provided, however, that Butler Benefit Service, Inc. is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each CLAIMANT 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 CLAIMANT has not INCURRED a covered expense or that the benefit is not covered under the Plan, or if the CLAIMANT shall fail to furnish such proof as is requested, no BENEFITS shall be payable under the Plan.

Under 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 CLAIMANT or the CLAIMANT'S ability to regain maximum function, or, in the opinion of a PHYSICIAN with knowledge of the CLAIMANT'S medical condition, would subject the CLAIMANT to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a CLAIMANT needs medical care for a condition which could seriously jeopardize his life; there is no need to contact the Plan for prior approval. The CLAIMANT should obtain such care without delay.

Further, if the Plan does not require the CLAIMANT to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The CLAIMANT 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 (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the CLAIMANT requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the CLAIMANT 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 CLAIMANT 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

Health claims should be filed with Butler Benefit Service, Inc. within ninety (90) days of the date charges for the service were INCURRED. Health claims **must** be filed with Butler Benefit Service, Inc. within twelve (12) months of the date charges for the service were INCURRED. BENEFITS are based upon the Plan's provisions at the time the charges were INCURRED. Charges are considered INCURRED when treatment or care is given or supplies are provided. Claims filed later than that date shall be denied.

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by Butler Benefit Service, Inc. in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by Butler Benefit Service, Inc., together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan;
7. The name of the covered EMPLOYEE; and
8. The name of the PATIENT.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. Butler Benefit Service, Inc. 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 Butler Benefit Service, Inc. within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the CLAIMANT of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The CLAIMS PROCESSOR, UTILIZATION REVIEW AGENT or PHARMACY BENEFIT MANAGER shall notify the CLAIMANT, 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:

- o If the CLAIMANT has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
- o If the CLAIMANT has not provided all of the information needed to process the claim, then the CLAIMANT 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 CLAIMANT will be notified of a determination of BENEFITS as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the CLAIMANT to provide the information.

Pre-service Non-urgent Care Claims:

- o If the CLAIMANT 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.
- o If the CLAIMANT has not provided all of the information needed to process the claim, then the CLAIMANT 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 CLAIMANT 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 CLAIMS PROCESSOR, UTILIZATION REVIEW AGENT or PHARMACY BENEFIT MANAGER and the CLAIMANT (if additional information was requested during the extension period).

CLAIMS PROCEDURES

Concurrent Claims:

- Plan Notice of Reduction or Termination. If the CLAIMS PROCESSOR, UTILIZATION REVIEW AGENT or PHARMACY BENEFIT MANAGER is notifying the CLAIMANT 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 CLAIMANT will be notified sufficiently in advance of the reduction or termination to allow the CLAIMANT to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- Request by CLAIMANT Involving Urgent Care. If the CLAIMS PROCESSOR, UTILIZATION REVIEW AGENT or PHARMACY BENEFIT MANAGER receives a request from a CLAIMANT 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 CLAIMANT makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the CLAIMANT 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 CLAIMANT Involving Non-urgent Care. If the CLAIMS PROCESSOR, UTILIZATION REVIEW AGENT or PHARMACY BENEFIT MANAGER receives a request from the CLAIMANT 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).

Post-service Claims:

- If the CLAIMANT 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 CLAIMANT has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the CLAIMANT 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 CLAIMANT will be notified of the determination by a date agreed to by the CLAIMS PROCESSOR, UTILIZATION REVIEW AGENT or PHARMACY BENEFIT MANAGER and the CLAIMANT.

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 CLAIMANT, 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 CLAIMANT, 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.

Notification of an Adverse Benefit Determination

The CLAIMS PROCESSOR, UTILIZATION REVIEW AGENT or PHARMACY BENEFIT MANAGER shall provide a CLAIMANT 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 following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the PLAN DOCUMENT and Summary Plan Description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the CLAIMANT to perfect the claim and an explanation of why such information is necessary;

CLAIMS PROCEDURES

4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the CLAIMANT'S right to bring a civil action following an adverse benefit determination on final review;
5. A statement that the CLAIMANT 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 CLAIMANT'S claim for BENEFITS;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the CLAIMANT, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is MEDICALLY NECESSARY or EXPERIMENTAL), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the CLAIMANT'S medical circumstances, or a statement that such explanation will be provided to the CLAIMANT, free of charge, upon request; and
9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

Appeals 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 CLAIMANT believes the claim has been denied wrongly, the CLAIMANT may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a CLAIMANT with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. CLAIMANTS at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination;
2. CLAIMANTS the opportunity to submit written comments, documents, records, and other information relating to the claim for BENEFITS;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate NAMED FIDUCIARY of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the CLAIMANT relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
7. That a CLAIMANT will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the CLAIMANT'S claim for BENEFITS in possession of the PLAN ADMINISTRATOR or Butler Benefit Service, Inc.; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the CLAIMANT'S medical circumstances; and
8. In an Urgent Care Claim, for an expedited review process pursuant to which
 - o A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the CLAIMANT; and
 - o All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the CLAIMANT by telephone, facsimile, or other available similarly expeditious method.

First Appeal Level

Requirements for First Appeal

The CLAIMANT must file the first 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 CLAIMANT chooses to orally appeal, the CLAIMANT may telephone:

Benefit Claims Manager
Butler Benefit Service, Inc.
at (563) 327-2200 or (866) 927-2200.

To file an appeal in writing, the CLAIMANT'S appeal must be addressed as follows and faxed to the following number:

Butler Benefit Service, Inc.
Attn: Benefit Claims Manager
P.O. Box 3310
Davenport, Iowa 52808-3310
Fax: (563) 327-2250 or (866) 927-2250.

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

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

If the CLAIMANT 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 First Appeal

The CLAIMS PROCESSOR, UTILIZATION REVIEW AGENT OR PHARMACY BENEFIT MANAGER shall notify the CLAIMANT 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 36 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 15 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 30 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 First Appeal

The CLAIMS PROCESSOR, UTILIZATION REVIEW AGENT OR PHARMACY BENEFIT MANAGER shall provide a CLAIMANT 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:

CLAIMS PROCEDURES

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the PLAN DOCUMENT and Summary Plan Description on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the CLAIMANT 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 CLAIMANT'S claim for BENEFITS;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the CLAIMANT upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the CLAIMANT'S medical circumstances, will be provided free of charge upon request;
7. A description of any additional information necessary for the CLAIMANT to perfect the claim and an explanation of why such information is necessary;
8. A description of the Plan's review procedures and the time limits applicable to the procedures;
9. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claims;
10. A statement of the CLAIMANT'S right to bring an action following an adverse benefit determination on final review; and
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination.

In the case of an adverse benefit determination on review, the PLAN ADMINISTRATOR shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the CLAIMANT has 60 days to file a second appeal of the denial of BENEFITS. The CLAIMANT again is entitled to a "full and fair review" of any denial made at the first appeal, which means the CLAIMANT has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the CLAIMANT'S second appeal must be in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal

The CLAIMS PROCESSOR, UTILIZATION REVIEW AGENT or PHARMACY BENEFIT MANAGER shall notify the CLAIMANT 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 36 hours after receipt of the second appeal.

Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second 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 30 days after receipt of the second appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time the second 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 Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the CLAIMANT to perfect the claim and an explanation of why such information is needed; (ii) a description of the Plan's review procedures and the time limits applicable to the procedures; and (iii) for Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claim. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the PLAN ADMINISTRATOR shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

Decision on Second Appeal to be Final

If, for any reason, the CLAIMANT does not receive a written response to the appeal within the appropriate time period set forth above, the CLAIMANT may assume that the appeal has been denied. The decision by the PLAN ADMINISTRATOR or other appropriate NAMED FIDUCIARY of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one (1) year after the Plan's claim review procedures have been exhausted.**

Appointment of Authorized Representative

A CLAIMANT 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 CLAIMANT to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the CLAIMANT must complete a form which can be obtained from the PLAN ADMINISTRATOR or Butler Benefit Service, Inc. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the CLAIMANT'S medical condition to act as the CLAIMANT'S authorized representative without completion of this form. In the event a CLAIMANT designates an authorized representative, all future communications from the Plan will be with the representative, rather than the CLAIMANT, unless the CLAIMANT directs the PLAN ADMINISTRATOR, in writing, to the contrary.

GENERAL PROVISIONS

Proof of Loss

The PLAN ADMINISTRATOR will have the right and opportunity to have examined any individual whose INJURY or SICKNESS is the basis of a claim hereunder when and as often as it may reasonably require during the pendency of a claim, and also the right and opportunity to make an autopsy in case of death (where such autopsy is not forbidden by law).

Free Choice of Physician

The COVERED INDIVIDUAL will have free choice of any legally qualified PHYSICIAN or surgeon, and the PHYSICIAN-patient relationship will be maintained. However, services provided by an Out-of-Network PHYSICIAN may reduce BENEFITS payable for COVERED SERVICES.

Payment of Claims

All Plan BENEFITS are payable to the provider of service, or subject to any written direction of the EMPLOYEE. All or a portion of any indemnities provided by the Plan on account of HOSPITAL, nursing, medical or surgical services may, at the EMPLOYEE'S option and unless the EMPLOYEE requests otherwise in writing not later than the time of filing proof of such loss, be paid directly to the HOSPITAL or person rendering such services; however, if any such benefit remains unpaid at the death of the EMPLOYEE or if the EMPLOYEE is a minor or is, in the opinion of the PLAN ADMINISTRATOR, legally incapable of giving a valid receipt and discharge for any payment, the PLAN ADMINISTRATOR may, at its option, pay such BENEFITS to any one or more of the following relatives of the EMPLOYEE: wife, husband, mother, father, CHILD or CHILDREN, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan will not be required to see the application of the money so paid.

Assignment

BENEFITS may not be ASSIGNED except by consent of the COMPANY, other than to providers of medical services and according to the provisions set forth in the PLAN DOCUMENT.

Rights of Recovery

Whenever payments have been made by the COMPANY with respect to ALLOWABLE EXPENSES in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the COMPANY will have the right, exercisable alone and in its sole discretion, to recover such excess payments or to withhold payment of any future BENEFITS to offset for such excess payment.

Workers' Compensation Not Affected

This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Legal Proceedings

No action at law or in equity will be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor will such action be brought at all unless brought within one (1) year from the expiration of the time within which proof of loss is required by the Plan.

Conformity with Governing Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Time Limitation

If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity is less than that permitted under any state and/or federally mandated law, such limitation is hereby extended to agree with the minimum period permitted by such law.

GENERAL PROVISIONS

Statements

All statements made by the COMPANY or by a COVERED INDIVIDUAL will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining BENEFITS under this document will be used in any contest to avoid or reduce the BENEFITS provided by the document unless contained in a written application for BENEFITS and a copy of the instrument containing such representation is or has been furnished to the COVERED INDIVIDUAL.

Any COVERED INDIVIDUAL who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The COVERED INDIVIDUAL may be subject to prosecution by the United States Department of Labor. Fraudulently claiming BENEFITS may be punishable by a substantial fine, imprisonment, or both.

Miscellaneous

Section titles are for convenience of reference only, and are not to be considered in interpreting the Plan.

PRONOUNS used in this PLAN DOCUMENT shall include both masculine and feminine gender unless the context indicates otherwise. Likewise, words used shall be construed as though they were in the plural or singular number, according to the context.

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect its right to enforce any other provision of this Plan.

If an inadvertent error should occur due to interpretation of mandated benefits, relevant laws and regulations before the final regulations are issued, the Plan, PLAN ADMINISTRATOR, Agent for the Service of Legal Process, Trustee, CLAIMS PROCESSOR, and COMPANY will be held harmless for such an error; and in no way will such an error be construed as a precedent-setting event.

Payment for expenses in relation to services which are generally accepted as cost-containment measures in large claim management cases that are not normally covered under this Plan will be reimbursable upon recommendation of the CLAIMS PROCESSOR and written approval by the PLAN ADMINISTRATOR.

DEFINITIONS

ABUTMENT

A tooth or root that retains or supports a fixed BRIDGE or a removable prosthesis.

ACCIDENTAL INJURY

A condition which is the result of bodily INJURY caused by an external force; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences; this incident must be of a sufficient departure from the CLAIMANT'S normal and ordinary lifestyle or routine; the condition must be an instantaneous one, rather than one which continues, progresses or develops.

ACTIVELY AT WORK/ACTIVE SERVICE

An EMPLOYEE is considered to be ACTIVELY AT WORK when performing, in the customary manner, all of the regular duties of his occupation with the COMPANY and is not confined to a HOSPITAL or other health care facility. An EMPLOYEE shall be deemed ACTIVELY AT WORK on each day of a regular paid vacation; on a regular non-working day, provided he was ACTIVELY AT WORK on the last preceding regular working day; or if he is absent solely due to INJURY or ILLNESS.

ADOPTED CHILD

Any CHILD legally placed in an EMPLOYEE'S home by an adoption agency who meets the eligibility requirements of this Plan, whether or not the adoption is final. Placement is defined as the assumption and retention of a legal obligation for total or partial support of a CHILD in anticipation of adoption of such CHILD.

ALLOWABLE EXPENSES

Any MEDICALLY NECESSARY expense, INCURRED while the COVERED INDIVIDUAL is eligible for BENEFITS under this Plan, provided such expense does not exceed the PPO contracted rate or the USUAL, CUSTOMARY AND REASONABLE rate, whichever applies.

ALTERNATE RECIPIENT

Any CHILD of a COVERED INDIVIDUAL who is recognized under a QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) as having a right to enrollment in this Plan with respect to such COVERED INDIVIDUAL.

AMALGAM

An alloy of mercury, silver and other metals used as a restorative material in making dies.

AMBULATORY SURGICAL CENTER

An institution or facility, either free-standing or as part of a HOSPITAL, with permanent facilities, equipped and operated for the primary purpose of performing SURGICAL PROCEDURES and to which a PATIENT is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a PHYSICIAN for the practice of medicine or dentistry or for the primary purpose of performing terminations of PREGNANCY shall not be considered to be an AMBULATORY SURGICAL CENTER.

AMENDMENT

A formal document that changes the provisions of the PLAN DOCUMENT, duly signed by the authorized person or persons as designated by the PLAN ADMINISTRATOR.

ANNUAL

Periodic, based on a CALENDAR YEAR.

ASSIGNMENT OF/ASSIGNED BENEFITS

ASSIGNMENT OF BENEFITS occurs when the COVERED INDIVIDUAL authorizes the Plan to pay BENEFITS directly to the provider of services.

BASELINE

The initial test results to which the results in future years will be compared in order to detect abnormalities.

BENEFITS

Those MEDICALLY NECESSARY services and supplies that qualify for payment under this Plan.

BENEFIT PERCENTAGE

That portion of ELIGIBLE EXPENSES to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any OUT-OF-POCKET EXPENSES in excess of the ANNUAL DEDUCTIBLE which are to be paid by the EMPLOYEE.

DEFINITIONS

BENEFIT PERIOD

A time period of one (1) CALENDAR YEAR. Such BENEFIT PERIOD will terminate on the earliest of the following dates:

- The last day of the one-year period so established;
- The day the MAXIMUM LIFETIME BENEFIT applicable to the COVERED INDIVIDUAL becomes payable; or
- The day the COVERED INDIVIDUAL ceases to be covered for Medical Expense Benefits.

BIRTHING CENTER

Any freestanding health facility, place, professional office or institution which is not a HOSPITAL or in a HOSPITAL, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to BIRTHING CENTERS in the jurisdiction where the facility is located. The BIRTHING CENTER must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a PHYSICIAN and either a REGISTERED NURSE (RN) or a licensed nurse-midwife; and have a written agreement with a HOSPITAL in the same locality for immediate acceptance of PATIENTS who develop complications or require pre- or post-delivery CONFINEMENT.

BITEWINGS

Dental x-rays showing approximately the coronal halves of the maxillary and mandibular teeth on the same film.

BRIDGE

A permanently cemented appliance which includes at least one PONTIC (to replace a missing tooth) and at least one ABUTMENT. BRIDGES are removable only by a DENTIST.

CALENDAR YEAR

A period of time commencing on January 1st and ending on December 31st of the same given year.

CARIES

A progressive destruction of the teeth from bacterially produced acids on tooth surfaces.

CAVITY

A carious lesion in a tooth.

CERTIFIED COUNSELOR

An individual qualified by education, training and experience to provide counseling in relation to emotional disorders, psychiatric conditions, or SUBSTANCE ABUSE.

CERTIFICATE OF CREDITABLE COVERAGE

The term "CERTIFICATE OF CREDITABLE COVERAGE" is defined as a written document provided by a prior Plan which will allow an individual to establish prior CREDITABLE COVERAGE to offset a pre-existing exclusion imposed by a subsequent group health plan. The certificate must indicate the date any WAITING PERIOD or affiliation period began as well as the dates coverage began and ended.

CHILD(REN)

Son or daughter of COVERED INDIVIDUAL, including natural CHILDREN, ADOPTED CHILDREN (as defined), STEP-CHILDREN and FOSTER CHILDREN.

CHIROPRACTIC SERVICES

Services performed by a person trained and licensed to practice chiropractic medicine, provided those services are for the remedy of diseases or conditions which the chiropractor is licensed to treat. ELIGIBLE EXPENSES include spinal manipulations and other therapeutic treatments, x-rays, supplies and equipment.

CLAIMANT

An individual for whom a service has been rendered or furnished and on whose behalf expenses for such services have been submitted to the Plan for consideration of benefits.

CLAIM DETERMINATION PERIOD

A CALENDAR YEAR or that portion of a CALENDAR YEAR during which the individual for whom claim is made has been covered under this Plan.

CLAIMS PROCESSOR

The person or firm employed by the COMPANY to provide consulting services to the COMPANY in connection with the operation of the Plan and any other functions, including the processing and payment of claims.

CLASP

A metal attachment on partial DENTURES or other removable appliances to hold them in place.

DEFINITIONS

CLOSE RELATIVE

The SPOUSE, parent (including step-parent), sibling (including step-sibling), CHILD (including legally adopted and STEP-CHILD), grandparent, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law of the COVERED INDIVIDUAL, whether the relationship is by blood or exists in law, or person who resides in the same household of the COVERED INDIVIDUAL.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COINSURANCE

That figure shown as a percentage in the Plan Summary used to compute the amount of benefit payable when the Plan states that a percentage is payable.

COMPANY

Frantz Manufacturing Company.

CONFINEMENT

A continuous stay in the HOSPITAL(S) or EXTENDED CARE FACILITY(IES) or combination thereof, due to a SICKNESS or INJURY diagnosed by a PHYSICIAN.

CO-PAYMENT

A CO-PAYMENT (CO-PAY) is the fixed dollar amount a COVERED INDIVIDUAL pays each time he receives certain COVERED SERVICES.

COSMETIC

Primarily directed at improving an individual's appearance rather than for restoration or improvement of a bodily function.

COVERED CHARGES/EXPENSES/SERVICES

Those expenses covered by this Plan, including the HOSPITAL, surgical, medical and dental care expenses described in this booklet. However, expenses are not covered if they are expressly excluded, are not MEDICALLY NECESSARY, are EXPERIMENTAL or INVESTIGATIONAL in nature, or if they exceed maximum amount considered by this Plan. See also the definitions of ELIGIBLE EXPENSES and ALLOWABLE EXPENSES.

COVERED INDIVIDUAL

Any EMPLOYEE, COBRA QUALIFIED BENEFICIARY, eligible DEPENDENT, or person who qualifies under other classifications as stated in the Plan Summary, meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

CREDITABLE COVERAGE

Includes an individual's coverage under a group health plan, MEDICARE, Medicaid, a public health plan, a medical or dental plan for members of the uniformed services and their DEPENDENTS an Indian or tribal organization medical program, a State health benefits risk pool, the Federal Employees Health Benefits program or a Peace Corps health benefits plan, or any other plan or program recognized under the Health Insurance Portability and Accountability Act of 1996, as amended. CREDITABLE COVERAGE is used to reduce an individual's PRE-EXISTING CONDITION exclusion period under a new plan as long as there is no break in coverage of sixty-three (63) or more consecutive days.

CRIMINAL ACT

A crime or offense which carries with it a punishment as determined by common law or statute within the presiding jurisdiction of law enforcement.

CROWN

The portion of the tooth above the cemento-enamel junction.

CUSTODIAL CARE

That type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a COVERED INDIVIDUAL, whether or not TOTALLY DISABLED, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DEFINITIONS

DEDUCTIBLE

A specified dollar amount of COVERED EXPENSES which must be INCURRED during a BENEFIT PERIOD before any other COVERED EXPENSES can be considered for payment according to the applicable BENEFIT PERCENTAGE.

DEFRA

The Deficit Reduction Act of 1984, as amended.

DENTIST

An individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. For the purpose of this definition, a PHYSICIAN will be considered to be a dentist when he performs any of the dental services described herein and is operating within the scope of his license.

DENTURE

A prosthesis which replaces missing teeth. Full Denture is a prosthesis which replaces all natural teeth in an arch. Partial Denture is a prosthesis which replaces fewer than the full number of natural teeth in either jaw.

DEPENDENT

The term "DEPENDENT" means:

- The EMPLOYEE'S legal SPOUSE who is a resident of the same country in which the EMPLOYEE resides. Such SPOUSE must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, a common law SPOUSE will not be recognized as a SPOUSE who is eligible for coverage under this Plan. The PLAN ADMINISTRATOR may require documentation proving a legal marital relationship.
- The EMPLOYEE'S CHILD who meets all the following requirements:
 - 1) Is a resident of the same country in which the EMPLOYEE resides.
 - 2) Is unmarried.
 - 3) Is a natural CHILD, STEP-CHILD, legally ADOPTED CHILD, FOSTER CHILDREN, a CHILD placed in the EMPLOYEE'S physical custody whom the EMPLOYEE intends to adopt, a CHILD for whom the EMPLOYEE and/or the EMPLOYEE'S SPOUSE has been named LEGAL GUARDIAN, or a CHILD for whom the EMPLOYEE is legally financially responsible. STEP-CHILDREN who reside in the EMPLOYEE'S household may be included as long as a natural parent remains married to the EMPLOYEE and also resides in the EMPLOYEE'S household.
 - 4) The EMPLOYEE must have primary physical custody of the CHILD; and
 - 5) The CHILD must be dependent upon the EMPLOYEE for 50% or more of his support.
 - 6) Is less than nineteen (19) years of age.

Waivers:

- Requirements 4, custody, and 5, support, may be waived in the event the EMPLOYEE is required to provide coverage due to a QUALIFIED MEDICAL CHILD SUPPORT ORDER [QMCSO].
- Requirements 4, custody, and/or 5, support, will be waived for those DEPENDENTS who satisfy the definition of DEPENDENT in every other way and who were covered under the health Plan provided through the COMPANY on the day immediately preceding the effective date of this Plan.

At any time, the Plan may require proof that a SPOUSE or CHILD qualifies or continues to qualify as a DEPENDENT as defined by this Plan.

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

- A SPOUSE who is legally separated or divorced from the EMPLOYEE.
- A CHILD who is married.
- Any person on active military duty more than thirty (30) days.
- Any DEPENDENT covered under this Plan as an individual EMPLOYEE.
- Any person who is covered as a DEPENDENT by another EMPLOYEE of the COMPANY.

DEPENDENT COVERAGE

Eligibility under the terms of the Plan for BENEFITS payable as a consequence of ELIGIBLE EXPENSES INCURRED for an ILLNESS or INJURY of a DEPENDENT.

DURABLE MEDICAL EQUIPMENT

Equipment which is able to withstand repeated uses, primarily and customarily used to serve a medical purpose, and not generally useful to a person in the absence of ILLNESS or INJURY.

DEFINITIONS

EDUCATIONAL INSTITUTION

An institution accredited in the current publication of accredited institutions of higher education including vocational technical schools.

ELIGIBLE EXPENSE

Any MEDICALLY NECESSARY treatment, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan.

ELIGIBLE PROVIDER

Eligible providers shall include the following legally licensed or duly certified health care providers to the extent that same, within the scope of their license, are permitted to perform services which are considered ELIGIBLE EXPENSES under the Plan:

- Ambulatory Surgical Center
- Audiologist
- Birthing center
- Certified counselor under the supervision of an MD, DO, or PhD
- Certified registered nurse Anesthetist
- Certified Nurse Midwife
- Chiropractor
- Clinic
- Dentist
- Dialysis Center
- Extended care facility
- Home Health Agency
- Hospice
- Hospital
- Laboratory
- Licensed practical nurse
- Medical Doctor (M.D.)
- Medical Supply Purveyor
- Nurse Practitioner
- Occupational therapist
- Ophthalmologist
- Optometrist
- Oral Surgeon
- Osteopath (D.O.)
- Out-patient psychiatric treatment facility
- Out-patient Substance Abuse Treatment Facility
- Pharmacy/Pharmacist
- Physical therapist
- Physician (M.D., D.O.)
- Physician Assistant
- Podiatrist
- Professional Ambulance Service
- Psychiatrist
- Psychologist (PhD)
- Registered Dietitian
- Registered nurse
- Skilled nursing facility
- Social worker under the supervision of an MD, DO, or PhD
- Speech therapist

"Eligible Provider" shall not include the COVERED INDIVIDUAL or any CLOSE RELATIVE of the COVERED INDIVIDUAL.

EMERGENCY

A condition with acute symptoms which requires immediate psychiatric or medical services. Failure to seek immediate medical care for this condition could result in serious or permanent medical consequences. Examples include but are not limited to: severe chest pain, seizure, severe abdominal pain, loss of consciousness or severe bleeding.

EMPLOYEE

An active EMPLOYEE of the COMPANY receiving compensation from the COMPANY for services rendered to the COMPANY. EMPLOYEE means a person who is in an EMPLOYER - EMPLOYEE relationship with the COMPANY and who is classified by the COMPANY as a regular EMPLOYEE. The term "EMPLOYEE" shall not include any individual classified by the COMPANY as an independent contractor, a consultant, an individual performing services for the COMPANY who has entered into an independent contract or consultant agreement with the COMPANY (even if a court, the Internal Revenue Service, or any other entity determines that such individual is a common-law EMPLOYEE) or a leased EMPLOYEE as defined Section 414(n) of the Code. The term EMPLOYEE does not include any EMPLOYEE covered by a collective bargaining agreement that does not provide for coverage under the Plan, provided that health care BENEFITS were the subject of good faith bargaining between the EMPLOYEE'S bargaining representative and the COMPANY. The term EMPLOYEE does not include an EMPLOYEE classified by the COMPANY as a temporary EMPLOYEE.

EMPLOYEE COVERAGE

Coverage hereunder providing BENEFITS payable as a consequence of an INJURY or ILLNESS of an EMPLOYEE.

EMPLOYER

Frantz Manufacturing Company.

DEFINITIONS

ENROLLMENT DATE

The earlier of the first date of coverage or the first date of the WAITING PERIOD, if any, for coverage. The ENROLLMENT DATE for Special Enrollees or LATE ENROLLEES is the actual date of coverage.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

EXPERIMENTAL OR INVESTIGATIONAL

Any medical procedure, equipment, treatment, or course of treatment, or drug or medicine that is limited to research, not proven in an objective manner to have therapeutic value or benefit, restricted to use at medical facilities capable of carrying out scientific studies, or is of questionable medical effectiveness. To determine whether a procedure is EXPERIMENTAL the COMPANY will consider, among other things, commissioned studies, opinions, and references to or by the American Medical Association, the Federal Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies and any other association or federal program or agency that has the authority to approve medical testing or treatment.

FAMILY

A Covered EMPLOYEE and his eligible DEPENDENTS.

FLUORIDE

A solution of fluorine which is applied to the teeth for the purpose of preventing dental CARIES.

FOSTER CHILD

A CHILD whom the EMPLOYEE is raising as his/her own, who resides in the EMPLOYEE'S home, who is chiefly dependent upon the EMPLOYEE for support and for whom the EMPLOYEE has full parental responsibility and control. A FOSTER CHILDREN must have been placed in the EMPLOYEE'S home by the appropriate governing authority.

GENERIC DRUG

A PRESCRIPTION DRUG which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a GENERIC DRUG any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

GENETIC INFORMATION

Information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

HOME HEALTH CARE AGENCY

A MEDICARE-approved public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must be primarily engaged in and duly licensed by the appropriate licensing authority (if such licensing is required) to provide skilled nursing services and other therapeutic services. It must have policies established by a professional group associated with the agency or organization including at least one PHYSICIAN and at least one REGISTERED NURSE (R.N.) to govern the services provided, and it must provide for full-time supervision of such services by a PHYSICIAN or registered graduate nurse. Its staff must maintain a complete medical record on each individual and it must have a full-time administrator.

HOME HEALTH CARE PLAN

A program for continued care and treatment of the COVERED INDIVIDUAL established and approved in writing by the COVERED INDIVIDUAL'S attending PHYSICIAN. The attending PHYSICIAN must certify that the proper treatment of the ILLNESS or INJURY would require continued CONFINEMENT as a resident IN-PATIENT in a HOSPITAL or EXTENDED CARE FACILITY in the absence of the services and supplies provided as part of the HOME HEALTH CARE PLAN.

DEFINITIONS

HOSPICE

A health care program providing a coordinated set of services rendered at home, in OUT-PATIENT or clinic settings, or in institutional settings for COVERED INDIVIDUALS suffering from a condition that has a terminal prognosis. A HOSPICE must have an interdisciplinary group of personnel which includes at least one PHYSICIAN and one registered graduate nurse, and its staff must maintain central clinical records on all PATIENTS. A HOSPICE must meet the standards of the National Hospice Organization (NHO) and applicable state licensing.

HOSPITAL

An institution which meets all of the following conditions:

- It is engaged primarily in providing medical care and treatment to an ill or injured person on an IN-PATIENT basis at the PATIENT'S expense.
- It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to HOSPITALS.
- It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ILLNESS or an INJURY.
- Such treatment is provided for compensation by or under the supervision of PHYSICIANS, with continuous twenty-four (24) hour nursing services by REGISTERED NURSES (RNs).
- It is accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO). The JCAHCO accreditation limitation may be waived at the discretion of the Plan if the only HOSPITAL in the immediate area is not JCAHCO approved.
- It is a provider of services under MEDICARE.
- It is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.

The definition of "HOSPITAL " will also include an institution qualified for the treatment of psychiatric problems, SUBSTANCE ABUSE, or tuberculosis that does not have surgical facilities and/or is not approved by MEDICARE, provided that such institution satisfies the definition of HOSPITAL in all other respects.

HOSPITAL MISCELLANEOUS EXPENSES

The actual charges made by a HOSPITAL in its own behalf for services and supplies rendered to the COVERED INDIVIDUAL which are MEDICALLY NECESSARY for the treatment of such COVERED INDIVIDUAL. HOSPITAL MISCELLANEOUS EXPENSES do not include charges for ROOM AND BOARD or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the HOSPITAL or otherwise.

ILLNESS

A bodily disorder, disease, physical SICKNESS, mental infirmity, or functional nervous disorder of a COVERED INDIVIDUAL. A recurrent ILLNESS will be considered one ILLNESS. Concurrent ILLNESSES will be considered one ILLNESS unless the concurrent ILLNESSES are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one ILLNESS.

IMPACTED TOOTH

A tooth that is positioned or wedged against another tooth, or covered by bone or soft tissue, so that it cannot erupt.

IMMUNIZATION

An injection or oral preparation with a specific antigen to promote antibody formation to make a person immune to disease or less susceptible to a contagious disease.

INCURRED

The point in time when a service is performed, or a supply is provided, or a purchase is made.

INFERTILITY

The inability or diminished ability to produce offspring.

INJURY

The term "INJURY" shall mean only accidental bodily INJURY caused by an external force, occurring while the Plan is in effect. All injuries to one person from one accident shall be considered an "INJURY."

INLAY

A cast RESTORATION made to fit a prepared tooth CAVITY and then cemented into place.

DEFINITIONS

IN-PATIENT

The classification of a COVERED INDIVIDUAL when that COVERED INDIVIDUAL receives medical care, treatment, services, or supplies at a HOSPITAL while registered as a bed PATIENT at that HOSPITAL, SKILLED NURSING FACILITY or EXTENDED CARE FACILITY.

IN-PATIENT CARE

HOSPITAL ROOM AND BOARD and general nursing care for a person confined in a HOSPITAL or EXTENDED CARE FACILITY as a bed PATIENT for twenty-four (24) consecutive hours or more.

INTENSIVE CARE UNIT (ICU)

An area within a HOSPITAL which is reserved, equipped, and staffed by the HOSPITAL for the treatment and care of critically ill PATIENTS who require extraordinary, continuous, and intensive nursing care for the preservation of life.

INTENSIVE OUT-PATIENT TREATMENT/PARTIAL HOSPITALIZATION

A distinct and organized intensive ambulatory treatment service, less than 24-hour daily care specifically designed for the diagnosis and active treatment of a MENTAL HEALTH AND/OR SUBSTANCE ABUSE DISORDER when there is a reasonable expectation for improvement or to maintain the COVERED INDIVIDUAL'S functional level and to prevent relapse or hospitalization. Such program must provide: diagnostic services; psychiatric nurses and staff trained to work with psychiatric PATIENTS; services of SOCIAL WORKERS; individual, group and family therapies; activities and occupational therapies; PATIENT education; and chemotherapy and biological treatment interventions for therapeutic purposes.

LATE ENROLLEE

A COVERED INDIVIDUAL who enrolls under the Plan other than during the first thirty-one (31) day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

LEGAL GUARDIAN

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor CHILD.

LICENSED PRACTICAL NURSE (LPN)

An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LIFETIME

The term "LIFETIME" (which is used in connection with benefit maximums and limitations) means the period during which a COVERED INDIVIDUAL is covered under this Plan, whether or not coverage is continuous. Under no circumstances does "LIFETIME " mean during the actual LIFETIME of the COVERED INDIVIDUAL.

LOCAL GROUND AMBULANCE

MEDICALLY NECESSARY transportation to and from a HOSPITAL or from a HOSPITAL to a nursing facility in the surrounding area where the ambulance transportation originated. To determine if the ambulance transportation is covered, this Plan considers if no other method of transportation is appropriate, that the services necessary to treat the INJURY or ILLNESS are not available in the HOSPITAL, nursing facility or chemical dependency facility in which the COVERED INDIVIDUAL is an IN-PATIENT or OUT-PATIENT and the point of destination is the nearest one with adequate and appropriate methods of care.

MALOCCLUSION

An abnormality in the positioning and relationship of teeth.

MANDIBLE

The lower jaw.

MAXILLA

The bone forming one-half of the upper jaw. The upper jaw consists of two maxillae; however, it is commonly referred to as the maxilla.

MAXIMUM LIFETIME BENEFIT

The highest dollar amount of ALLOWABLE EXPENSES that could be paid to or on behalf of any COVERED INDIVIDUAL during the COVERED INDIVIDUAL'S LIFETIME (as defined by the Plan), subject to the terms of this Plan.

DEFINITIONS

MEDICAL CARE FACILITY

A HOSPITAL, a facility that treats one or more specific ailments or any type of SKILLED NURSING FACILITY.

MEDICALLY NECESSARY/MEDICAL NECESSITY

Care and treatment that is recommended or approved by a PHYSICIAN or DENTIST; is consistent with the PATIENT'S condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the PATIENT or provider of services which can be safely provided to the PATIENT. All of these criteria must be met; merely because a PHYSICIAN recommends or approves certain care does not mean that it is MEDICALLY NECESSARY. The PLAN ADMINISTRATOR has the discretionary authority to decide whether care or treatment is MEDICALLY NECESSARY.

MEDICARE

The medical care benefits provided under Title XVIII of the Social Security Act of 1965, as subsequently amended.

MENTAL HEALTH ILLNESS/DISORDER

Any disease or condition, regardless of whether the cause is organic, this 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.

MENTAL HEALTH CLINIC

A facility established for the purpose of providing consultation, diagnosis and treatment in connection with MENTAL HEALTH DISORDER, and approved as such by a state department or agency having authority over such facilities.

MINOR EMERGENCY MEDICAL CLINIC

A freestanding facility which is engaged primarily in providing minor EMERGENCY and episodic medical care to a COVERED INDIVIDUAL. A board-certified PHYSICIAN, a REGISTERED NURSE, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be a MINOR EMERGENCY MEDICAL CLINIC, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in any way made a part of a regular HOSPITAL shall be excluded from the terms of this definition.

MODALITY

A method of treatment; includes, but is not limited to, spinal manipulation (adjustment), ultrasound therapy, hot or cold packs, manual or mechanical traction.

MORBID OBESITY

MORBID OBESITY is a condition of persistent and uncontrollable weight gain that is a potential threat to life. It is characterized by a weight that is at least 100 pounds over or twice the ideal weight for the frame, age, height, and gender specified in the most recently published Metropolitan Life Insurance table. MORBID OBESITY may also be defined by comparable body mass index (BMI) measures.

NAMED FIDUCIARY

Frantz Manufacturing Company, which has the authority to control and manage the operation and administration of the Plan.

NEGOTIATED

In most cases, a simple discount arrangement.

NEWBORN

An infant from the date of birth until the mother is discharged from the HOSPITAL.

NO-FAULT AUTO INSURANCE

The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

OCCUPATIONAL THERAPIST

A licensed practitioner who treats, primarily, the loss of motor function of skeletal muscles by educating the PATIENT to use other muscles and/or artificial devices to enable them to perform acceptably in any particular occupation or the ordinary tasks of daily living.

DEFINITIONS

ORTHOTIC APPLIANCE

An external device intended to correct any defect in form or function of the human body.

OUT-OF-POCKET EXPENSE

The amount of COVERED CHARGES that are payable by the COVERED INDIVIDUAL or FAMILY unit.

OUT-PATIENT

The classification of a COVERED INDIVIDUAL when that COVERED INDIVIDUAL receives medical care, treatment, services, or supplies at a clinic, a PHYSICIAN'S office, a HOSPITAL if not a registered bed PATIENT at that HOSPITAL, an OUT-PATIENT psychiatric facility, or an OUT-PATIENT alcoholism treatment facility.

OUT-PATIENT PSYCHIATRIC TREATMENT FACILITY

An administratively distinct governmental, public, private or independent unit or part of such unit that provides OUT-PATIENT mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all PATIENTS.

OUT-PATIENT SUBSTANCE ABUSE TREATMENT FACILITY

An institution which provides a program for diagnosis, evaluation, and effective treatment of alcoholism and/or SUBSTANCE ABUSE; provides detoxification services needed with its effective treatment program; provides infirmity-level medical services that may be required; is at all times supervised by a staff of PHYSICIANS; prepares and maintains a written plan of treatment for each PATIENT, based on the PATIENT'S medical, psychological, and social needs and supervised by a PHYSICIAN; and meets licensing standards.

OUT-PATIENT SURGERY

OUT-PATIENT SURGERY includes, but is not limited to, the following types of procedures performed in a HOSPITAL, surgi-center or clinic:

- Operative or cutting procedures for the treatment of an ILLNESS or INJURY;
- The treatment of fractures and dislocations; or
- Endoscopic or diagnostic procedures such as biopsies, cystoscopy, bronchoscopy, and angiocardiography.

PARTICIPATING PROVIDER

A provider that has entered into an agreement with the Plan or PREFERRED PROVIDER ORGANIZATION to accept agreed-upon discounted rates for covered services.

PATIENT

The COVERED INDIVIDUAL who is awaiting or receiving medical or dental care and treatment.

PHARMACY

A licensed establishment where covered PRESCRIPTION DRUGS are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

PHARMACY BENEFIT MANAGER

The organization contracting with the COMPANY to provide cost containment services related to the prescription drug benefits provided by this Plan

PHYSICAL THERAPIST

A licensed practitioner who treats PATIENTS by means of electro-, hydro-, aero-, and mechano-therapy, massage and therapeutic exercises. Where there is no licensure law, the PHYSICAL THERAPIST must be certified by the appropriate professional body.

PHYSICIAN

A legally licensed medical or dental doctor or surgeon, osteopath, podiatrist, optometrist, chiropractor or registered clinical PSYCHOLOGIST, physician assistant, nurse practitioner or licensed nurse midwife to the extent that same, within the scope of his license, is permitted to perform services provided in this Plan. A PHYSICIAN shall not include the COVERED INDIVIDUAL or any CLOSE RELATIVE of the COVERED INDIVIDUAL.

PLAN

The term "Plan" means without qualification the Plan outlined herein.

PLAN DOCUMENT

The legal document according to which this Plan is administered.

DEFINITIONS

PLAN ADMINISTRATOR

The COMPANY, which is responsible for the management of the Plan. The PLAN ADMINISTRATOR may employ persons or firms to process claims and perform other Plan-connected services.

PLAN SPONSOR

Frantz Manufacturing Company.

PLAN YEAR

The reporting year for ERISA purposes. The PLAN YEAR will commence each January 1st and end on the next following December 31st.

PONTIC

The part of a fixed BRIDGE that is suspended between ABUTMENTS and that replaces a missing tooth; and artificial tooth in a removable DENTURE.

PRE-ADMISSION TEST

Any diagnostic test or study required as part of a HOSPITAL'S admission policy or which is necessary for a scheduled SURGICAL PROCEDURE, and which is performed prior to a HOSPITAL CONFINEMENT.

PRE-EXISTING CONDITION

A disease, INJURY, or ILLNESS of a COVERED INDIVIDUAL for which the COVERED INDIVIDUAL has been under the care of a licensed PHYSICIAN or has received medical care, services, or supplies within the three (3) month period immediately preceding his effective date of coverage. Medical care, services, or supplies shall include, but shall not be limited to, medication, therapy, x-ray or lab tests, counseling, or any other treatment recommended by a licensed provider of medical care or services.

PREFERRED PROVIDER ORGANIZATION/NETWORK (PPO)

An organization composed of a group of health care providers who offer their services at a discount rate to the EMPLOYER if a COVERED INDIVIDUAL uses such PPO member's services in accordance with the formal agreement between the COMPANY and the PREFERRED PROVIDER ORGANIZATION.

PREGNANCY

That physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

PRESCRIPTION DRUG

All drugs that are required under Federal law to bear the label, "Caution: Federal law prohibits dispensing without prescription," or any substitute required label, and injectable insulin (whether or not by prescription), as long as the drug was prescribed by a licensed PHYSICIAN.

PRIMARY PLAN

A plan whose allowable BENEFITS are not reduced by those of another plan.

PRIVATE DUTY NURSING

A continuous bedside nursing service, rendered by one nurse to one PATIENT, either in a HOSPITAL, nursing facility, HOSPICE facility or the PATIENT'S home, as opposed to general duty nursing, which renders services to a number of PATIENTS in an IN-PATIENT setting.

PROCUREMENT COSTS

Those charges for services associated with the procurement of a human organ for transplant, including, but not limited to, surgical removal of an organ from a living donor, pathology and radiology services and services necessary to preserve the viability of the organ to be transplanted.

PROPHYLAXIS

The cleaning of teeth by a DENTIST or dental hygienist.

PRONOUNS

Any reference to "You, Yours, or Yourself" means the eligible EMPLOYEE and Covered DEPENDENTS "He, His, Him" refers to either sex; not to be discriminatory, but to avoid "he/she" type wording.

PSYCHIATRIC CARE

The term "PSYCHIATRIC CARE," also known as psychoanalytic care, means treatment for a mental ILLNESS or disorder, a functional nervous disorder, alcoholism, or drug addiction. A psychiatric condition includes but is not limited to anorexia nervosa and bulimia, schizophrenia, and depressive disorders including but not limited to manic-depressive.

DEFINITIONS

PSYCHOLOGIST

A registered clinical PSYCHOLOGIST. A PSYCHOLOGIST who specializes in the evaluation and treatment of mental ILLNESS who is registered with the appropriate state registering body or, in a state where statutory licensure exists, holds a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, meets the following qualifications: has a doctoral degree from an accredited university, college, or professional school and has two years of supervised experience in health services of which at least one year is post-doctoral and one year in an organized health services program; or, holds a graduate degree from an accredited university or college and has not less than six years as a PSYCHOLOGIST with at least two years of supervised experience in health services.

PULP

The connective tissue that fills the PULP chamber and root canals of teeth.

QUALIFIED BENEFICIARY

A COVERED INDIVIDUAL who qualifies for continuation of coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as then constituted or later amended.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A QUALIFIED MEDICAL CHILD SUPPORT ORDER is a medical child support order which creates or recognizes an ALTERNATE RECIPIENT'S right to, or assigns to an ALTERNATE RECIPIENT the right to, receive BENEFITS for which a COVERED INDIVIDUAL is eligible, and which the PLAN ADMINISTRATOR has determined meets the requirements as outlined in this Plan.

RECOVERY (subrogation)

Shall mean any and all sums of money and/or any promise to pay sums of money in the future, received by you from persons or entities, or their insurers, who may be responsible to you or your DEPENDENT on account of an INJURY or ILLNESS for which the Plan has paid you BENEFITS, regardless of how such sums are characterized or labeled, including, without limitation, sums paid or promised to be paid as compensation for actual medical expenses, pain and suffering, aggravation, wrongful death, loss of consortium to you or your covered DEPENDENT'S wife or CHILDREN, punitive or exemplary damages, attorney fees, costs, expenses, or any other direct or derivative compensatory damages that arise out of or are to any extent based upon the INJURY or ILLNESS suffered by you or your covered DEPENDENT.

REGISTERED NURSE (RN)

An individual who has received specialized nursing training and is authorized to use the designation of "RN," and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

REHABILITATION INSTITUTION

A legally constituted and operated institution (other than a HOSPITAL) established to provide medical treatment for PATIENTS who require IN-PATIENT CARE for chemical dependency, but do not currently require continuous HOSPITAL services for such condition, and which has permanent facilities for IN-PATIENT medical care on the premises, including 24-hour nursing service under the supervision of a full-time REGISTERED NURSE (RN), and maintains daily medical records on all PATIENTS. In no event will the term "rehabilitation institution" include any institution, or part thereof, which is used principally as a rest facility or nursing facility, a facility for the aged, or one providing primarily CUSTODIAL CARE.

RELINE

The resurfacing of the tissue-borne areas of a DENTURE with new material.

RESIDENTIAL TREATMENT PROGRAM

A program provided by a facility established for the purpose of residential treatment of chemical dependency and approved as such by a state department or agency having authority over such programs.

RESTORATION

Fillings, INLAYS, CROWNS, BRIDGES, partial and complete DENTURES.

RETIREE

An EMPLOYEE of the COMPANY who has retired from ACTIVE SERVICE with the COMPANY.

ROOM AND BOARD

All charges, by whatever name called, which are made by a HOSPITAL, HOSPICE, or EXTENDED CARE FACILITY as a condition of occupancy. Such charges do not include the professional services of PHYSICIANS nor intensive nursing care (by whatever name called).

DEFINITIONS

SEALANT

A resin (plastic) material placed on the occlusal surfaces of permanent bicuspid and molars to prevent decay.

SEMI-PRIVATE

A class of accommodations in a HOSPITAL or EXTENDED CARE FACILITY in which at least two PATIENT beds are available per room.

SICKNESS

Physical SICKNESS; disease; mental, emotional or nervous disorders; and PREGNANCY. Recurrent, related or concurrent SICKNESSES are considered as one "SICKNESS," unless a concurrent SICKNESS is totally unrelated to the other SICKNESS.

SKILLED NURSING/EXTENDED CARE FACILITY

An institution, or distinct part thereof, operated pursuant to law, and one which meets all of the following conditions:

It is licensed to provide and is engaged in providing, on an IN-PATIENT basis for persons convalescing from INJURY or ILLNESS, professional nursing services rendered by a registered graduate nurse (RN) or by a LICENSED PRACTICAL NURSE (LPN) under the direction of a REGISTERED NURSE and physical restoration services to assist PATIENTS to reach a degree of body functioning to permit self-care in essential daily living activities.

- Its services are provided for compensation from its PATIENTS and under the full-time supervision of a PHYSICIAN or registered graduate nurse.
- It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time registered graduate nurse.
- Its staff maintains a complete medical record on each PATIENT.
- It has an effective utilization review plan.
- It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally handicapped, custodial or educational care, or care of mental disorders.
- It is approved and licensed by MEDICARE.

This term shall apply to expenses INCURRED in an institution referring to itself as a SKILLED NURSING FACILITY, EXTENDED CARE FACILITY, or any such other similar facility.

SOCIAL WORKER

An individual who is qualified through education, training, and experience to provide services in relation to the treatment of emotional disorders, psychiatric conditions, or SUBSTANCE ABUSE.

SPECIAL CARE UNIT

A section, ward, or wing within the HOSPITAL which is separated from other HOSPITAL facilities and a) is operated exclusively for the purpose of providing professional care and treatment for critical injuries or ILLNESS; b) has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and c) provides ROOM AND BOARD and constant observation and care by a REGISTERED NURSE (RN) or any other specially trained HOSPITAL personnel.

SPEECH THERAPIST

An individual who is skilled in the treatment of communication and swallowing disorders due to ILLNESS, INJURY or birth defect, who is a member of the American Speech and Hearing Association and has a Certificate of Clinical Competence and who is licensed in the state in which services are provided.

SPOUSE

A person to whom a covered EMPLOYEE is legally married, as determined and defined by the laws of the state of the covered EMPLOYEE'S residence.

STEP-CHILD

Any unmarried biological or ADOPTED CHILD of the SPOUSE of an EMPLOYEE who has not reached the age of 19.

SUBSTANCE ABUSE

Regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

SURGICAL OPINION, ADDITIONAL

A consultation with another PHYSICIAN which the Plan may require to determine the appropriateness of a SURGICAL PROCEDURE as the preferred course of treatment as recommended by the attending PHYSICIAN.

DEFINITIONS

SURGICAL PROCEDURES

Cutting, suturing, treatment of burns, correction of fractures, reduction of dislocation, manipulation of joints under general anesthesia, electrocauterization, tapping (paracentesis), application of plaster casts, administration of anesthetic agent into joint or spine; decompression of pneumothorax, endoscopy, or injection of sclerosing solution by a licensed PHYSICIAN.

TEFRA

The Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

TERMINALLY ILL

Having a life expectancy of six months or less due to an ILLNESS from which the COVERED INDIVIDUAL is not expected to recover. This is usually a chronic ILLNESS or condition for which there is no known cure.

THERAPY SERVICES

Services or supplies used for the treatment of an ILLNESS or INJURY to promote the recovery of a COVERED INDIVIDUAL. Therapy services are covered to the extent specified in the Plan and may include:

- Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
- Dialysis Treatments - the treatment of acute or chronic kidney disease which may include the supportive use of an artificial kidney machine.
- Occupational Therapy - treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
- Physical Therapy - the treatment by physical means, electrotherapy, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, INJURY, or loss of body part.
- Radiation Therapy - the treatment of disease by X-ray, radium, or radioactive isotopes.
- Respiration Therapy - introduction of dry or moist gases into the lungs for treatment purposes.
- Speech Therapy - treatment of communication and swallowing disorders due to an ILLNESS, INJURY or birth defect.

TMJ

"TMJ" means temporomandibular joint syndrome and all related complications or conditions.

TOTAL DISABILITY (TOTALLY DISABLED)

A physical state of a COVERED INDIVIDUAL resulting from an ILLNESS or INJURY which wholly prevents:

- An EMPLOYEE from engaging in his regular or customary occupation and from performing any and all work for compensation or profit.
- A DEPENDENT from performing the normal activities of a person of like age and sex and in good health.

TREATMENT PLAN

A health care provider's report, provided on a form satisfactory to the Claims Administrator, which itemizes the services recommended by the provider for the necessary dental care of a COVERED INDIVIDUAL. For dental/orthodontic treatment plans, the report shows the DENTIST'S charge for each dental service, and is accompanied by supporting x-rays or other diagnostic records where required or requested by the Claims Administrator.

USUAL, CUSTOMARY, AND REASONABLE (UCR)

The term "usual, customary, and reasonable" refers to the designation of a charge as being the usual charge made by a PHYSICIAN or other provider of services, supplies, medications, or equipment that does not exceed the prevailing charge made for such medical service, supply or item by a majority of health care providers of the same discipline or type rendering or furnishing such care or treatment within the same geographical area as determined by the COMPANY. The term "area" in this definition means a county or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill, or expertise.

UTILIZATION REVIEW AGENT

The organization contracting with the COMPANY to perform cost containment services.

DEFINITIONS

VISIT

Each attendance to the COVERED INDIVIDUAL by a PHYSICIAN or medical practitioner, including a REGISTERED NURSE (RN), regardless of the type of professional service provided, whether termed a consultation, treatment or given some other name.

WAITING PERIOD

The amount of time that must pass before an individual is eligible to be covered for BENEFITS under the terms of the group health plan.

WELL CARE/WELL CHILD CARE

The term "well-care" means medical treatment, services, or supplies rendered solely for the purpose of health maintenance and not for the treatment of an ILLNESS or INJURY.

WELL NEWBORN CARE

Medical treatment, services or supplies rendered to NEWBORN CHILD solely for the purpose of health maintenance and NOT for the treatment of an ILLNESS or INJURY prior to its discharge from the HOSPITAL following birth.