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Illowa Investments,
L.L. Pelling,
Manatts, Inc.,
Norris Asphalt Paving,
United Concrete, Inc.,
Valley Environmental Services LLC.
& Wendling Quarries

Group Health Benefits

Effective: January 1, 2009

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SUMMARY PLAN DESCRIPTION

This booklet contains a general description of benefits available under the Plan and is written to help participants understand them. The details of coverage are limited to the terms and conditions specified in the Plan. Participants may examine the Plan or obtain copies of it at any time. It is on file with Manatts, Inc.

This Plan was established for the exclusive benefit of all employees and employers participating in the Manatts, Inc. Group Health Plan Trust, with the intention it will continue indefinitely. However, Manatts, Inc. reserves the right to amend, modify or terminate this Plan at any time without prior notice to the Plan participants. Any amendment or modification will be in writing, effected through a written resolution signed by an officer of Manatts, Inc., and will be binding. If this Plan is terminated, participants may not receive benefits for claims incurred on or after the effective date of termination.

In addition, this Plan may not discriminate against any participant based on: health status; medical condition (including both physical and mental illnesses; claims experience; receipt of health care; medical history; genetic information; medical evidence of good health (including participation in certain dangerous recreational activities and conditions arising out of acts of domestic violence); and disability as mandated by the Health Insurance Portability and Accountability Act of 1996.

Based on the factors described above, this Plan may not require any individual (as a condition of enrollment or continued enrollment under this Plan) to pay a premium or contribution which is greater than the premium or contribution paid by a similarly situated individual enrolled in this Plan. Nothing in the preceding sentence will be construed: (a) to restrict the amount that may be charged for coverage under this Plan; or (b) to prevent this Plan from establishing premium discounts or rebates or modifying otherwise applicable coinsurance amounts, co-pays or deductibles in return for adherence to programs of health promotion and disease prevention.

INTRODUCTION

This Plan is designed to cover a participant's various health care expenses. This is a self-funded Plan of benefits which provides coverage for the health care needs of each covered person up to the lifetime maximum as specified in the benefit summary.

It is important each participant understands this Plan in order to use it effectively. Each participant is encouraged to take the time to read this booklet to gain a basic understanding of the benefits. The **Benefit Summary** which follows provides a brief review of the covered benefits. The "**What Are Covered Expenses?**" section provides greater detail regarding the participant's benefits. Specially designated sections outline care not covered by this Plan.

If the participant has any questions about this Plan of benefits, he/she may contact First Administrators, Inc.

Correspondence can be mailed to:

First Administrators, Inc.
P.O. Box 9900
Sioux City, IA 51102

or

the participant may call:

Nationwide 1-800-206-0827
Sioux City 712-279-8400

PREFERRED PROVIDER ORGANIZATIONS (PPO)

SELECTFIRST™

SelectFirst™ is a fee-for-service Preferred Provider Organization (PPO) designed to provide quality care for a participant and his/her dependents, and to help control the rising costs of health care. This Plan has elected to provide health care services through the SelectFirst™ Program. Contracting physicians, hospitals and their staffs have agreed to comply with certain benefit management provisions and in return, participants are directed to them through incentives built into this Plan. A directory of these providers will be furnished to the participant, without charge.

The SelectFirst™ area includes the State of Iowa and the contiguous counties in the states surrounding Iowa.

MULTIPLAN OR FIRST HEALTH

Multiplan or First Health are also fee-for-service Preferred Provider Organizations (PPOs) designed to provide quality care for a participant and his/her dependents, and to help control the rising costs of health care. This Plan has elected to provide health care services through either the Multiplan or First Health for participants and their families who live or work outside of Iowa. A directory of these providers will be furnished to the participant, without charge. The Company will determine which PPO is appropriate for each location.

If a participant is working or living outside the SelectFirst™ area for an extended period of time, and is currently a participant of the SelectFirst™ Program, he/she has the option of switching to the Multiplan or First Health. The participant will need to notify the Company of the need to change to the other PPO Network Program. The Company will provide the participant with the correct PPO directory of contracting providers. The participant will also need to notify the Company when he/she is back in the SelectFirst™ area and will need to rejoin the SelectFirst™ program.

Please see your identification card for your participating provider network. Participating physicians within your PPO area can be located at:

SelectFirst™:

www.firstadministrators.com.

Multiplan: www.multiplan.com/

First Health: www.firsthealth.com

PROTECTED HEALTH INFORMATION

PLAN SPONSOR'S CERTIFICATION OF COMPLIANCE

The Company is the Plan Sponsor of this Plan, unless you have been notified, in writing, that another entity is your Plan Sponsor. Your Plan, any business associate servicing your Plan, or the Benefit Services Administrator cannot disclose protected health information to your Plan Sponsor unless the Plan Sponsor agrees to abide by the provisions outlined in this section.

The Plan Sponsor of your Plan has provided certification they agree to abide by these provisions.

PURPOSE OF DISCLOSURE TO PLAN SPONSOR

Your Plan, any business associate servicing your Plan, or the Benefit Services Administrator will disclose protected health information to your Plan Sponsor only to permit the Plan Sponsor to administer the Plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Any disclosure to and use by your Plan Sponsor of protected health information will be subject to and must be consistent with the provisions outlined in the "Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information" and "Adequate Separation Between the Plan Sponsor and the Plan" sections that follow.

Neither your Plan, nor the Benefit Services Administrator, nor any business associate servicing your Plan will disclose protected health information to your Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to plan participants.

Neither your Plan, nor the Benefit Services Administrator, nor any business associate servicing your Plan will disclose protected health information to your Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

RESTRICTIONS ON PLAN SPONSOR'S USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your Plan Sponsor:

- (a) will not use or further disclose protected health information, except as permitted or required by law;
- (b) will ensure that any agent, including any subcontractor, to whom it provides protected health information, agrees to the same restrictions and conditions that apply to the Plan Sponsor;
- (c) will not use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (d) will report to the Plan, promptly upon the learning of, any use or disclosure of protected health information that is inconsistent with the uses and disclosures stated in the provisions outlined in this section ("Protected Health Information");
- (e) will make protected health information available to Plan participants in accordance with 45 CFR § 164.524;
- (f) will make protected health information available for amendment, and will, on notice, amend protected health information in accordance with 45 CFR § 164.526;
- (g) will track disclosures it may make of protected health information so that it can provide the information required by your Plan to account for disclosures in accordance with 45 CFR § 164.528; and
- (h) will make its internal practices, books, and records relating to its use and disclosure of protected health information available to your Plan, and to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-64.

When protected health information is no longer needed for the plan administrative functions for which the disclosure was made, your Plan Sponsor will, if feasible, return or destroy all protected health information, in whatever form or medium received from the Plan, including all copies of any data or compilations derived from and/or revealing member identity. If it is not feasible to return or destroy all of the protected

health information, your Plan Sponsor will limit the use or disclosure of protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

ADEQUATE SEPARATION BETWEEN THE PLAN SPONSOR AND THE PLAN

Certain individuals under the control of your Plan Sponsor may be given access to protected health information received from the Plan, a business associate servicing the group health plan, or the Benefit Services Administrator. This class of employees will be identified by the Plan Sponsor to the Plan and the Benefit Services Administrator from time to time as required under 45 Code of Federal Regulations §164.504.

These individuals include all those who may receive protected health information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

These individuals will have access to protected health information only to perform the plan administration functions that the Plan Sponsor provides for the Plan.

Individuals granted access to protected health information will be subject to disciplinary action and sanctions, including loss of employment or termination of affiliation with the Plan Sponsor, for any use or disclosure of protected health information in violation of or noncompliance with the provisions outlined in this section ("Protected Health Information"). The Plan Sponsor will promptly report such violation or noncompliance to the Plan, and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee causing the violation or noncompliance, and to mitigate any negative effect the violation or noncompliance may have on the member, the privacy of whose protected health information may have been compromised by the violation or noncompliance.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Title II of the Health Insurance Portability and Accountability Act of 1996 and the security regulations issued thereunder (collectively "HIPAA") requires Group Health Plans to secure participants' private health information that it creates, receives, maintains, or transmits electronically. This Plan will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic health information, and will require its agents and contractors to do the same. Reporting of known security incidents to the Plan is part of those safeguards.

This Plan has established safeguards that are supported by reasonable and appropriate security measures to ensure that the Plan does not disclose, or permit one of its agents or contractors to disclose, Protected Health Information to the entity adopting this Plan.

**MANATTS, INC. GROUP HEALTH PLAN TRUST
BENEFIT SUMMARY**

Group #: 50500; 50510; 50520; 50540; 50550, 50570, 50580

Group #: 50500, 50510, 50520, 50540, 50550, 50570, 50580, 50590, 50595 (SelectFirst™ PPO)

Group #: 50500-1, 50510-1, 50520-1, 50540-1, 50550-1, 50590-1, 50595 (Multiplan)

Group #: 50550-2 (Multiplan) **Group #:** 50550 (First Health)

Effective Date: January 1, 2009

MEDICAL BENEFITS	PAGE
<p>Notes:</p> <ol style="list-style-type: none"> If a participant requires treatment for a medical emergency and is unable to reach a PPO provider, benefits for such treatment will be paid as if the treatment had been provided by a PPO provider, limited to this Plan's maximum allowable fee. If a covered treatment or service is not available through the PPO Network, and the participant receives such treatment or services from a non-PPO provider, benefits will be paid as if the treatment had been provided by a PPO provider. If a PPO provider refers a participant to a non-PPO provider for a covered treatment or service, whether that treatment or service is available through the PPO Network or not, benefits will be paid at the PPO level of benefits. If a participant who resides, or who is traveling, outside of the PPO area receives covered treatment or service from a non-PPO provider, benefits will be paid at the non-PPO level of benefits and all physician services are subject to this Plan's maximum allowable fee. Ancillary services provided by a non-PPO provider in a PPO facility will be considered at the PPO benefit level. Interpretation of x-ray and laboratory results ordered by a PPO provider, and provided by a non-PPO provider will be considered at the PPO benefit level. Charges for interpretation of x-ray or lab services performed in an independent radiology or pathology facility and billed by the PPO physician ordering the services will be considered in the same manner as any other x-ray or lab service performed in a PPO provider's office. Non-PPO emergency room physician charges will be considered at the PPO benefit level when services are provided in a PPO facility. 	-
<p>Utilization Review (Pre-certification):</p> <p>The Utilization Review program includes Preadmission Certification, Prenatal Screening and Pre-procedure Review. Failure to comply with the Preadmission Certification provision will result in a 50% penalty, up to a maximum penalty of \$2,000 per confinement, not applicable to the calendar year deductible or out-of-pocket maximums. If the admission is not medically necessary, benefits will be denied. This penalty applies to the hospital and attending physician charges. The 50% penalty applies before the calendar year deductible and coinsurance percentages are applied. (Reduce covered charge by 50% up to a maximum penalty of \$2,000, then apply calendar year deductible and coinsurance percentage.)</p> <p>Emergency admissions require notice within two business days. Failure to comply will result in benefits being denied if the services are not medically necessary or not covered by the plan <i>and</i> if the confinement lasts longer than medically necessary, the room and board charges will be denied for all non-covered days.</p> <p>The Pre-procedure Review and Prenatal Screening provisions are <i>not</i> mandatory.</p>	26
<p>Prior Approval:</p> <p>Certain services require prior approval. Failure to obtain prior approval for the following services will result in a 50% penalty, up to a maximum penalty of \$2,000 per confinement, not applicable to the calendar year deductible or out-of-pocket maximums. If the services are not medically necessary, benefits will be denied. This penalty applies to the hospital and attending physician charges. The 50% penalty applies before the calendar year deductible and coinsurance percentages are applied. (Reduce covered charge by 50% up to a maximum penalty of \$2,000, then apply calendar year deductible and coinsurance percentage.)</p> <p>The services requiring prior approval are: <i>Home Health Services, Hospice Services, Private Duty Nursing, Home Infusion Therapy and Transplants</i> (bone marrow/stem cell transfer, heart, heart and lung, liver, pancreas, single lung). The 50% penalty applies <i>before</i> calendar year deductible and coinsurance percentages are applied.</p> <p>Certain services, supplies, and procedures should receive prior approval to be eligible for benefits. These include, but are not limited to: <i>Bone Growth Stimulator, Cardiac Rehabilitation Services</i> over 18 sessions; <i>Communication System</i> (Touch Talker); <i>Cornea Surgery</i> to improve vision (keratoplasty); <i>Cosmetic Surgery</i> including, but not limited to: scar revisions, reconstruction of the nose (rhinoplasty), port wine stain surgery, surgery on the eyelids (blepharoplasty), surgery to correct overbite or underbite (orthognathic surgery), and breast surgery (including reconstruction, reduction, and gynecomastia); <i>Ear Implants and Electromagnetic Bone Conduction Devices</i> for hearing loss; <i>Electrical Stimulation of the Spine</i> (Dorsal Column Stimulator); <i>Electronic Limbs</i> (Myo-electric and other electronic prosthetic devices); <i>Growth Hormones</i> (not covered under any circumstances for males over 5'6" and females over 5'2"); <i>Infertility Treatment</i> including drug-induced stimulation of ovulation, artificial insemination, in vitro fertilization or forms of in vitro fertilization, or any infertility procedures currently excluded as investigational when they become recognized as accepted medical practices; <i>Insulin Infusion Pump</i>; <i>Morbid Obesity Surgery</i> including, but not limited to, stomach surgery (gastroplasty), stomach stapling (gastric stapling), stomach bypass (gastric bypass), or surgery for the removal of fat from the belly wall (panniculectomy and abdominoplasty); <i>Motorized Wheelchair</i> including chairs with three or four wheels; <i>Outpatient Mental Health Treatment</i>, after each five consecutive visits; <i>Speech Therapy</i>; <i>Surgery to Correct Funneled or Hollowed Chest</i> (Pectus Excavatum Surgery); and <i>Uvulopalatopharyngoplasty</i> to reduce sleep apnea. Prior approval is valid for 60 days. <i>Note</i> - inpatient services also require Preadmission Certification.</p>	31

BENEFIT SUMMARY (continued)

MEDICAL BENEFITS (continued)			PAGE
<p>Physician Services:</p> <p>PPO Physician: If services and/or treatment are received from a PPO physician, the participant is responsible for either a \$20 PPO Office Services Co-Pay or, in addition to the calendar year deductible, a percentage of the PPO fee schedule allowance. This Plan will pay the balance due up to the PPO fee schedule allowance. The participant will not be responsible for any unpaid charges in excess of the PPO fee schedule allowance.</p> <p>Non-PPO Physician in the SelectFirst™ Area: If services and/or treatment are received within the SelectFirst™ area from a non-SelectFirst™ Physician, the participant is responsible for the difference between the SelectFirst™ fee schedule allowance and the billed charges and, either a \$20 Office Services Co-Pay, or, in addition to the calendar year deductible, a percentage of the SelectFirst™ fee schedule allowance. This Plan will only pay the balance due, up to the SelectFirst™ fee schedule allowance, and the participant is responsible for all unpaid charges.</p> <p>Non-PPO Physicians outside of the SelectFirst™ Area: If services and/or treatment are received from a non-PPO physician outside of the SelectFirst™ area, the participant is responsible for the difference between this Plan's maximum allowable fee and the billed charges and, either a \$20 Office Services Co-Pay, or, in addition to the calendar year deductible, a percentage of this Plan's maximum allowable fee. This Plan will only pay the balance due, up to the lesser of the billed charge or this Plan's maximum allowable fee, and the participant is responsible for all unpaid charges.</p> <p>Physician office services also do not include prescription drugs dispensed in a physician's office (paid at eighty percent (80%) (PPO or non-PPO) subject to the calendar year deductible).</p>			31
MEDICAL BENEFITS	PATIENT'S LIABILITY		GENERAL PLAN LIMITS
	PPO	NON-PPO	
Office Services Co-Pay	\$20/visit	\$20/visit	The \$20 co-pay does not apply to the calendar year deductible or the out-of-pocket maximum. The office services co-pay applies to all physician office services except those excluded under Physician Services above. After the co-pay is applied, all related office services, except those excluded under Physician Services above, are paid at 100% subject to the PPO fee schedule as specified above under Physician Services .
Calendar Year Deductible - Per Individual/CAL YR - Per Family/CAL YR	\$500 \$1,000		Applies to all covered services, unless otherwise specified. Fourth quarter carryover deductible applies. Common accident deductible applies. Excludes Office Services Co-pay.
	PPO PAYS	NON-PPO PAYS	
Allergy Benefits - Allergy Injections in the Physician's Office	90% 100%	70% 100%	Includes allergy testing and supplies. The office services co-pay is waived if there is no office exam charge.
Ambulance	90%	70%	Includes air or ground ambulance.
Ambulatory/Outpatient Surgical Facility	90%	70%	
Anesthesia - Inpatient/Outpatient - By Operating Physician or Surgical Assistant	90% 50%	70% 50%	Includes CRNA. Excludes the administration of local or topical anesthesia when billed separately from related surgical or medical procedures.

BENEFIT SUMMARY (continued)

MEDICAL BENEFITS (continued)	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Birthing Center	90%	70%		38
Cardiac Rehabilitation	90%	70%	Prior approval is recommended if over 18 sessions.	39
Chemical Dependency - Inpatient (includes Chemical Dependency Facility) - Outpatient	90% 90%	70% 70%	Limited to 30 days/CAL YR, combined with Mental Health. Limited to \$10,000 lifetime.	32
Chiropractic Benefits	\$20/visit	\$20/visit	Limited to 15 visits per calendar year. Subject to the \$20 office services co-pay, then this Plan pays at 100%, subject to the PPO fee schedule as specified under the Physician Services section.	39
Consultations - Inpatient/Outpatient	90%	70%		31
Dental Services Under The Medical Plan	90%	70%	Excludes routine dental services.	38
Durable Medical Equipment	90%	70%	Rental not to exceed the purchase price.	39
Emergency Room - Due to a non-acute condition	90% 70%	90% 70%	Must be due to a medical emergency (acute condition).	39
Hemodialysis - Inpatient - Outpatient	90% 90%	70% 70%	In a hospital. In a Medicare-approved dialysis center.	39
Home Health Services	90%	70%	Prior approval is required. Skilled nursing visits limited to 2 hours/day.	33
Hospice Services - Respite Care	90% 90%	70% 70%	Prior approval is required. Includes bereavement counseling. Must be in increments of at least 5 consecutive days, limited to 15 days/lifetime for outpatient and 15 days/lifetime for inpatient.	34
Hospital Benefits - Inpatient - Room and Board - BCU / ICU / CCU - Miscellaneous - Outpatient	90% 90% 90% 90%	70% 70% 70% 70%	Limited to 365 days/confinement. Limited to semi-private room rate.	31
Infertility Treatment	90%	70%	Prior approval is recommended for drug-induced stimulation of ovulation, artificial insemination, or in vitro fertilization or forms of in vitro fertilization. Limited to \$15,000/lifetime for the diagnosis and treatment of male or female infertility including prescription drugs. Does not apply to the out-of-pocket maximums.	38
Maternity Benefits - Routine Newborn Care	90% 90%	70% 70%	Includes pre- and postnatal care, complications and delivery. If the mother is discharged from a hospital within 48 hours of normal labor and delivery, the plan provides benefits for one postpartum home visit by an RN (from a home health agency or employed by the attending physician).	37 37

BENEFIT SUMMARY (continued)

MEDICAL BENEFITS (continued)	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Mental Health - Inpatient - Outpatient (includes Community Mental Health Center)	90% 90%	70% 70%	Limited to 30 days/CAL YR, combined with Chemical Dependency. Limited to 30 visits per CAL YR. Prior approval should be obtained after each 5 consecutive visits. Refer to the "Prior Approval" section of the benefit summary. Note: Services other than therapy, provided by a non-psychiatric professional (such as; family physician, MD or Do), are subject to the office services co-pay and does not count towards the visit limits.	32
Nursing Facility	90%	70%	Limited to the facility's semi-private room rate.	32
Outpatient Diagnostic X-Ray and Lab - Interpretations	90% 90%	70% 70%	Routine services will be considered under Preventive Care Benefits.	37
Physician Services - Inpatient - Outpatient Hospital - Office	90% 90% ❖	70% 70% ❖	Limited to one visit/day per specialty. ❖ See Office Services Co-Pay section for co-pay and coinsurance percentages.	31 - 32
Prescription Drugs (Including Mail-Order Drug Plan) Note: When a generic equivalent is available and the participant specifically requests the brand name drug, he/she will be responsible for the difference in price between the generic drug and the brand name drug. Only the cost of the generic equivalent will be considered for benefits. The difference in cost is a non-covered benefit. If your doctor indicates in writing that you may only take the brand name prescription, the cost of the prescription will be considered.	80%	80%	Includes: - Prescription drugs dispensed from a physician's office; - Viagra — limited to 4 pills per 30-day supply; - Oral contraceptives and subcutaneous implants (i.e., Norplant and Depo Provera) when prescribed by a physician for the purpose of birth control. Benefits are limited to the employee and spouse only . Show your drug reference discount card at the participating pharmacy. The participant will be responsible to pay the full discounted price of the prescription drug, at the time it is filled. Limited to: - 30 day supply for short-term treatment - 90 day supply for chronic conditions	38, 39
Preventive Care Benefits - Immunizations	90% 100%	70% 100%	Includes Annual routine physical examination (including Department of Transportation [DOT] Physicals), diagnostic x-ray and lab (including interpretations), related tests (colonoscopy, EKG, mammograms, pap smears and other cancer screenings), hearing examinations and immunizations. Each participant will be eligible to receive any of the approved routine services once during the calendar year, whether or not they are provided on the same day as the annual routine physical examination. The office services co-pay is waived if there is no office exam charge.	38
Private Duty Nursing	90%	70%	Prior approval is required.	39
Radiation Therapy and Chemotherapy	90%	70%		39
Second Surgical Opinion (Voluntary)	90%	70%	Includes third opinion if first and second conflict.	34
Smoking Cessation	80%	80%	Limited to one course of treatment per year. Includes prescription drugs and patches.	-
Surgical Benefits - Inpatient/Outpatient - Assistant Surgeon	90% 90%	70% 70%	Limited to 20% of the eligible expense for the surgical procedure performed.	33

BENEFIT SUMMARY (continued)

MEDICAL BENEFITS (continued)	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Temporomandibular Joint Syndrome (TMJ)	90%	70%		38
Therapy Benefits - Respiratory/Inhalation Therapy - Physical Therapy - Occupational Therapy - Speech Therapy	90% 90% 90% 90%	70% 70% 70% 70%	Prior approval is recommended.	39
Transplant Benefit - Transportation - Procurement - Bone Marrow Donor Search	90% 90% 90% 90%	70% 70% 70% 70%	Includes cornea, heart, heart/lung, lung, kidney, liver pancreas and limited coverage is also available for certain autologous and allogeneic bone marrow/stem cell transfer transplants. Prior approval is required. Limited to \$10,000/transplant episode for transportation in an ambulance to a transplant center. Limited to \$20,000/transplant episode. Limited to \$20,000/transplant episode.	35
Urgent Care Clinic	\$20 co-pay	\$20 co-pay	See Office Services Co-Pay section for co-pay and coinsurance percentages.	-
Well-Baby/Well-Child Care	90%	70%	For child's first 6 years of life. Includes normal newborn care, physical examinations, developmental assessments, immunizations, and labs.	39
	PATIENT'S LIABILITY			
Out-of-Pocket Maximums - Per Individual/CAL YR - Per Family/CAL YR		\$1,500 \$3,000	Includes: calendar year deductible and all participant coinsurance amounts except for infertility treatment. Excludes: office services co-pay, fourth quarter deductible carryover, participant's coinsurance amounts for infertility treatment, penalties for failure to comply with utilization review or prior approval provisions.	29
MEDICAL PLAN'S MAXIMUM LIABILITY				
Lifetime Maximum Benefit			\$2,000,000	30

COVERAGE AND ELIGIBILITY

EMPLOYEE ELIGIBILITY

An employee is eligible for medical coverage if he/she is a regular full-time employee or full-time seasonal employee.

EMPLOYEE ENROLLMENT AND EFFECTIVE DATE

An employee is eligible for coverage the first day of the month following **thirty (30)** days of employment. However, coverage is **not** automatic. This Plan will be effective on the first day of the month following receipt of the employee's enrollment form or application. Each employee has a **one hundred twenty (120) day** window in which to enroll. Remember, the date of the enrollment form or application determines the effective date.

If the employee is eligible for coverage, but not actively at work on the day his/her coverage is scheduled to begin because of any reason other than his/her own medical condition or disability, this Plan will become effective the day the employee returns to active work. This actively at work provision will not delay the effective date of coverage if the sole reason the employee is not working is because the day is not a regularly scheduled workday.

If the employee does not apply to become a covered employee by completing an enrollment form or application within the **one hundred twenty (120) day** period, he/she will not be eligible for coverage under this Plan except during Open Enrollment or a special enrollment period). If he/she is a returning full-time seasonal employee, who previously waived coverage under this Plan, he/she may enroll for coverage following his/her return to work (see the section on **Open Enrollment Period**).

In some cases, there may be special circumstances that will allow an employee to enroll for coverage. For further details on these circumstances, see the section on **Special Enrollment Periods**.

An employee of a new related employer or a newly acquired subsidiary will be considered to have completed his/her waiting period if, on the date of the acquisition, the employee has been a full-time employee, not otherwise ineligible for coverage for a period equal to the required waiting period of this Plan. Additionally, an employee of a new related employer or a newly acquired subsidiary will be deemed to have

completed his/her pre-existing condition waiting period to the extent that the provision was satisfied under his/her prior health care plan.

A covered employee who elects to become a covered dependent under this Plan may do so and he/she will be deemed to have completed his/her pre-existing condition limitation period to the extent that it was satisfied under this Plan as a covered employee on the date of the transfer of coverage.

EMPLOYEE TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the last day of the month in which the covered employee's active employment with the Company is terminated;
- (b) the last day of the month the covered employee ceases to be in a class of employees eligible for coverage;
- (c) the end of the period for which the participant has made contributions if he/she fails to make the next required contribution;
- (d) the date this Plan is terminated with respect to the Company, and there is no successor plan;
- (e) the date the covered employee receives the lifetime maximum benefit, as specified by this Plan; or
- (f) the last day of the month the covered employee voluntarily elects to be terminated from this Plan, subject to the pre-tax premium rules as outlined under **Pre-Tax Premium Program**.

If the covered employee ceases active employment due to layoff, authorized leave of absence, or transfer to a related employer or a subsidiary, participation may be continued pursuant to rules adopted by the Plan Sponsor and applied on a uniform basis to all covered employees similarly situated. Notwithstanding the foregoing provision, his/her participation may be continued if he/she is on an approved disability leave of absence pursuant to rules adopted by the Plan Sponsor and applied to all covered employees similarly situated on a uniform basis.

If the covered employee wishes to cancel coverage, he/she must notify the company within thirty-one (31) days prior to the desired date of cancellation. Cancellation will be subject

to the pre-tax premium rules as outlined under the **Pre-Tax Premium Program**.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any healthcare services after the termination date even though these services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

DEPENDENT ELIGIBILITY

A covered employee may choose to cover his/her dependents (as defined) under this Plan.

A covered employee's unmarried dependent children may be covered until they reach the age of nineteen (19). They may be covered until the age of twenty-six (26) if they are unmarried, full-time students enrolled in an accredited school. In the event an eligible dependent over the age of nineteen (19) and under the age of twenty-six (26) completes the graduation process in the full-time accredited school, coverage will end three (3) months of:

- Graduation, or
- Commencement of other coverage, whichever occurs first.

Dependent children include natural children, adopted children (as defined), stepchildren, foster children and grandchildren or children for whom the employee has legal guardianship who are unmarried. *Coverage of children for whom the employee has legal guardianship will cease at age eighteen (18) or high school graduation, whichever comes first.* Refer to the definition of "Dependent" for more information.

Adopted Child

The term "dependent" found in this Plan shall include any unmarried child meeting the dependent eligibility requirements of this Plan who has been placed for adoption or who has been adopted by the participant prior to age eighteen (18).

Such a child shall be eligible for coverage as of the date of placement for adoption, or as of the date of actual adoption, whichever occurs first.

Coverage under this Plan for the adopted child shall be the same coverage which is available to all other dependent children under this Plan except that all pre-existing condition exclusions or additional waiting periods will be waived for such a child provided the child is enrolled within the time-periods specified under the section entitled **Dependent Enrollment and Effective Date**.

QMCSO PROVISION

This Plan will provide benefits to the child(ren) of a participant if a Qualified Medical Child Support Order (QMCSO) is issued regardless of whether the children reside with the participant. If a QMCSO is issued, then the child(ren) shall become alternate recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other participant. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

Procedural QMCSO Requirements

Within a reasonable period of time following receipt of a medical child support order, the Plan will notify the participant and each child specified in the order whether the order is or is not a Qualified Medical Child Support Order. A QMCSO is an order which creates or recognizes the right of an alternate recipient (participant's child who is recognized under the order as having a right to be enrolled under this Plan) or assigns to the alternate recipient the right to receive benefits. To be considered a Qualified Order, the medical child support order must contain the following information:

- (a) the name and last known mailing address of the participant and the name and address of each child to be covered by this Plan;
- (b) a reasonable description of the type of coverage to be provided by this Plan to each named child, or the manner in which the type of coverage is to be determined; and
- (c) the period to which such order applies.

If the order **is** determined to be a Qualified Order, each named child will be covered by this Plan in the same manner as any other dependent child is covered by this Plan.

Coverage for a child under a QMCSO will begin on the latest of the following dates:

- (a) If the employee already has coverage in force, the child will be covered as of the date specified in the order, or if no date is specified in the order, the date the QMCSO is received;
- (b) If the employee is within the waiting period as specified under the section entitled **Employee Enrollment and Effective Date** the child's coverage will become effective the same date the employee's coverage is effective; or

- (c) If the employee is otherwise eligible but previously waived coverage, the employee's and the child's coverage will become effective as of the date specified in (a) above.

Each named child will be considered a participant under this Plan but may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks and other material which would otherwise be sent directly to the named child.

If it is determined that the order **is not** a Qualified Order, each named child may appeal that decision by submitting a written letter of appeal to the Plan Administrator. The Plan Administrator shall review the appeal and reply in writing within thirty (30) days of receipt of the appeal.

This Plan will not provide any type or form of benefit, or any option, not otherwise provided under this Plan and all other dependent eligibility, effective date and termination provisions will apply.

DEPENDENT ENROLLMENT AND EFFECTIVE DATE

Generally, coverage for dependents will become effective on the same day the employee's coverage begins. Any new dependent can become a covered dependent as of one of the following applicable dates:

- (a) the eligibility date for which written application is made and delivered to the Plan Administrator, if made on or before the date the individual becomes a dependent;
- (b) the eligibility date for which such written application is received when the application is made and delivered to the Plan Administrator within thirty-one (31) days after the individual becomes a dependent; or
- (c) the eligibility date determined under the terms of an applicable special enrollment period. In some cases, such as marriage, birth, adoption, and placement for adoption, there may be special circumstances that will allow a dependent to enroll for coverage after the initial enrollment period. For further details on these circumstances, see the section on **Special Enrollment Periods**.

If, after a break in coverage, an unmarried dependent child regains status as a full-time

student, as defined, he/she will be subject to the pre-existing conditions limitation period to the extent that remains unsatisfied after any creditable coverage is considered.

A covered dependent who becomes eligible as an employee under this Plan will be considered to have satisfied his/her waiting period and his/her pre-existing condition limitation period on the date he/she becomes so eligible if, on that date, he/she has fully satisfied the waiting period and pre-existing condition limitation period.

If the employee is absent from active work because of any reason other than his/her own medical condition or disability when coverage for his/her dependents would otherwise take effect, coverage for the dependents will become effective only upon the employee's return to active work.

DEPENDENT TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the date on which the employee's coverage terminates for any reason other than having received the maximum lifetime benefit;
- (b) the last day of the month in which he/she ceases to be a dependent as defined by this Plan; however, for full-time students under the age twenty-six (26), who complete the graduation process, coverage will end three (3) months after the end of the month they graduate;
- (c) the end of the period for which the employee has made contributions for a dependent's coverage if he/she fails to make the next required contribution;
- (d) the date the maximum lifetime benefit has been paid to or on behalf of the covered dependent;
- (e) the last day of the month the covered dependent voluntarily elects to be terminated from this subject to the rules of the **Pre-Tax Premium Program**;
- (f) the date this Plan is amended to terminate dependent coverage of a class of employees of which the employee is a member;
- (g) in the event of legal separation or divorce, coverage for the employee's spouse ceases the end of the month in which the event occurred; or

- (h) August 31st, if a dependent is a full-time student during the spring semester with plans to return to school for the fall semester, but fails to return to school at the end of the summer break.

If the covered dependent student is unable to attend school full-time because of sickness or accidental injury, coverage will continue until the first day of the next regular term.

If the covered dependent wishes to cancel coverage, he/she must notify the Company within thirty (30) days of the desired date of cancellation.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any hospital, medical or dental services after the termination date even though the services are furnished as a result of an injury that occurred prior to termination of coverage.

SPECIAL ENROLLMENT PERIODS

Special Enrollment rights are provided both to current employees who were eligible but declined enrollment in the Plan when first offered because they were covered under another plan and to individuals acquiring a dependent.

If an individual moves from a high deductible plan to a low deductible plan mid-year, there will be no reimbursement if the high deductible has already been met.

Pre-existing condition exclusion periods for special enrollees may not exceed nine (9) months.

Individuals Losing Other Coverage

This Plan will permit a current employee or dependent that is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if **each** of the following conditions is met:

- (a) the current employee or dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered;
- (b) the current employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the current employee having coverage under another group health plan or due to the employee having other health insurance coverage, but only if this Plan required such a written statement at that time and provided the current employee with notice of the requirement (and consequences of the requirement) at that time;

- (c) the current employee or dependent lost other coverage pursuant to one of the following events:

- the current employee or dependent was under COBRA and the COBRA coverage was exhausted;
- the current employee or dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of legal separation, divorce, loss of dependent status, death, termination of employment, or reduction in the number of hours worked);
- the current employee or dependent moved out of an HMO service area with no other option available;
- the current employee or dependent met or exceeded a lifetime limit on all benefits (the event for reaching the lifetime limit is the earliest date that a claim is denied);
- the Plan is no longer offering benefits to a class of similarly situated individuals;
- the benefit package option is no longer being offered and no substitute is available; or
- the employer contributions were terminated; and

- (d) under the terms of this Plan, the current employee requests enrollment into this Plan not later than thirty (30) days after an event, as described in (c) above.

For an eligible current employee or dependent who has met **each** of the conditions specified above, this Plan will be effective on the date the other coverage was lost.

Dependent Beneficiaries

This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current employee (and, if not otherwise enrolled, the current employee or spouse may be enrolled at the same time):

- (a) if the current employee has coverage under this Plan (or the current employee has met any waiting period applicable to becoming covered under this Plan and is eligible to be enrolled under this Plan, but failed to enroll during a previous enrollment period); and
- (b) if a person becomes a dependent of the current employee through marriage, birth, or adoption or placement for adoption.

In the case of the birth or adoption of a child, the spouse of the current employee may also be enrolled as a dependent if the spouse and/or other eligible dependents are otherwise eligible for coverage.

The dependent special enrollment period will be a period of thirty (30) days beginning on the date of marriage, birth, adoption or placement for adoption.

If a current employee requests enrollment for a dependent during the dependent special enrollment period, the coverage for the dependent will become effective:

- (a) in the case of marriage, on the date of the marriage;
- (b) in the case of a dependent's birth, as of the date of birth; or
- (c) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

If the covered current employee has family coverage, newborns are automatically covered under this Plan from the moment of birth. An enrollment form or application will not be required.

DEPENDENT CHILDREN WITH DISABILITIES

Coverage of the employee's unmarried dependent child shall not cease because of attainment of the termination age specified in this Plan, while the employee's coverage is in force and the employee's child otherwise qualifies as a dependent, if the child:

- (a) is incapable of self-sustaining employment by reason of a permanent, handicapping mental or physical disability; and
- (b) became so disabled prior to attainment of the termination age specified in this Plan.

The employee must submit to the Company, within thirty (30) days of such dependent's attainment of the termination age, written proof of the disability as described and continue to pay premiums, if any, for the dependent's coverage. The coverage of any such dependent will be subject to all other termination provisions of this Plan.

The Company, upon receipt of proof of the disability, shall have the right and opportunity to have a physician it designates examine any such dependent when and as often as it may reasonably require. The Company will not require the dependent to be examined more than once each year after such disability has

continued on an uninterrupted basis for at least two years following the date the initial written proof of disability was received by the Company.

All rights under the provisions of this section shall automatically and immediately cease on the earliest of the following dates:

- (a) the date the dependent's disability as described no longer exists;
- (b) the date the dependent fails to submit to any required medical examination;
- (c) the date the dependent otherwise ceases to qualify as a dependent except for the attainment of the maximum age as specified by this Plan; or
- (d) the date the employee fails to submit any required proof of the uninterrupted existence of the dependent's disability.

OPEN ENROLLMENT PERIOD

The Plan will offer an annual enrollment period where an employee may elect to change the current coverage elected (family/single), or elect to waive participation in the plan.

Any otherwise eligible full-time employee and/or dependents, who have previously waived coverage may elect to participate in the Plan and will be subject to the pre-existing condition clause contained in the plan unless prior eligible creditable coverage is provided.

Seasonal employees on lay-off and not actively at work, you may elect to *initially* enroll in the plan within the first 30 days after you return to work. The effective date of your plan will be the first of the month following your signature date. The pre-existing provisions will apply.

An employee currently enrolled in the Plan may elect to change coverage (from family to single, etc.) or waive participation in the plan for the next Plan year. Please note that voluntary termination from the plan will void any COBRA continuation rights you have as an active member of the health plan. If you are a seasonal employee enrolled in the plan during your layoff period, you may make changes to your coverage during the month of December for a January 1st effective date or within 30 days after your return to work. This change will be effective the first of the month following your signature date.

Enrollment changes will only be allowed during these time periods, unless there is an

event/family status change as defined by the IRS (ex: marriage, divorce, birth of a child, loss of coverage, etc.). Please refer to Special Enrollment section.

FAMILY AND MEDICAL LEAVE ACT OF 1993

This section only applies to employers required to comply with the Federal Family and Medical Leave Act.

ENTITLEMENT TO LEAVE

This Act requires an employer which employs fifty (50) or more employees (within a seventy-five (75) mile radius) to allow an employee who has been employed for twelve (12) months or more and accumulated hours of service in excess of 1,250 hours from the date of employment or the end of the last qualified leave, to take a total of twelve (12) weeks of leave during any twelve (12) month period, as defined by the employer, for:

- (a) the birth of a son or daughter of the employee and in order to care for such son or daughter;
- (b) placement of a son or daughter with the employee for adoption or foster care;
- (c) care for a spouse, son, daughter, or parent of the employee, if such spouse, son, daughter, or parent has a serious health condition;
- (d) a serious health condition that makes the employee unable to perform the functions of the position of such employee; or
- (e) a qualifying exigency arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

EXPIRATION OF ENTITLEMENT

The entitlement to leave under subparagraphs (a) and (b) of Entitlement to Leave for a birth or placement of a son or daughter shall expire at the end of the 12-month period beginning on the date of such birth or placement.

SERVICEMEMBER FAMILY LEAVE

An eligible employee who is the spouse, son, daughter, parent or next of kin of a covered servicemember shall be entitled to a total of twenty-six (26) workweeks of leave during a single 12-month period to care for the

servicemember. The leave described in this paragraph shall only be available during a single 12-month period.

COMBINED TOTAL LEAVE

During the single 12-month period as described in Servicemember Family Leave, an eligible employee shall be entitled to a combined total of twenty-six (26) workweeks of leave under Entitlement to Leave and Servicemember Family Leave. Nothing in this paragraph shall be construed to limit the availability of leave under Entitlement to Leave during any other 12-month period.

Any employee taking a leave shall be entitled to continue to use his/her benefits during the duration of the leave if he/she participates in a "group health plan" as defined in §5000(b)(1) of the Internal Revenue Code of 1986. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the employee had remained employed. If the employee who is responsible for payment misses a premium payment during the leave of absence, the employer may terminate coverage provided that the employee has been given notification of termination and a grace period as defined by the FMLA. If the benefits are terminated during the leave, the employee is entitled to be fully reinstated upon returning to work. If the employee for any reason fails to return from the leave, the employer may recover from the employee the premium or portion of the premium that the employer paid, provided the employee fails to return to work for any reason other than the recurrence of the health condition or circumstances beyond the control of the employee.

Leave taken under the Act does not constitute a "qualifying event" so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the employee is not returning to work. Therefore, if an employee does not return at the end of twelve (12) weeks Family and Medical Leave, the COBRA qualifying event occurs at that time.

This is only a summary of the Family and Medical Leave Act of 1993. Please contact the employer for more information.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

The Plan Sponsor shall fully comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If any part of this Plan is found to be in conflict with this Act, the conflicting provision shall be null and void. All other benefits and exclusions of the Plan will remain effective to the extent there is no conflict with this Act.

USERRA provides for, among other employment rights and benefits, continuation of health care coverage to a covered employee and covered dependents, during a period of active service or training with any of the Uniformed Services. The Plan provides that a covered employee may elect to continue coverages in effect at the time the employee is called to active service. The maximum period of coverage for the employee and the covered employee's dependents under such an election shall be the lesser of:

- (a) the twenty-four (24) month period beginning on the date on which the person's absence begins; or
- (b) the period beginning on the date on which the covered employee's absence begins and ending on the day after the date on which the covered employee fails to apply for or return to a position of employment as follows:
 - for service of less than thirty-one (31) days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight hours after a period allowing for the safe transportation from the place of service to the covered employee's residence or as soon as reasonably possible after such eight hour period;
 - for service of more than thirty (30) days but less than one hundred eighty-one (181) days, no later than fourteen (14) days after the completion of the period of service or as soon as reasonably possible after such period;
 - for service of more than one hundred eighty (180) days, no later than ninety (90) days after the completion of the period of service; or

- for a covered employee who is hospitalized or convalescing from an illness or injury incurred in or aggravated during the performance of service in the Uniformed Services, at the end of the period that is necessary for the person to recover from such illness or injury.

A covered employee who elects to continue health plan coverage under the Plan during a period of active service in the Uniformed Services may be required to pay not more than 102% of the full premium under the plan associated with such coverage for the employer's other employees, except that in the case of a covered employee who performs service in the Uniformed Services for less than thirty-one (31) days, such covered employee may not be required to pay more than the employee share, if any, for such coverage. Continuation coverage cannot be discontinued merely because activated military personnel receive health coverage as active duty members of the Uniformed Services, and their family members are eligible to receive coverage under the Department of Defense's managed health care program, TRICARE.

In the case of a covered employee whose coverage under a health plan was terminated by reason of services in the Uniformed Services, the pre-existing condition exclusion and waiting period may not be imposed in connection with the reinstatement of such coverage upon reemployment under this Act. This applies to the covered employee who is reemployed and any dependent whose coverage is reinstated. The waiver of the pre-existing exclusion shall not apply to illness or injury which occurred or was aggravated during performance of service in the Uniformed Services.

"Uniformed Services" shall include full time and reserve components of the United States Army, Navy, Air Force, Marines, Coast Guard, Army National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If you are a covered employee called to a period of active service in the Uniformed Service, you should check with the Plan Administrator for a more complete explanation of your rights and obligations under USERRA.

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by us or your former employer, will apply.

COVERAGE CONTINUATION UNDER FEDERAL LAW - COBRA

The following information about the participant's right to continue his/her health care coverage in the Plan is important. Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to the participant when he/she would otherwise lose group health coverage under the Plan. It can also become available to the participant's spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. The following paragraphs generally explain COBRA coverage, when it may become available to the participant and his/her family, and what the participant needs to do to protect the right to receive it.

COBRA (and the description of COBRA coverage contained in this SPD) applies only to the group health plan benefits offered under the Medical Plan and not to any other benefits offered under the Plan or by Manatts, Inc. (such as life insurance, disability, or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this SPD is intended to expand the participant's rights beyond COBRA's requirements.

For additional information about the participant's rights and obligations under the Plan and under federal law, the participant should contact First Administrators, Inc., which is the Benefits Services Administrator or Manatts, Inc., which is the Plan Administrator.

WHAT IS COBRA COVERAGE?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who is Entitled to Elect COBRA?"

After a qualifying event occurs and any required notice of that event is properly provided to Plan Administrator, COBRA coverage must be

offered to each person losing Plan coverage who is a "qualified beneficiary." The participant, his/her spouse, and dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSO's may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information about the Medical, component of the Plan is available in other portions of this SPD.

WHO IS ENTITLED TO ELECT COBRA?

The employee will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because his/her hours of employment are reduced; or his/her employment ends for any reason other than his/her gross misconduct.

As the spouse of an employee, the spouse will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

- the employee dies;
- the employee's hours of employment are reduced;
- the employee's employment ends for any reason other than his or her gross misconduct;
- the employee becomes entitled to Medicare benefits prior to his/her qualifying event; or
- the spouse becomes divorced or legally separated from the employee.

As the dependent child of an employee, the dependent child will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits;
- the parents become divorced or legally separated; or
- the dependent stops being eligible for coverage under the Plan as a "dependent child."

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage within eighteen (18) months because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same eighteen (18)-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled "Length of COBRA Coverage.")

WHEN IS COBRA COVERAGE AVAILABLE?

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. The participant need not notify Plan Administrator of any of these three qualifying events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available only if the participant notify the Benefit Services Administrator in writing within sixty (60) days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose)

coverage under the terms of the Plan as a result of the qualifying event.

If these procedures are not followed, or if the written notice is not provided to Plan Administrator during the sixty (60) day notice period, **THE PARTICIPANT WILL LOSE HIS/HER RIGHT TO ELECT COBRA.**

ELECTING COBRA COVERAGE

To elect COBRA, the participant must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the Benefit Services Administrator (An election notice will be provided to qualified beneficiaries at the time of a qualifying event. The participant may also obtain a copy of the Election Form from the Benefit Services Administrator. Under federal law, the participant must have sixty (60) days after the date of the COBRA election notice provided to him/her at the time of his/her qualifying event to decide whether he/she wants to elect COBRA under the Plan.

Mail the completed Election Form to:

COBRA Specialist
First Administrators, Inc
PO Box 5091
Sioux Falls, SD 57117-5091

The Election Form must be completed in writing and mailed to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including email and faxed communications.

The election must be postmarked no later than sixty (60) days after the date of the COBRA election notice provided at the time of the qualifying event. **IF THE PARTICIPANT DOES NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, HE/SHE WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.**

If the participant rejects COBRA before the due date, he/she may change his/her mind as long as he/she furnishes a completed Election Form before the due date.

The participant does not have to send any payment with his/her Election Form when he/she elect COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's spouse may elect COBRA even if the employee does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the sixty (60) day election period specified in the Plan's COBRA election notice **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

When the participant completes the Election Form, he/she must notify the Benefit Services Administrator if any qualified beneficiary has become entitled to Medicare and, if so, the date of Medicare entitlement. If the participant becomes entitled to Medicare (or first learns that he/she is entitled to Medicare) after submitting the Election Form, immediately notify the Benefit Services Administrator of the date of the Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

In considering whether to elect COBRA, the participant should take into account that a failure to elect COBRA will affect his/her future rights under federal law. First, he/she can lose the right to avoid having pre-existing condition exclusions applied to the participant by other group health plans if he/she has a sixty-three (63) day gap in health coverage, and election of COBRA may help avoid such a gap. Second, the participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if

he/she elect COBRA coverage and do not exhaust COBRA coverage for the maximum time available. Finally, the participant should take into account that he/she has special enrollment rights under federal law. The participant has the right to request special enrollment in another group health plan for which he/she is otherwise eligible (such as a plan sponsored by the spouse's employer) within thirty (30) days after the participant's group health coverage under the Plan ends because of one of the qualifying events listed above. The participant will also have the same special enrollment right at the end of COBRA coverage if he/she gets COBRA coverage for the maximum time available.

LENGTH OF COBRA COVERAGE

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of thirty-six (36) months.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan's Medical and Dental components for his spouse and children who lost coverage as a result of his termination can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (thirty-six (36) months minus eight (8) months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within eighteen (18) months **BEFORE** the termination or reduction of hours.

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of eighteen (18) months.

EXTENSION OF MAXIMUM COVERAGE PERIOD

If the qualifying event that resulted in the participant's COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. The participant must notify the Benefit Services Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and the participant notifies the Benefit Services Administrator in a timely fashion, all of the qualified beneficiaries in the family may be entitled to receive up to an additional eleven (11) months of COBRA coverage, for a total maximum of twenty-nine (29) months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The qualified beneficiary must be determined disabled at any time during the first sixty (60) days of COBRA coverage. Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the participant notifies the Benefit Services Administrator in writing of the Social Security Administration's determination of disability within sixty (60) days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; or
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

The participant must also provide this notice within eighteen (18) months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

If these procedures are not followed or if the written notice is not provided to the Benefit Services Administrator during the sixty (60) day notice period and within eighteen (18) months after the covered employee's termination of employment or reduction of hours, **THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the eighteen (18) months (or, in the case of a disability extension, the twenty-nine (29) months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is thirty-six (36) months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare.)

This extension due to a second qualifying event is available only if the participant notifies the Benefit Services Administrator in writing of the second qualifying event within sixty (60) days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

If these procedures are not followed or if the written notice is not provided to the Benefit Services Administrator during the sixty (60) day notice period, **THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period."

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

The participant must notify the Benefit Services Administrator in writing within thirty (30) days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied).

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Benefit Services Administrator of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no

longer be disabled, the participant must notify the Benefit Services Administrator of that fact within thirty (30) days after the Social Security Administration's determination.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than thirty (30) days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. Manatts, Inc. will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Benefit Services Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period)."

COST OF COBRA COVERAGE

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of the COBRA premiums may change from time to time during the period of COBRA coverage and will most likely increase over time. The participant will be notified of COBRA premium changes.

PAYMENT FOR COBRA COVERAGE

All COBRA premiums must be paid by check or money order.

The participant's first payment and all monthly payments for COBRA coverage must be made payable to Manatts, Inc. and mailed to:

First Administrators, Inc.
COBRA Department
PO Box 5091
Sioux Falls, SD 57117-5091

The payment is considered to have been made on the date that it is postmarked. The participant will not be considered to have made any payment by mailing a check if his/her check is returned due to insufficient funds or otherwise.

If the participant elects COBRA, he/she does not have to send any payment with the Election Form. However, he/she must make his/her first payment for COBRA coverage not later than forty-five (45) days after the date of election. (This is the date the Election Form is postmarked, if mailed, or the date the Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered). See the section above entitled "Electing COBRA Coverage."

The first payment must cover the cost of COBRA coverage from the time coverage under the Plan would have otherwise terminated up through the end of the month before the month in which the participant makes his/her first payment. (For example, Sue's employment terminated on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election). The participant is responsible for making sure that the amount of his/her first payment is correct. He/she may contact the Benefit Services Administrator or Plan Administrator using the contact information provided below to confirm the correct amount of the first payment.

Claims for reimbursement will not be processed and paid until the participant has elected COBRA and make the first payment for it.

If the participant does not make the first payment for COBRA coverage in full within forty-five (45) days after the date of his/her election, he/she will lose all COBRA rights under the plan.

After the participant makes his/her first payment for COBRA coverage, he/she will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided at the time of the qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If the participant makes a monthly payment on or before the first day of the month to which it applies, his/her COBRA coverage under the Plan will continue for that month without any break. The Benefit Services Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill for the COBRA coverage – it is the participant's responsibility to pay his/her COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, the participant will be given a grace period of thirty (30) days after the first day of the month to make each monthly payment. COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if the participant pays a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, his/her coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

If the participant fails to make a monthly payment before the end of the grace period for that month, **HE OR SHE WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.**

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Manatts, Inc. during the covered employee's period of employment with Manatts, Inc. is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

ASSISTANCE WITH QUESTIONS

Questions concerning the Plan or the participant's COBRA rights should be addressed to the contact or contacts identified below. For more information about 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) 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 the participant family's rights, he/she should keep the Plan Administrator informed of any changes in the addresses of family members. The participant should also keep a copy, for his/her records, of any notices sent to the Benefit Services Administrator or the Plan Administrator.

PLAN CONTACT INFORMATION

The participant may obtain information about the Plan and COBRA coverage on request from:

First Administrators, Inc.
COBRA Department
PO Box 5091
Sioux Falls, SD 57117-5091
877-457-2137 (Toll Free)

or

Manatts, Inc. Group Health Plan Trust
1771 Old 6 Road
PO Box 535
Brooklyn, IA 52211

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent SPD (if the participant is not sure whether this is the Plan's most recent SPD, he/she may request the most recent one from the Benefit Services Administrator or the Plan Administrator).

INDIVIDUAL HEALTH COVERAGE PROVISION

If the state in which a qualified beneficiary resides does not offer adequate alternative mechanisms for providing access to health benefits for individuals, Federal law requires insurance companies that sell individual health insurance policies in the state where a qualified beneficiary resides to offer a beneficiary, whose continuation coverage is exhausted, the opportunity to purchase an individual health insurance policy from the insurer. The offer of individual health coverage need not be made if the participant is covered under another group health plan, Medicare or Medicaid, or by any other policy of health insurance.

The participant should contact the Company for additional information if he/she is interested in continuation of coverage through this provision.

CREDITABLE COVERAGE PROVISION

Qualifying periods of time during which a participant had "creditable coverage" will be applied toward the satisfaction of the participant's pre-existing condition exclusion period. Prior carriers or employers will provide certification regarding a participant's prior coverage. In addition, the participant may request a certificate of creditable coverage under this Plan at any time from the Benefit Services Administrator or the Plan Administrator, up to twenty-four (24) months after the participant's coverage ceases. This certification will be used to determine what portion of the participant's pre-existing condition exclusion period, if any, must still be satisfied.

Written requests for Certificates must include:

- the name of the individual for whom the Certificate is requested;
- the last date that the individual was covered under the plan;
- the name of the participant that enrolled the individual in the plan;
- a telephone number to reach the individual for whom the Certificate is requested, in the event of any difficulties;
- the name of the person making the request and evidence of that person's authority to request and receive the Certificate on behalf of the individual;
- the address to which the Certificate should be mailed; and
- the requestor's signature.

After receiving a request that meets these requirements, the plan will act in a reasonable and prompt fashion to provide the Certificate.

Prior coverage does not qualify under this provision if there is a break in coverage of sixty-three (63) consecutive days or more. Waiting periods are not considered periods without coverage nor are they counted as creditable coverage. Refer to the **Definitions** section for a definition of "Creditable Coverage."

As required by the Trade Act of 2002, the days between the date an individual loses group health coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

PRE-EXISTING CONDITION EXCLUSION PERIOD

This Plan includes an exclusion period for new participants with pre-existing (not otherwise excludable) medical conditions. A pre-existing medical condition is an injury or illness which was present prior to the participant's date of enrollment (see definition) for which any medical advice, diagnosis, care or treatment (including having a prescription for legend drugs, whether or not the drugs are taken) was provided or recommended by a physician prior to the participant's date of enrollment. Genetic information is not treated as a pre-existing condition in the absence of a diagnosis of a condition related to the genetic information.

This provision will also be in effect if there is a change in the participant's coverage which the participant elected to make and which increased this Plan's liability.

The pre-existing condition exclusion period works as follows:

If a participant has a pre-existing, allowable medical condition (physical or mental) within the six (6) month period prior to his/her date of enrollment for medical coverage (this six (6) month period is called the look-back period), that allowable condition will not be covered by this Plan until nine (9) months following the participant's date of enrollment.

The nine (9) month pre-existing condition exclusion period will be reduced by the length of the aggregate period of any creditable prior coverage

This Plan will apply the standard method of counting creditable coverage. The standard method of counting creditable coverage determines an individual's creditable coverage without reference to specific benefits provided during the individual's prior coverage periods.

Charges incurred during the nine (9) month pre-existing condition exclusion period will be reviewed by the Benefit Services Administrator and allowable conditions which appear to be pre-existing will be investigated.

Benefits will be available for all covered services with the exception of the allowable condition(s) specifically identified as being pre-existing.

The pre-existing condition exclusion period never applies to pregnancy, regardless of whether the woman had previous coverage. In addition, a pre-existing condition exclusion period will not be applied to a newborn, an adopted child who is under age eighteen (18) at the time of the adoption, or a child placed for adoption who is under age eighteen (18) at the time of placement for adoption,

if the child becomes covered under a group health plan or other creditable coverage within thirty (30) days of the birth, adoption, or placement for adoption. This exception does not apply, however, after the child has a break in coverage of sixty-three (63) or more consecutive days.

All pre-existing condition exclusion periods (and accompanying six (6) month look-back periods) for *special enrollees* begin on the participant or dependent's effective date. Pre-existing condition exclusion periods (and accompanying six (6) month look-back periods) for *new hires* will begin on the date the participant enters a class eligible for coverage.

PRE-TAX PREMIUM PROGRAM

The pre-tax premium program allows an employee to purchase this Plan with pre-tax dollars. Under the pre-tax premium program, the money that the employee would normally have deducted on an after-tax basis would instead be deducted on a pre-tax basis through salary redirection. The advantage of the pre-tax premium program is that the employee pays no FICA (Social Security) taxes or federal income taxes on the pre-tax premium contributions he/she makes. Furthermore, the premium is also exempt from state income taxes in most states. This means a higher take-home pay for the employee than if he/she purchased this Plan with after-tax dollars.

Note: Because the premium contributions the employee makes to this Plan are not taxed as wages for Social Security purposes, the employee's ultimate Social Security benefits might be somewhat less than they could have been. This depends on many things, including the employee's earnings history, whether he/she is above or below the Social Security "wage base", and what happens to the Social Security laws between now and when he/she retires.

The pre-tax premium program is available to the employee if he/she meets the eligibility requirements under this Plan. The employee's premium will automatically be deducted from his/her paycheck on a pre-tax basis. If the employee wishes to pay his/her premiums on an after-tax basis, he/she must notify Human Resources. The employee's enrollment regarding the tax status of his/her premiums will continue in effect until he/she changes it. The employee can make this change only during the period prior to the start of each Plan Year as designated by the Plan Administrator or if he/she experiences a family status change, as defined by the Internal Revenue Service.

The employee's choices are in effect for the entire Plan Year. The employee may only apply to change his/her selected benefits as defined by Section 125 of the Internal Revenue Service Code and its applicable regulations. The change must be consistent with the family status change, to the extent that it is necessary or appropriate, as a result of the family status change.

Remember, the employee's eligibility to apply for coverage after initial enrollment is limited to the special enrollment provisions as stated under **Special Enrollment Periods**.

BENEFIT MANAGEMENT PROVISIONS

To ensure that cost-effective services are provided, SelectFirst™ places responsibility for benefit management with providers, as they control health care utilization. When benefit management procedures are not followed, the result will be a reduction in payment to contracting providers for which the patient is not liable.

UTILIZATION REVIEW

The utilization review program reviews the medical necessity of hospital inpatient and nursing facility admissions for all medical, surgical, mental health, chemical dependency and rehabilitation admissions. It also includes review of outpatient mental health and chemical dependency treatment, surgery, pre-procedure review (includes inpatient and outpatient services), and the prenatal screening program.

When a participant receives care from a SelectFirst™ provider, they will handle the preadmission certification and pre-procedure review. If a penalty for failure to comply is involved, the participant is not responsible. However, if a participant seeks care from a non-SelectFirst™ provider, he/she is responsible for compliance with the utilization review provisions as described in the following sections, and any penalties incurred will be the participant's responsibility.

The utilization review unit is staffed with registered, licensed nurses with at least five years of medical/surgical or mental health/chemical dependency experience.

Their phone lines are available twenty-four (24) hours per day, every day of the year. The utilization review coordinator can be reached at:

Nationwide1-800-782-9955

If services are determined to be not medically necessary or not covered by this Plan, benefits will be denied.

Important Note: If the participant disagrees with a reduction in or denial of benefits, he/she should refer to the Claim Determination and Claim Review Procedure sections for information on how to file an appeal. These sections also outline the time frames in which the Plan must respond to a claim and/or appeal.

Preadmission Certification

Each hospital, rehabilitation or nursing facility stay, planned or unplanned, requires preadmission certification. Preadmission certification includes physician review, continued stay review, and discharge planning.

Planned inpatient stays must be reported to the utilization review unit prior to the actual admission. Unplanned/Urgent Care (emergency) admissions must be reported **within two (2) business days** following the date of admission.

SelectFirst™ Providers

All scheduled inpatient admissions for SelectFirst™ participants must be pre-certified by First Administrators, Inc. before hospitalization occurs. It is the SelectFirst™ provider's responsibility to obtain preadmission certification for all scheduled hospitalizations.

Non-SelectFirst™ Providers

If a participant obtains services from a non-SelectFirst™ hospital, it is the responsibility of the patient to pre-certify the hospital admission. **The participant** will be responsible for any penalty for failure to pre-certify.

A request for pre-certification will be accepted from anyone familiar with the patient, but ultimate responsibility remains the patient's. In most cases pre-certification is given during the initial conversation. If, for some reason, an inpatient stay does not meet the criteria, the nurse reviewer will consult with a physician reviewer and respond to the appropriate parties.

Physician Review

Nurse reviewers certify the majority of inpatient stays, but if the participant's condition or treatment plan does not satisfy certain criteria, consultation begins with a physician reviewer. The selection of a physician reviewer depends on the patient's diagnosis and the procedures that have been or will be involved in the course of treatment. The physician selected will represent a medical specialty which is directly related to the patient's condition.

The attending physicians' name(s) will be shared with the physician reviewer after a decision is made. Then the attending physician is encouraged to talk with the physician reviewer about any questions or concerns regarding the decision.

In the event of a denial or reduction of benefits, the participant (or his/her authorized representative), the attending physician and the hospital are notified immediately. Such a

decision can be appealed within one hundred eighty (180) days. In this case, First Administrators, Inc. will contact other physicians to review the admission. If any of these physicians decides to approve benefits, the decision will be reversed.

Continued Stay Review

The utilization review staff does not assign lengths of stay when an inpatient stay is certified. Each admission is closely monitored to verify that services being provided remain medically necessary. This review begins on the second day of a hospital stay. Physician reviewers are consulted whenever services being provided or requested do not meet medical necessity standards.

Discharge Planning

Discharge planning begins the day of admission. The purpose of this provision is to ensure maximum coordination among the family, health care provider and utilization review staff in the event discharge to alternative care is warranted. Every effort is made throughout each stay to maintain patient care in the most cost-effective setting while not sacrificing the quality of care.

If a participant fails to comply with any part of the preadmission certification provision (physician review, continued stay review, or discharge planning), the hospital and attending physician charges will be reduced by 50%, then paid at the normal benefit allowance, up to a maximum penalty of \$2,000 per confinement per participant. This reduction in benefits penalty will not apply to the participant's calendar year deductible or out-of-pocket maximums. If the admission is not medically necessary, benefits will be denied.

If a participant fails to report an emergency admission within two business days following the date of admission, the hospital and attending physician charges will be denied if the services are determined to be not medically necessary or not covered by this Plan. If the confinement lasts longer than medically necessary, the hospital room and board charges will be denied for all non-covered days.

This penalty will be waived for maternity stays with a duration of forty-eight (48) hours for a normal vaginal delivery, or ninety-six (96) hours for a cesarean section. Penalties may be applied to maternity stays which exceed these guidelines.

Pre-Procedure Review Program (Voluntary)

First Administrators, Inc. will review elective inpatient and outpatient surgical procedures for the purpose of determining their medical necessity. If the proposed surgical procedure is to be provided on an inpatient basis, preadmission certification will be required.

When a physician recommends that a participant undergoes one of the procedures on the following list, the participant or his/her physician may contact the Benefit Services Administrator before the procedure is performed.

Listed below are the surgical procedures for which Pre-Procedure Review is recommended:

- (a) Arthroscopy (Knee Only);
- (b) Carotid Endarterectomy (Artery);
- (c) Carpal Tunnel Release;
- (d) Cesarean Section;
- (e) Cholecystectomy (Excision of Gallbladder);
- (f) Coronary Artery Bypass;
- (g) ERCP (Endoscopic Retrograde; Cholangiopancreatography X-ray Gallbladder/Pancreas);
- (h) Hysterectomy (Abdominal or Vaginal);
- (i) Laminectomy (Excision of Vertebral Posterior Arch);
- (j) PTCA (Percutaneous Transluminal Coronary Angioplasty);
- (k) T & A (Tonsillectomy & Adenoidectomy);
- (l) TURP (Transurethral Resection of the Prostate); and/or
- (m) Upper GI Endoscopy

The list of surgical procedures is subject to change at any time.

Prenatal Screening (Voluntary)

This program is designed to assist expectant mothers during pregnancy. Each expectant mother covered by this Plan will be asked to participate. The goal is to assist expectant mothers and their physicians, by detection of possible complications, thus hopefully preventing pre-term labor and premature birth.

To participate in the program, the participant should contact the First Administrators, Inc. pre-certification department to obtain "certification" during the **first trimester** of pregnancy and to respond to a checklist. Questions asked will focus on medical history, obstetrical history and everyday habits. Upon evaluation, if no special

needs appear, the prenatal screening process is complete. If special needs appear, Case Management will monitor the pregnancy as needed.

Case Management Administration

Individual case management (ICM) is a program designed to assist participants with potentially long-term, high-cost or catastrophic illnesses and/or injuries. The objective is to offer alternatives to traditional care settings. Health care benefits are tailored to meet medical needs while promoting quality and cost-effective outcomes. Case management administration is performed on a case-by-case basis. Benefits may include supplies or services which are not normally a covered benefit under this Plan.

Individual case management's goal is to return people to productive lives after a catastrophic illness or injury whenever possible.

Examples of the types of conditions requiring an evaluation are:

- AIDS, brain tumors, cancer, gastrointestinal conditions, head and spinal cord injuries, severe burns and/or strokes.

HOW SELECTFIRST™ WORKS

PAYMENT METHOD

A provision of the SelectFirst™ contract provides that all services performed within the SelectFirst™ area are based upon a fee schedule or discount. **This is true even if the provider of service does not participate in the SelectFirst™ Network.** The participant is responsible for the difference between the amount billed and the payment if he/she chooses to obtain services from a non-SelectFirst™ provider. Services provided by non-SelectFirst™ providers outside the SelectFirst™ area will be subject to the lesser of the actual amount charged or the maximum allowable fee.

NON-SELECTFIRST™ PROVIDERS UNDER THE SUPERVISION OF SELECTFIRST™ PROVIDERS

When services are performed by a non-SelectFirst™ licensed practitioner under the direct supervision of a SelectFirst™ provider, charges for the non-SelectFirst™ licensed practitioner will be payable at the SelectFirst™ reimbursement level.

HOW THE MEDICAL PLAN WORKS

DESCRIPTION OF MEDICAL BENEFITS

Individual Deductible

Each participant, unless otherwise specified, will be responsible for the individual calendar year deductible amount specified in the benefit summary before any medical benefits will be paid by this Plan. See the benefit summary for individual deductible amounts.

Family Deductible

If the employee chooses to take family coverage, the total deductible the employee and his/her covered dependents have to pay in a calendar year will never be more than the family deductible amount specified in the benefit summary; each participant's responsibility will be limited to the individual deductible amount specified in the benefit summary. The family deductible is the same no matter how many dependents the employee has. See the benefit summary for family deductible amounts.

Office Services Co-pay

In most cases, each separate visit to a physician's office will require an office services co-pay (see **Office Services Co-pay** in the benefit summary for exceptions). This co-pay does not apply to the calendar year deductible or to the out-of-pocket maximum described below.

Deductible Carryover

Eligible expenses incurred during October, November and December which were applied toward that year's deductible will also be applied toward the next year's deductible.

Common Accident Deductible

If two (2) or more family members are injured in the same accident, only one deductible will be applied to all of the related charges.

Coinsurance

Once the calendar year deductible has been paid, this Plan will pay the coinsurance percentages outlined in the benefit summary.

Out-of-Pocket Maximum

There are limits on how much the employee will have to pay per individual, or per family, in allowable medical expenses per calendar year. The benefit summary specifies what the out-of-pocket maximum includes and what it excludes. The out-of-pocket maximum never includes ineligible charges. Once the out-of-pocket maximum has been met, this Plan pays 100% of the allowable expenses.

In addition, this Plan may contain other calendar year or lifetime benefit maximums. These maximums are included in the overall medical lifetime maximum benefit.

Plan Maximum

All allowable medical expenses under this Plan are limited to an overall lifetime maximum benefit for each participant. This lifetime maximum applies across all plans or options sponsored by the employer for all eligible expenses.

The lifetime maximum benefits paid under any predecessor plan(s), this Plan, and any subsequent plan(s) will be as specified in the benefit summary.

Once a participant has met the lifetime maximum, he/she will be terminated under the Plan and any subsequent changes to benefit levels (including changes to the lifetime maximum) will not affect the termination status of the participant. Future Plan open or special enrollment events will not affect the termination status of a participant that was previously terminated for achieving the lifetime maximum.

In addition, this Plan may contain other calendar year or lifetime benefit maximums. These maximums are included in the overall medical lifetime maximum benefit.

WHAT ARE COVERED EXPENSES?

All covered services must be medically necessary. The Benefit Services Administrator determines what is medically necessary; however, if necessary, the Plan Administrator makes the final determination whether a service is medically necessary, and that decision is final and conclusive. This Plan may include benefits not normally considered medically necessary. These are specifically included as benefits on the following pages.

The fact that a physician or dentist may have prescribed, ordered, recommended, or approved the provision of certain services or supplies does not necessarily mean such services or supplies are medically necessary or make the service a covered expense.

Following is an explanation of the covered expenses under this Plan. If services and/or treatment are received from a physician (SelectFirst™ or not) within the SelectFirst™ area, or by a Multiplan or First Health physician anywhere, those expenses are subject to the lesser of the PPO fee schedule amount or the actual amount charged. If services and/or treatment are received outside the SelectFirst™ area by a non-PPO physician, those expenses are subject to the lesser of the actual amount charged or the maximum allowable fee. See the "Notes" section in the benefit summary for additional information regarding eligible expenses under this Plan.

Prior Approval

Certain services **require** prior approval. There are also certain services which **should** receive prior approval to be eligible for benefits. These services, and applicable penalties, are listed in the "Prior Approval" section of the benefit summary.

HOSPITAL BENEFITS

Hospital benefits include the daily room and board charge for each day of confinement, up to the semi-private room rate for the level of care the patient is receiving. If the hospital does not have semi-private rooms, benefits will be paid at the private room rate. Charges for a private room will also be covered when the private room is medically necessary. Charges for special care units (e.g., isolation or intensive care rooms and operating rooms) are covered provided the level of care was prescribed by a physician and deemed to be medically necessary. **Please**

note: Observation exceeding twenty-three (23) hours will be considered an inpatient admission and must be reviewed. See the Preadmission Certification criteria contained in the Benefit Management Provisions section of this Plan for proper direction in obtaining Utilization Review.

Hospital confinements must be a result of an injury or illness. This will not apply when charges are incurred in connection with services for a newborn child. If the child is a "well-baby," but the mother remains necessarily confined to the hospital, an additional inpatient day shall also be available for the newborn.

Payment will be made for hospital miscellaneous charges such as oxygen tents and surgical supplies during a period of confinement for which room and board benefits are payable.

Hospital confinements are subject to the hospital benefit limitations specified in the benefit summary. Successive periods of hospital confinements due to the same or related causes are considered as one period of hospital confinement if they are separated by less than ninety (90) consecutive days.

Personal convenience items, including, but not limited to, televisions, telephones and admission kits are not payable expenses under this Plan.

Hospital Weekend Admissions

Except for emergencies, admissions to the hospital on a weekend are usually not necessary. Hospital benefits will not be payable under this Plan for Friday, Saturday or Sunday admissions unless the confinement is:

- (a) medically necessary as determined under this Plan;
- (b) for a medical emergency;
- (c) for maternity; or
- (d) for a next-day surgical procedure.

PHYSICIAN SERVICES

Outpatient Services

Outpatient services by a physician for treatment of an injury or illness are covered benefits of this Plan. Please refer to the benefit summary for specific limitations.

In-Hospital Services

In-hospital services by a physician for treatment of an injury or illness are covered benefits of this Plan. Only one visit per day per specialty will be considered an eligible expense, unless additional visits are deemed to be medically necessary.

This benefit also includes consultations by other physicians, if medically necessary and recommended by the attending physician. A consultation must include an actual physical examination. The consulting physician must be conferring in a medical specialty different than the specialty of the attending physician or any other consulting physician.

Office Services

Physician office services include all services and/or treatment performed in the physician's office except: dental services, respiratory/inhalation therapy, radiation therapy, chemotherapy, speech therapy, occupational therapy, physical therapy, cardiac rehabilitation, and mental health/chemical dependency visits.

PPO Physicians

All office services, except those listed above, will be paid at 100% of the lesser of the PPO fee schedule and the actual amount charged, after the office services co-pay is applied. The participant is only responsible for the co-pay.

All other office services, as listed above, will be limited to the lesser of the PPO fee schedule and the actual amount charged and subject to the calendar year deductible and PPO coinsurance percentage. The participant is responsible for any applicable calendar year deductible and their share of the PPO coinsurance amount.

The office services co-pay will be waived, and the charges paid at 100% of the PPO fee schedule, for allergy injections performed in the physician's office if there is no office exam charge.

Non-SelectFirst™ Physicians in the SelectFirst™ Area

When a participant obtains office services from a non-SelectFirst™ physician in the SelectFirst™ area, all office services will be limited to the lesser of the SelectFirst™ fee schedule and the actual amount charged, and will be subject to either a \$20 office services co-pay or the calendar year deductible and non-PPO coinsurance percentage. The participant is responsible for the difference between the amount charged and the paid amount.

Non-SelectFirst™ Physicians Outside the SelectFirst™ Area and All Non-Multiplan or Non-First Health Physicians

When a participant obtains office services from a non-SelectFirst™ physician outside the SelectFirst™ area, a non-Multiplan physician or a Non-First Health physician, all office services will

be limited to the lesser of the maximum allowable fee and the actual amount charged, and will be subject to either a \$20 office services co-pay or the calendar year deductible and non-PPO coinsurance percentage. The participant is responsible for the difference between the amount charged and the paid amount.

Maternity Charges

All Physicians

Office call charges for pregnancy are part of the obstetrical global fee. Maternity visits for routine pregnancy are only payable at the time of delivery.

MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS

This Plan provides benefits for the following mental health and chemical dependency related services. Benefits are subject to the limits shown on the benefit summary.

Inpatient Hospital Benefits

Benefits include daily room and board charges up to the semi-private room rate. Unless otherwise excluded, this Plan will provide benefits for hospital miscellaneous charges such as therapy and supplies incurred during the time room and board benefits are payable.

Chemical Dependency Facility Benefits

A chemical dependency facility provides treatment for addictive disorders. This benefit will pay for the daily room and board charges up to the maximum number of days specified in this Plan. This Plan will also pay for miscellaneous charges such as therapy and supplies incurred during the time room and board benefits are payable. Confinement in a chemical dependency facility must be recommended by and under the supervision of a physician.

Outpatient Benefits

Payment for covered outpatient treatment of mental health and chemical dependency disorders for each participant will be limited as shown in the benefit summary.

NURSING FACILITY BENEFITS

Benefits are provided for a nursing facility if the care is medically necessary to treat an injury or illness and is prescribed by a physician. Nursing facility benefits for each participant are limited as specified in the benefit summary. Services must be medically necessary and care cannot be of a custodial nature.

Nursing facilities are used by those who require rehabilitation or additional time to recover from an injury or illness but do not need the acute care provided in a hospital.

Payable charges for services include room and board (including general nursing care), special treatment rooms, x-ray and laboratory examinations, physical, occupational or speech therapy, oxygen and other gas therapy and any other services customarily provided by a nursing facility. Room and board charges will be limited to the semi-private room rate of the nursing facility.

Nursing facility benefits do not include services in connection with a mental health or chemical dependency disorder.

HOME HEALTH SERVICES BENEFITS

Home health services benefits consist of the following medically necessary services for the treatment of an injury or illness when prescribed by a physician:

- (a) part-time nursing care provided in the participant's home by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed public health nurse (LPHN);
- (b) physical, occupational or speech therapy provided in the participant's home;
- (c) physical, occupational or speech therapy, or the use of medical appliances or equipment, provided on an outpatient basis by a home health agency, a hospital, or other facility under an arrangement with a home health care agency;
- (d) medical supplies, drugs and medications prescribed by a physician; and
- (e) laboratory services by or on behalf of a hospital.

Home health care benefits for each participant are limited as specified in the benefit summary.

Home health care benefits will not include any services performed by a member of the participant's immediate family or a person ordinarily residing in the participant's home. Home health care benefits do not include meals, personal convenience items or housekeeping services. No home health care services are payable for the treatment of a mental health or chemical dependency disorder.

Home health care is subject to prior approval by the Benefit Services Administrator.

SURGICAL BENEFITS

Surgical benefits include professional fees for performing a covered surgical procedure to treat an injury or illness subject to the surgical benefit limitations specified in the benefit summary. Services may be provided on an inpatient or outpatient basis at a hospital or in a physician's office. Surgical benefits include:

- (a) surgical, operative and cutting procedures, and major endoscopic procedures;
- (b) treatment of fractures or dislocations or suturing of wounds;
- (c) medically necessary surgical assistance by a physician. Benefits are limited to 20% of the eligible expense for the surgical procedure performed. Benefits are not provided if the assistant is an intern, resident, or member of the hospital staff or is compensated by the hospital. The surgical procedure and medical condition of the participant must require the services of a surgical assistant; and
- (d) administration of anesthesia in connection with a surgical procedure if the anesthetic is administered by a physician or certified registered nurse anesthetist (CRNA), the physician is not employed or compensated by the institution in which the surgery is performed and the physician bills for the administration of the anesthetics. Anesthesia benefits are subject to the anesthesia limitations specified in the benefit summary.

Compensation for usual pre-operative and post-operative care is included in the payment for surgical services.

Benefits for multiple surgical procedures will be considered at 100% of the eligible expense for the primary procedure and 50% of the eligible expense for any secondary procedures.

Benefits for two like surgical procedures (i.e., bilateral procedures) will be considered at 150% of the eligible expense for the procedure.

This Plan is in compliance with the Women's Health and Cancer Rights Act of 1998. For individuals who choose breast reconstruction surgery, the Plan will allow benefits for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Cosmetic Surgery

Cosmetic surgery is limited to corrective surgery that has the primary purpose of restoring function after an illness or accidental injury or due to a birth or physical defect. If the reason for surgery meets this criteria, approval by the Benefit Services Administrator should be obtained prior to the surgery. Cosmetic surgery may be covered even if there is only an incidental improvement in physical appearance.

Cosmetic surgery intended to improve appearance when it is unrelated to an injury, illness, or physical or birth defect is not covered under this Plan. Complications of a non-covered cosmetic surgery are also not covered under this Plan.

Surgery for Morbid Obesity

Before receiving services for morbid obesity surgery, prior approval should be requested from the Benefit Services Administrator. **All** of the following requirements must be met to receive benefits:

- (a) the patient's weight must be more than 200% over the ideal weight of a medium-frame person based on standard charts used by the life insurance industry;
- (b) the patient must have been considered morbidly obese by a physician for at least five years; and
- (c) non-surgical methods of weight loss must have been supervised by a physician for at least three years without success.

AMBULATORY/OUTPATIENT SURGERY FACILITY BENEFITS

This benefit includes coverage for the facility charges of an "ambulatory surgery center." An ambulatory surgery center is any public or private establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgical procedures, with continuous physician services and registered professional nursing services whenever a patient is in the facility, and which does not provide services or other accommodations for patients to stay overnight.

VOLUNTARY SECOND SURGICAL OPINION PROGRAM

The voluntary second surgical opinion program's goal is to provide sufficient information before a participant decides to have elective surgery. This information may be valuable and help the participant decide whether to use an alternative treatment for his/her medical condition.

This Plan suggests participants obtain a second opinion for the following surgeries:

Elective Surgery List

- | | |
|-----------------------|--------------------|
| • Back Surgery | • Hysterectomy |
| • Breast Surgery | • Knee Surgery |
| • Bunion Surgery | • Nasal Surgery |
| • Cataract Surgery | • Prostate Surgery |
| • Foot Surgery | • Tonsillectomy, |
| • Gallbladder Surgery | Adenoidectomy |
| • Hemorrhoid Surgery | • Varicose Vein |
| • Hernia Repair | Surgery |
| • Hip Surgery | • Wrist Surgery |

Whenever possible, the specialist providing the second opinion should use the same test results used by the first physician. Duplicate laboratory tests or x-rays taken are not usually medically necessary. Copies of the original test results should be provided to the specialist when the participant has the second opinion.

The final decision on whether or not to have surgery is the participant's. While the intent is not to limit access to medical care, this Plan wants each participant to be informed and comfortable with his/her decision to have surgery.

HOSPICE SERVICES BENEFITS

Hospice services are those which help terminally ill participants and their families continue life with minimal disruption of normal activities.

The decisions relating to patient care are shared by an interdisciplinary hospice care team. The team is responsible for assuring continuity of care and providing professional management of all services. The attending physician is considered a member of this team. The attending physician updates, reviews, and approves the care plan as often as appropriate to meet the changing needs of the hospice patient and their family. The physician remains the primary provider of medical care.

Services reimbursed by this Plan for hospice care must be necessary for the palliation or management of the terminal illness and related conditions. Services covered must be consistent

with the plan of care of the hospice care team. All services must be prescribed by and under the supervision of the attending physician and approval from the Benefit Services Administrator must be obtained prior to commencement of hospice care.

The following types of hospice expenses are covered by this Plan:

- (a) bereavement counseling or services of volunteers or clergy;
- (b) room and board in a hospice facility, hospital or nursing facility;
- (c) part-time or intermittent nursing care by a registered nurse (RN) or licensed practical nurse (LPN) for up to eight hours in any one day;
- (d) other necessary services such as medical supplies, medicines, drugs, physician's services and the rental or purchase of durable medical equipment;
- (e) psychological and dietary counseling;
- (f) physical and occupational therapy;
- (g) part-time or intermittent home health aide services, for up to eight hours in any one day. Services consist mainly of caring for the individual;
- (h) assessment of the individual's social, emotional and medical needs, and the home and family situation; and
- (i) respite care which is furnished during a period of time when the participant's family or usual caretaker cannot, or will not, attend to the participant's needs. Each participant is subject to the respite care limitations specified in the benefit summary.

Some items **not** covered under hospice services are:

- (a) funeral arrangement;
- (b) pastoral counseling;
- (c) financial or legal counseling which includes estate planning or the drafting of a will;
- (d) homemaker or caretaker services which are not solely related to care of the participant, including sitter or companion services for either the participant who is ill or other members of the family;
- (e) transportation; and
- (f) housecleaning and maintenance of the house.

TRANSPLANT BENEFITS

Benefits are payable for participant charges of transplant services.

Benefits include:

- (a) organ and tissue procurement which consists of removing, preserving and transporting the donated organ and/or tissue. Each participant is limited to the maximum specified in the benefit summary;
- (b) air and ground ambulance services to the transplant center. Each participant is limited to the maximum specified in the benefit summary;
- (c) bone marrow donor searches. Each participant is limited to the bone marrow donor search maximum specified in the benefit summary; and
- (d) private nursing care by a registered nurse (RN) and/or a licensed practical nurse (LPN);

Charges for organ and/or tissue transplant services are limited to the maximums specified in the benefit summary. Approval from the Benefit Services Administrator must be obtained prior to any organ and/or tissue transplant.

If a covered transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for charges incurred for procurement, transportation and bone marrow donor searches as described above.

When both the recipient and donor are covered by this Plan, services will be covered for each patient with eligible expenses applied to the recipient's coverage. If the donor is covered under this Plan but the recipient is not covered, no expenses will be covered for either the recipient or the donor.

Some items **not** covered under organ transplant benefits are:

- (a) travel, and lodging and meals;
- (b) any charges incurred by the donor of an organ and/or tissue unless otherwise specified by this Plan;
- (c) any services or supplies related to transplants involving artificial (mechanical) or non-human organs;
- (d) services or supplies that are paid by an organ donor's health care coverage;
- (e) expenses associated with the purchase of any organ and/or tissue;

- (f) any charges incurred for the transportation of the living donor for an organ and/or tissue transplant; or
- (g) expenses in connection with surgery or treatment classified by the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration) of the United States Department of Health and Human Services as “experimental”, “investigational” or as not “reasonable” or “necessary”.

Autologous Bone Marrow Transplants

Benefits for autologous bone marrow transplants, which include autologous hematopoietic stem cell transplants, autologous peripheral blood stem cell transplants, and syngeneic marrow/stem cell transplants, are limited to the treatment of the following conditions:

- (a) Non-Hodgkin’s lymphoma including:
 - low-grade lymphoma after recurrence following first-line therapy or in first remission with biologically aggressive disease;
 - intermediate-grade lymphoma after failing first-line chemotherapy, or in first complete remission with poor prognostic factors suggesting less than a 30% chance of durable first complete remission and with disease that remains sensitive to standard-dose chemotherapy; or
 - high-grade lymphoma sensitive to standard-dose chemotherapy with poor prognosis;
- (b) Hodgkin’s lymphoma recurrent after standard chemotherapy, showing response to standard chemotherapy or in early relapse;
- (c) Neuroblastoma, stage III or IV, when further treatment with a conventional-dose therapy is not as likely to achieve a durable remission for the patient;
- (d) Breast and ovarian cancers which involve either:
 - advanced disease shown to be responsive to standard-dose chemotherapy; or
 - limited disease with less than 30% chance of durable complete remission with standard therapy;

- (e) Germ-cell tumors after first relapse, with chemosensitive disease;
- (f) Ewing’s sarcoma and soft tissue sarcoma shown to be chemosensitive and with less than a 30% chance of durable complete remission with standard chemotherapy;
- (g) Acute lymphocytic and non-lymphocytic leukemia following a first or subsequent remission when:
 - the participant is at a high risk for relapse;
 - HLA compatible donors are not available for allogeneic bone marrow support; and
 - the expected outcome of autologous transplant is approximately equivalent to allogeneic transplant; or
- (h) Multiple myeloma after first complete remission or where disease can be shown to be chemosensitive to standard chemotherapy and where allogeneic transplant is not a viable option.

This Plan does not cover autologous bone marrow transplants, including autologous hematopoietic stem cell transplantation, autologous peripheral blood stem cell transplantation, and syngeneic marrow/stem cell transplants, for the treatment of the following:

- (a) any condition not listed previously;
- (b) chemotherapy-resistant breast cancer;
- (c) chemotherapy-resistant leukemia;
- (d) testicular malignancies that are not responding (as opposed to partial responders) to treatment and have failed second or third line regimens;
- (e) metastatic colon cancer;
- (f) malignant melanoma;
- (g) any malignancies for which the transplant is clearly a palliative form of treatment;
- (h) any malignancy for which there are less than two published papers in peer-reviewed medical journals attesting to some success with this method of treatment; or
- (i) high-grade intrinsic tumor of the brain, e.g., glioblastoma multiforme or anaplastic astrocytoma.

Allogeneic Bone Marrow Transplants

Benefits for allogeneic bone marrow transplantation, which include high-dose chemotherapy with allogeneic hematopoietic stem cell support, are limited to treatment of the following conditions:

- (a) severe aplastic anemia including Fanconi's anemia;
- (b) Myelodysplastic syndrome (chronic myelomonocytic leukemia, refractory anemia with excess blasts or refractory anemia with excess blasts in transformation);
- (c) Homozygous Beta-Thalassemia (thalassemia major);
- (d) Wiskott-Aldrich Syndrome;
- (e) severe combined immunodeficiencies;
- (f) Infantile Malignant Osteopetrosis (Albers-Schonberg syndrome or Marble Bone disease);
- (g) Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants);
- (h) Mucopolysaccharidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy); or
- (i) Lympho-hematopoietic malignancies including acute leukemia (undifferentiated, lymphoblastic or myeloblastic) at high risk for relapse; chronic myelocytic leukemia in chronic or accelerated phase; chronic lymphocytic leukemia; multiple myeloma; Hodgkin's or non-Hodgkin's lymphoma not curable with standard therapy or with autologous bone marrow transplantation. Benefits for allogeneic bone marrow transplantation in these categories require satisfaction of both of the following criteria:
 - disease characteristics and treatment history suggest that the probability of achieving a durable complete remission are greater with high-dose chemotherapy compared to standard-dose chemotherapy; and
 - the participant does not have a concurrent condition which would seriously jeopardize the achievement of a durable complete remission with high-dose chemotherapy with hematopoietic stem cell support.

This Plan does not cover allogeneic bone marrow transplantation or high-dose

chemotherapy with allogeneic hematopoietic stem cell support for the treatment of:

- (a) any condition not listed above;
- (b) primary intrinsic tumors of the brain; or
- (c) Polycythemia vera.

OUTPATIENT DIAGNOSTIC X-RAY AND LABORATORY BENEFITS

Benefits are payable for outpatient diagnostic x-ray or laboratory services which are provided or recommended by a physician. They may be performed in the physician's office, the outpatient department of a hospital or in a free-standing diagnostic lab or x-ray center.

MATERNITY BENEFITS

Expenses incurred as the result of pregnancy will be covered for female employees and spouses in the same manner as services for any other illness. Dependent children are not eligible for maternity benefits under this Plan.

Maternity benefits include pre-natal and post-natal care, complications, and delivery. Benefits will be paid according to the Plan provision for the type of expense incurred, i.e., hospital expenses under the hospital expense benefit, obstetrical delivery under the surgical expense benefit, etc. Maternity benefits are subject to the limitations specified in the benefit summary.

Benefits will be provided for an elective induced abortion if a life-threatening condition exists or if the abortion is otherwise medically necessary.

This Plan is in compliance with The Newborns' and Mothers' Health Protection Act of 1996. This act specifies that if plans provide maternity benefits for mothers and newborns, those benefits must include a minimum of forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a cesarean delivery. Earlier discharges are permitted if the attending physician and the mother agree to an earlier discharge. Penalties cannot be applied if inpatient maternity stays that are within these time frames are not pre-certified. However, penalties may be applied to maternity stays that exceed these timeframes, if not pre-certified.

Newborn Care

Hospital expenses incurred for care of a newborn will be considered part of the mother's maternity expenses and will be paid as part of her claim until the mother's discharge from the hospital. Routine newborn care includes hospital nursery room and board, inpatient physician

visits, and circumcision. Covered charges for a newborn for complications will be added to the charges for the mother until the mother is discharged from the hospital.

BIRTHING CENTER BENEFITS

Birth centers provide care for pregnant women through the services of a nurse midwife. A nurse midwife provides obstetric services with an obstetrician on twenty-four (24) hour medical back-up in case of complications. The mother and baby are usually discharged from the center within 10-12 hours after birth with home follow-up visits provided. Services may vary from center to center.

Covered services include the room and board charges and eligible expenses for any necessary services and supplies while confined. Benefits are limited to expenses incurred while confined for a period of time not to exceed twenty-four (24) hours. Expenses incurred beyond the initial twenty-four (24) hour period may be covered expenses under other benefits of this Plan.

INFERTILITY TREATMENT BENEFITS

Services or supplies related to the diagnosis and treatment of female or male infertility will be covered, but each participant is subject to the limitations specified in the benefit summary.

Infertility treatment benefits do not include the following:

- (a) infertility treatment if the infertility is the result of voluntary sterilization;
- (b) collection or purchase of donor semen (sperm) or oocytes (eggs);
- (c) services of a surrogate parent; and
- (d) freezing sperm, oocytes, or embryos.

DENTAL SERVICES COVERED UNDER MEDICAL BENEFITS

The following dental services are covered under this Medical Plan:

- (a) accidental injuries treated within seventy-two (72) hours of the injury;
- (b) correction of congenital abnormalities of the jaw;
- (c) excision of a lesion;
- (d) excision of temporomandibular (jaw) joints;
- (e) incision of accessory sinus, mouth, salivary glands, or ducts;

- (f) manipulation of a jaw dislocation;
- (g) reduction of facial bone fractures;
- (h) repair of mouth or lips to correct accidental injury;
- (i) surgical removal of impacted teeth as an outpatient (includes outpatient hospital or dentist's office); and
- (j) inpatient services for the surgical removal of impacted teeth if the participant has a medical condition that requires inpatient hospitalization (e.g., hemophilia).

PREVENTIVE CARE BENEFITS

This Plan has been designed to encourage each participant to promote good health by providing benefits for certain preventive care. A routine physical exam is available each calendar year. Department of Transportation (DOT) physicals will be considered under the routine physical exam benefits. Pap smears, adult immunizations and cancer screenings are also preventive care benefits under this Plan. Preventive care benefits for each participant are subject to the **Preventive Care Benefits** limitations specified in the benefit summary.

COMPANY-SPONSORED WELLNESS EXAMS

Once a year, the Company provides a wellness exam for all employees. The company-sponsored wellness exam is administered separately from the provisions of this medical Plan, and is not part of the preventive benefits offered by this Plan.

MAIL ORDER PRESCRIPTION DRUG BENEFITS

This Plan includes a mail order drug benefit to help participants save money on generic and brand name maintenance drugs. Maintenance drugs are those medications which a physician has prescribed to treat an ongoing condition such as high blood pressure, diabetes or heart condition. The participant pays the full cost of the prescription to the mail order plan, then submits the receipt to First Administrators, Inc. for reimbursement. Covered services are subject to the calendar year deductible and coinsurance amounts specified in the benefit summary.

To take advantage of this optional benefit, please request a kit from the Human Resources Department.

OTHER COVERED MEDICAL CARE

Provided below is a list of other medical services covered by this Plan.

- (1) treatment of acquired immune deficiency syndrome (**AIDS**), the human immunodeficiency virus (HIV) and related conditions;
- (2) **allergy tests** and allergy injections;
- (3) professional air or ground **ambulance** service to and from the nearest, local adequate hospital or nursing facility for medically necessary treatment of an injury or illness;
- (4) **biofeedback** for medical and psychological diagnoses if medically necessary and performed by a qualified practitioner;
- (5) unreplaced **blood**, blood plasma and blood plasma expanders, and their administration;
- (6) **cardiac rehabilitation**. Prior approval recommended for treatment which exceeds eighteen (18) sessions;
- (7) manual, mechanical manipulation of the spinal column (**chiropractic** benefits);
- (8) **drugs** (including insulin, insulin supplies, insulin syringes and prenatal vitamins) and medications obtainable only with a physician's written prescription and dispensed only by a licensed pharmacist or in a physician's office, which are listed in the *U.S. Pharmacopeia* and approved by the United States Food and Drug Administration. See also **Mail Order Prescription Drug Benefits**;
- (9) purchase or rental up to the purchase price of **durable medical** and mechanical equipment which is medically necessary for the treatment of the patient, such as wheelchairs, hospital beds, and respirators (equipment that is not available for purchase will require continuous rental);
- (10) initial **elective sterilization**, including tubal ligations and vasectomies;
- (11) **hemodialysis** (kidney disease treatment);
- (12) **oral contraceptives** and subcutaneous implants (i.e., Norplant and Depo Provera), prescribed by a physician for the purpose of birth control, are covered benefits for the **employee and spouse only**. Oral contraceptives prescribed for dependents for treatment of a medical condition will be reviewed by the Benefit Services

Administrator to determine the medical necessity of the treatment.

- (13) **oxygen** and equipment for its administration;
- (14) **physical therapy** provided by a licensed physical therapist;
- (15) **physician's professional** services provided in a hospital's outpatient or emergency room facility, the physician's office, or the participant's home;
- (16) **private duty nursing** services of a registered nurse (RN) in or out of a hospital or a licensed practical nurse (LPN) in a hospital. Private duty nursing services are covered only to the extent that they are medically necessary. Payment is not made for services which are custodial. Prior approval by the Benefit Services Administrator and/or reinsurer is required;
- (17) **prosthetic appliances** used to aid in the function of or to replace a limb or an eye if the appliance is the original appliance or a replacement required by pathological changes or normal growth;
- (18) **radiation therapy** and chemotherapy;
- (19) **speech**, inhalation/respiratory, and occupational therapy (limited to a medical condition) under the supervision of a physician. Occupational therapy supplies are excluded;
- (20) medically necessary **supplies**, including, but not limited to, casts and splints; and
- (21) **well-baby care** and immunizations for first 6 years of life.

MEDICAL EXCLUSIONS

Certain medical services are not covered under this Plan. No claims will be paid for:

- (1) **acupuncture** or acupressure therapy;
- (2) **blood** or blood plasma that is replaced by or for the patient except in the case of a hemophiliac;
- (3) services provided by a **certified registered nurse** in independent practice (other than an anesthetist). This exclusion does not apply to private duty nursing;
- (4) **complications** of a non-covered procedure;
- (5) medical treatment received while **confined** to jail, prison, correctional institution or home by court order. A person is considered "confined" to his or her home if such confinement is ordered by a court of competent jurisdiction and the person's behavior during this period is constantly being monitored by the court. A person is considered "confined" during a court ordered period of probation following confinement in a jail, prison, correctional institution or his or her home;
- (6) **contraceptive devices**;
- (7) charges for services in connection with one or more **corns**, calluses or toenails, unless the charges are for the partial or complete removal of nail roots or reasonably necessary in the treatment of a metabolic or peripheral vascular disease;
- (8) any charges for **custodial care**, sanitarium care or rest cures;
- (9) expenses applied toward satisfaction of the **deductibles** or coinsurance expenses of this Plan;
- (10) any **dental work** or treatment or dental x-rays unless otherwise specified as covered under this Plan;
- (11) **educational** and **recreational therapy** and services and supplies which are non-medical;
- (12) **elastic stockings** and bandages including trusses, lumbar braces, garter belts and similar items which can be purchased without a prescription;
- (13) any charges for the reversal of **elective sterilizations** (tubal ligation or vasectomy);
- (14) charges for a dependent for any medical expense for which he/she is entitled to

benefits as an **employee** or former employee of any employer participating in the Manatts, Inc. Group Health Plan Trust;

- (15) any charges which **exceed a benefit maximum**;
- (16) **experimental** or investigational services;
- (17) services provided by a **family member**, whether relationship is by blood or marriage, or by any person who regularly resides in the participant's home;
- (18) charges for services in connection with weak, strained or flat **feet**, any instability or imbalance of the foot, any metatarsalgia or bunion unless the charges are for an open cutting operation;
- (19) any confinement, treatment, service, or supply in or by a **government owned** or operated facility, or where care is provided at government expense, i.e., a VA facility, unless there is a legal obligation for the participant to pay for such treatment or service in the absence of coverage. If the injury or illness is non-service related, this Plan will be liable for benefits for covered services;
- (20) **hearing aids**, examinations, or the fitting and/or repair of such hearing appliances;
- (21) **hospital admissions** which are primarily for diagnostic evaluations, physical therapy, or occupational therapy, unless medically necessary;
- (22) charges incurred while engaging in an **illegal occupation**, commission of or attempted commission of an assault or a felonious act;
- (23) the portion of a charge for services and supplies **in excess** of the maximum allowable fee;
- (24) **marriage** and **family counseling** or other training services;
- (25) **maxillary** and mandibular **implants** (osseointegration);
- (26) the purchase, or rental of, **motor vehicles** such as cars and vans, or equipment and costs associated with converting a motor vehicle to accommodate a disability;
- (27) **nonprescription** medicines, vitamins, nutrients, and food supplements, even if prescribed or administered by a physician;
- (28) charges for which the participant would **not be responsible** in the absence of this Plan;

- (29) charges incurred while the participant is **not eligible** for coverage;
- (30) any confinement, treatment, service, or supply if **not recommended** and approved by a physician and deemed to be not medically necessary for the condition of the participant, or any surgery or other type of medical treatment performed on an elective, non-medically necessary basis;
- (31) any injury sustained or illness contracted while **on duty** with any military, naval, or air force of any country or international organization or the result of an act of declared or undeclared war (including resistance to armed aggression) occurring while a participant;
- (32) **orthoptics** (eye-muscle exercises), eyeglasses, contact lenses, exams for a fitting or prescription (including vision exercises), or surgery to correct eye refractions (such as keratotomies);
- (33) **orthotic foot devices** such as arch supports and in-shoe supports, orthopedic shoes, elastic supports, or exams to prescribe or fit such foot devices, supports or shoes;
- (34) medical treatment received **outside the United States** or its territories, if the covered individual traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies;
- (35) **personal convenience** items, including, but not limited to, air conditioners, dehumidifiers, ramps, home remodeling, hot tubs, or swimming pools, which can be used in the absence of an injury or illness;
- (36) **PPO discount** amounts, "cash discounts", over-the-counter (OTC) items, and sales tax. Surcharges and/or taxes for reimbursement of uncompensated care costs or other taxes imposed by a governmental body are eligible expenses under this Plan;
- (37) **pre-existing** conditions as defined by this Plan;
- (38) **repairs**, maintenance or adjustments of durable medical equipment;
- (39) **Retin-A** for cosmetic purposes;
- (40) charges due to insurrection or voluntary participation in a **riot**;
- (41) **self-help** and self-cure programs including prescription gum used for the purpose of smoking cessation;
- (42) **sex transformation** counseling or surgery, or treatment related to a sexual dysfunction or a gender identification problem;
- (43) services and supplies received from a **social worker** unless the social worker is *employed* by an MD, DO, or psychologist and the treatment is *billed* by an MD, DO, or psychologist;
- (44) cost of **travel** or lodging related to getting medical treatment, or travel, even if recommended by a physician, unless specified as a covered benefit of this Plan;
- (45) **weight reduction programs** and supplies (including, but not limited to, dietary supplements, foods, equipment, laboratory testing, examinations, and prescription drugs) whether or not weight reduction is medically necessary;
- (46) **wigs** and artificial hair pieces;
- (47) hospital and professional services to which the participant is entitled **without charge** or to which the participant is entitled by any governmental program (except Medicaid);
- (48) services and supplies that are, or could have been, compensated under **Workers' Compensation** laws, including services or supplies applied toward satisfaction of any deductible under the Company's Workers' Compensation plan.

OTHER FACTS ABOUT THE HEALTH PLAN

COORDINATION OF BENEFITS

Coordination of benefits (COB) refers to a process that is utilized when a participant has other insurance or coverage that provides the same or similar benefits as this Plan. The benefits payable under this Plan, when combined with the benefits paid under other coverage, will not be more than 100% of either our payment arrangement amount or the other carrier's payment arrangement amount.

This Plan, utilizing its normal benefit calculation method, will determine the amount to be paid and then subtract the payment(s) made by plans determined to be primary. The sum of all payments will never exceed the actual charge.

When services are received, the participant needs to inform the Benefit Services Administrator know that he/she has other coverage. Other coverage includes: group insurance; other group benefit plans (e.g., HMOs, PPOs, and self-insured programs); Medicare or other governmental benefits; and the medical benefits coverage in the participant's automobile insurance (whether issued on a fault or no fault basis). To help the Benefit Services Administrator coordinate benefits, the participant should:

- (a) inform the provider by giving him/her information about the other coverage at the time services are received. The provider will pass the information on to the Benefit Services Administrator when the claim is filed; and/or
- (b) indicate that there is other coverage when filling out a claim form by completing the appropriate boxes on the form. The participant will receive a letter from the Benefit Services Administrator if any additional information is needed.

It is important that the participant provides the Benefit Services Administrator with the requested information concerning other coverage. If the participant does not provide the necessary information, claims will be denied.

The following guidelines will be used to determine which plan will be primary:

- (a) If one plan has a COB provision and the other does not, the plan without COB will be primary.

- (b) If both plans have COB, the plan covering the participant as an employee will be primary over the plan covering him/her as a dependent.
- (c) If the participant is the main person covered under both plans (if he/she is not a dependent under either plan), the plan that has covered him/her the longest will be primary.
- (d) The plan covering the participant as an active participant will pay before the plan covering him/her as an inactive participant. Participants in retiree plans, COBRA or other similar continuation coverage are considered inactive participants.
- (e) For a dependent child, the primary plan is the plan of the parent whose birthday (excluding year of birth) occurs earlier in the calendar year. For example, if the father's birthday is June 1 and the mother's birthday is May 1, the mother's plan of benefits would be primary on the children.
- (f) If both parents have the same birth month and day, the plan which has been in effect longest would be primary.
- (g) When the parents of a dependent child are divorced or separated and the parent with custody has not remarried, that parent's plan is primary for the child. The plan of the parent without custody pays second. When the parent with custody has remarried, that parent's plan is primary, the stepparent's plan is secondary and the plan of the parent without custody will be coverage of last resort. If there is a court decree which stipulates which parent has financial responsibility for the medical bills for the dependent child, the benefits of that parent's plan will be determined before the benefits of any other plan which cover the child as a dependent.
- (h) The medical benefits of auto coverage will pay before this plan if the auto coverage does not contain a coordination of benefits provision that specifies it is secondary or excess to health insurance or health benefit plans. Provided, however, this plan will not cover any medical benefits payable under no-fault auto coverage.
- (i) If none of the above rules determines the order of benefits, the benefits of the plan which has covered an insured person longer are determined first.

Special Rules for SelectFirst™ Providers

If this Plan is the secondary payer, and the provider is a SelectFirst™ participating provider, the billed charges will be subject to the SelectFirst™ fee schedule or discount. This Plan's payments as secondary payer, combined with the primary payer's payment, will never exceed the allowable payment according to the SelectFirst™ fee schedule or discount arrangement.

MEDICARE AS SECONDARY PAYER

Since 1980, Congress has passed legislation making Medicare the secondary payer and group health plans the primary payer in a variety of situations. These laws apply only if the participant has both Medicare and company health coverage under this Plan and the Company has the minimum required number of employees as described in the following paragraphs.

Working Aged

This provision applies only to group health plans of employers with at least twenty (20) employees for each working day for at least twenty (20) calendar weeks in the current or preceding year. Under this provision, Medicare is the secondary payer if the beneficiary is both of the following:

- (a) age sixty-five (65) or older; and
- (b) a current employee or spouse of a current employee covered by an employer group health plan.

Working Disabled

This provision applies only to group health plans of employers that had at least one hundred (100) full-time, part-time, or leased employees on at least 50% of the regular business days during the preceding calendar year. Under this provision, Medicare is the secondary payer if the beneficiary is all of the following:

- (a) under age sixty-five (65);
- (b) a recipient of Medicare disability benefits; and
- (c) a current employee, or a spouse or dependent of a current employee, covered by an employer group health plan.

End-Stage Renal Disease (ESRD)

The ESRD requirements apply to group health plans of all employers, regardless of the number of employees. Under these provisions, Medicare is the secondary payer during the first thirty (30) months of Medicare coverage if both of the following are true:

- (a) the beneficiary has Medicare coverage as an ESRD patient; and
- (b) the beneficiary is covered by an employer group health plan.

If the beneficiary is already covered by Medicare due to age or disability and becomes eligible for Medicare ESRD coverage, Medicare generally is the secondary payer during the first thirty (30) months of ESRD eligibility. However, if the group health plan is secondary to Medicare (based on other Medicare secondary payer requirements) at the time the beneficiary becomes covered for ESRD, the group plan remains secondary to Medicare.

The above provisions are a general summary of the laws, which may change from time to time. For more information, contact the Company or the Social Security Administration.

MEDICARE AS PRIMARY PAYER

When the foregoing subsection "Medicare as Secondary Payer" does not apply, benefits otherwise payable under this Plan for allowable expenses shall be reduced so that the sum of benefits payable under this Plan and Medicare shall not exceed the total of such allowable expense. Benefits shall be payable under this Plan after Medicare benefits have been paid whether or not such participant is disabled and not in an active employment status and under or over age sixty-five (65), other than as specified for an ESRD beneficiary in the foregoing subsection.

Benefits shall be considered payable by Medicare for purposes of this section whether or not the participant eligible for Medicare benefits:

- has enrolled in or applied for benefits under Medicare;
- has failed to take any other action required by Medicare to qualify for benefits; or
- received benefits payable by Medicare if services were received in a facility to which Medicare would have paid.

In the event a participant enters into a private contract with a Physician in accordance with Medicare private contracting arrangements, this Plan shall not coordinate benefits or assume a primary payer position on any such participant.

RELEASE OF INFORMATION

The Benefit Services Administrator may, without notice to or consent of the covered person, release to or obtain from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Benefit Services Administrator, at its sole discretion, considers necessary to apply the provisions of this Plan.

RIGHT OF RECOVERY

Whenever benefits have been paid in excess of the minimum amount necessary to satisfy the intent of the Coordination of Benefits provision (***established so a covered person cannot profit from this Plan***), the Plan Administrator will have the right to recover those payments to the extent of the excess amount from any one or more of the following as the Plan Administrator determines:

- (a) any persons to whom such payments were made; or
- (b) any insurance companies or any other organizations.

The Plan Administrator will also have the right to cause the payment of any amounts it determines to be warranted to satisfy the intent of the Coordination of Benefits provision of this Plan to any organizations making payments under other plans which should have been made under this Plan.

THIRD PARTY REIMBURSEMENT

If benefits have been paid or are payable under this Plan for services received by a participant, and it is later established that the charges for these services were not paid or are not payable by the participant or that the participant was otherwise reimbursed or may be reimbursed, except by insurers of policies of health insurance issued to the participant as an individual, this Plan will be entitled to a refund of the amount of the benefits paid which are in excess of the benefits that would have been payable based on the actual charges incurred and paid.

SUBROGATION

A. Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan Beneficiaries, and/or their

dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where another party may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

2. Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
 3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
- ### B. Subrogation
1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of

action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized.

2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Covered Person(s) fails to file a claim or pursue damages against:
 - a) the responsible party, its insurer, or any other source on behalf of that party;
 - b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c) any policy of insurance from any insurance company or guarantor of a third party;
 - d) worker's compensation or other liability insurance company; or,
 - e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

C. Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without

regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

D. Excess Insurance

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

The Plan's benefits shall be excess to:

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

E. Separation of Funds

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

F. Wrongful Death

1. In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

G. Obligations

1. It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
 - b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
 - c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.
2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).
3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person(s)' cooperation or adherence to these terms.

H. Offset

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

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

I. Minor Status

1. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

J. Language Interpretation

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

K. Severability

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

WORKERS' COMPENSATION

This Plan is not meant to be a substitute for workers' compensation. Any benefits paid by this Plan which are determined to be the liability of any workers' compensation plan of benefits will be refunded to this Plan by the participant and/or his/her heirs or estate. Any participant hereby agrees to reimburse this Plan for any payments so made under this Plan out of any monies recovered from any workers' compensation plan

as the result of judgment, settlement or otherwise, and the participant does agree to take such action, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Plan Administrator may require to facilitate the enforcement of this Plan's rights and not to prejudice those rights. Any portion of any settlement that is agreed upon which is for future expenses will also be recoverable under this Plan, as those expenses occur.

OVERPAYMENT OF CLAIMS

Each participant hereby authorizes the deduction of any excess benefit received or benefits which should not have been paid, from any present or future compensation payments.

CONFORMITY WITH LAW

To the extent not pre-empted by ERISA, this Plan shall be governed by the laws of the state of Iowa without regard to the conflict of laws provisions thereof. If any provision of this Plan is contrary to any law to which it is subject, or if a law relevant to this Plan is not specifically addressed within the contents of pertinent documents, such provision will be amended to satisfy the law's minimum requirement.

CLAIMS FILING AND APPEALS

ASSIGNMENT OF BENEFITS

In the SelectFirst™ PPO Area

Because of a contractual agreement with SelectFirst™, benefits will be automatically assigned to participating providers. This Plan will not honor assignment of benefits received for any nonparticipating physicians or facilities. These benefits will be sent directly to the participant. Providers who do not participate in this network will not have benefits directly assigned to them. It is the participant's responsibility to make full payment to a non-participating provider.

Outside the SelectFirst™ Area

This Plan accepts all assignments of benefits to make direct payments to providers of services, including, but not limited to, physicians, hospitals, and nursing facilities.

In General

Unless applicable law otherwise requires, no amount payable at any time will be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind and any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount, whether presently or at a later date payable, will be void. This Plan will not be liable for, or subject to, the debts or liabilities of any person entitled to any amount payable under this Plan. If by reason of the bankruptcy or other event happening at any such time such amount would not be enjoyed by them, then the Plan Administrator in its sole discretion, may terminate their interest in any such amount and will hold or apply it to or for the benefit of the participant, their spouse, children or other dependents, or any of them, in such manner as the Plan Administrator may deem proper.

FILING OF CLAIMS

SelectFirst™ Physician Billings

SelectFirst™ physicians agree to submit claims for all covered services provided to SelectFirst™ participants.

SelectFirst™ Participating Hospital Billings

Participating hospitals are required to submit billings for covered services provided to SelectFirst™ participants.

All Other Providers

Claims must be received within twelve (12) months of the day charges are incurred to be eligible for benefits, except as provided in the PPO contract.

In General

Whenever a participant obtains healthcare services he/she should present the Plan's Benefit ID card. Instructions for billing by the provider of care or the member are included on the Plan's Benefit ID card. Most physicians, hospitals and clinics will file claims for the participant; however, the participant is ultimately responsible for the filing of his/her claims.

A paper healthcare claim will be considered filed when it is received by the Benefit Services Administrator. Electronic claims are considered received the day subsequent to the transmission of the claim by the provider. There are specific fields that are required for each type of claim to constitute a "clean claim". This criteria is available, upon request, from the Benefit Services Administrator.

For claims not filed by the provider of service, the following steps should be taken to ensure that claims are filed correctly. Claim forms may be obtained from either the Benefit Services Administrator or the Company.

- (1) Claims must be received within twelve (12) months of the day charges are incurred.
- (2) Complete the personal section of the claim form. Be sure to indicate any other group, franchise or association-sponsored plan the participant has in addition to this Plan.
- (3) Sign the assignment of benefits portion of the claim form. Unless assigned, benefit payments will be directed to the participant.
- (4) Either have the provider complete the appropriate section or attach the original itemized bill to the claim form. This bill should identify the patient, the date(s) of service, the nature of treatment or service and the amount charged. Canceled checks or cash receipts do not contain the information needed to process a claim.
- (5) Sign and date the form in the authorization section.

- (6) Use a separate claim form for each covered participant and retain a copy for the participant's files.
- (7) For hospital admissions, present the Plan's Benefit ID card to the admitting clerk.
- (8) If the participant needs assistance in completing the claim form, he/she should contact the Company or the Benefit Services Administrator.
- (9) All claims should be filed according to the instructions on the Plan's Benefit ID card.

CLAIM DETERMINATION

This section describes the procedures the Plan will follow in making a determination on a claim for benefits. A claim is any request for a plan benefit, made by a participant or a representative of a participant, that complies with the Plan's reasonable procedure for making benefit claims.

Upon receipt of a claim, the Plan must respond to the participant within the time frames stated below. These time frames are the maximum number of calendar days in which a determination must be made and communicated to the participant.

Urgent Care Claims

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

The participant's physician may determine if the claim is an urgent care claim. Otherwise, an individual acting on behalf of the plan, applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

A response to an urgent care claim will be provided within seventy-two (72) hours of the receipt of the claim by the Plan. If a participant fails to provide sufficient information, the Plan will notify the participant within twenty-four (24) hours of receiving the claim of the specific information necessary to complete the claim. The participant will then have forty-eight (48) hours to provide the additional information and, once received, a decision will be communicated

within forty-eight (48) hours. Without complete information, the claim will be denied.

Urgent care claims include, but are not limited to, requests for pre-certification. Please see the Utilization Review section for further information.

Pre-Service Claims

A pre-service claim is any claim for a benefit under this Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

If the participant fails to follow the Plan's procedures for filing a pre-service claim, the Plan will notify the participant of the failure and the proper procedures to be followed within five (5) days of such failure. Otherwise, a response to a pre-service claim will be provided within fifteen (15) days of the receipt of the claim by the Plan. This period may be extended one time by the Plan for up to fifteen (15) days if an extension is necessary due to matters beyond control of the Plan. The participant will be notified of the extension prior to the expiration of the initial fifteen (15) day period, the circumstances requiring the extension and the date by which a decision is expected. If the extension is necessary due to the failure of the participant to provide sufficient information, the Plan will notify the participant of the specific information necessary to complete the claim. The participant will then have forty-five (45) days to provide the additional information and, once received, a decision will be communicated within fifteen (15) days. Without complete information, the claim will be denied. If the Plan does not provide a notice of extension within fifteen (15) days, the participant has the right to begin an appeal, as outlined in the Claim Review Procedures section.

Pre-service claims include, but are not limited to, requests for pre-certification. Please see the Utilization Review section for further information.

Concurrent Care Claims

Concurrent Care is an ongoing course of treatment (inpatient or outpatient) to be provided over a period of time or number of treatments which has been approved by the Plan. If ongoing treatment benefits are reduced or terminated by the Plan before the end of the period for which such treatment was approved, the participant will be notified sufficiently in advance to allow the participant to appeal the adverse determination and obtain a decision on the appeal before the reduction or termination goes into effect.

If a participant requests an extension of a course of treatment that is an urgent care claim as defined above, the Plan will notify the participants of its determination within twenty-four (24) hours of the Plan's receipt of the request.

If the participant requests an extension of a course of treatment that is not an urgent care claim, the request will be considered a new claim and will be subject to the time frames and procedures that are appropriate to the type of claim (i.e., pre-service or post-service). Please refer to the appropriate section for timelines and procedures specific to these types of claims.

Post-Service Claims

A post-service claim is any claim for a benefit that is not a pre-service claim. Post-service claims are claims for services already received by the participant.

The Plan will respond to a post-service claim within thirty (30) days of receipt. This period may be extended one time by the Plan for up to fifteen (15) days if an extension is necessary due to matters beyond control of the Plan. The participant will be notified of the extension prior to the expiration of the initial thirty (30) day period and will be given the date by which a decision is expected. If the Plan does not provide a notice of extension within thirty (30) days, the participant has the right to begin an appeal, as outlined in the Claim Review Procedure section.

If a participant fails to provide sufficient information, the participant will be notified within thirty (30) days of the Plan's receipt of the claim of the specific information necessary to complete the claim. The participant will then have forty-five (45) days from receipt of the notice to provide the additional information, and once received, a decision will be communicated within fifteen (15) days. Without complete information, the claim will be denied.

NOTIFICATION OF DECISION

If a claim has been wholly or partially denied, written notification will be provided by the Plan which will describe:

- (a) the specific reason(s) for the denial;
- (b) reference to the specific Plan provision(s) on which the denial is based;
- (c) a description of any additional material or information necessary for the participant to perfect the claim and an explanation of why such material or information is necessary; and

- (d) an explanation of this Plan's claims review procedure, including a statement of the participant's right to bring civil action under ERISA Section 502(a) following an adverse benefit determination;
- (e) a copy of any internal rule, guideline, protocol or other similar criterion relied upon in denying the claim or, in lieu thereof, a statement that such information is available free of charge upon request;
- (f) an explanation of the scientific or clinical judgment relied upon in denying the claim based on medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to the participant's medical circumstances or, in lieu thereof, a statement that such information is available free of charge upon request; and
- (g) for urgent care claims, a description of the expedited appeal process.

For urgent care claims, this information may be provided to the participant orally, provided that written notification is furnished within three (3) days of the oral notification.

CLAIMS REVIEW PROCEDURE

Claim Inquiry

If a claim has been wholly or partially denied, and if the participant does not agree with the reduction, or if the participant has a complaint regarding a claim, he/she may make an inquiry by calling the number listed on the Notification of Decision.

Filing an Appeal

In case of an adverse benefit determination, the participant has the right to a full and fair review. An adverse benefit determination is a denial, reduction or termination of a benefit.

With the exception of urgent care claims, the request to review a claim must be in writing and must be submitted to the address on the notification of decision. This request must be submitted within one hundred eighty (180) days following the receipt of the adverse benefit determination. For information on appealing an adverse benefit determination of an urgent care claim, see the Urgent Care Claims section below.

The participant may submit written comments, documents, or other information in support of the appeal. The participant will be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in

making the decision. The review will take into account all information regarding the denied or reduced claim whether or not presented or available at the initial determination.

The review will be conducted by someone other than the original decision maker(s) and without regard to the original decision. If a decision requires medical judgment, an appropriate medical expert who was not previously involved in the case will be consulted. If the decision on appeal is adverse, the participant may request in writing the identity of the medical expert who was consulted.

Urgent Care Claims

For appeals involving urgent care claims, the participant may request either orally or in writing an expedited appeal. For an expedited appeal, information, including the decision, will be communicated by telephone, facsimile, or other similarly prompt method.

Notification of the decision on appeal will be provided within seventy-two (72) hours of the Plan's receipt of the appeal request.

Pre-Service Claims

For appeals involving pre-service claims, notification of the decision will be provided within thirty (30) days of the Plan's receipt of the appeal request.

Concurrent Care Claims

If a participant appeals an adverse benefit determination of a claim involving an ongoing course of treatment, the decision on appeal will be made according to the time frames and procedures that are appropriate to the type of claim (i.e., urgent care, pre-service or post-service). Please refer to the appropriate section for timeliness and procedures specific to these types of claims.

Post-Service Claims

For appeals involving post-service claims, notification of the decision will be provided within sixty (60) days of the Plan's receipt of the appeal request.

NOTIFICATION OF DECISION ON APPEAL

If the decision on appeal is adverse, written notification will be provided by the Plan that will describe:

- (a) specific reason(s) for adverse determination;
- (b) reference to the specific Plan provision(s) on which determination is based;
- (c) a statement that the participant is entitled to receive, upon request and at no cost, reasonable access to, and copies of all documents, records and other information relevant to the participant's claim for benefits;
- (d) a statement describing any voluntary appeal procedures offered by the Plan and the participant's right to obtain information about such procedures as well as the right to bring civil action as described in ERISA Section 502(a);
- (e) a copy of any internal rule, guideline, protocol or other similar criterion if relied upon in making the adverse determination or, in lieu thereof, a statement that such information is available free of charge upon request; and
- (f) an explanation of the scientific or clinical judgment relied upon in making the adverse determination, based on medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to the participant's medical circumstances or, in lieu thereof, a statement that such information is available free of charge upon request.

AUTHORIZED REPRESENTATIVE

A participant may authorize another person to represent him/her and with whom he/she wants the Benefit Services Administrator to communicate regarding specific claims or an appeal. This authorization must be in writing, signed and dated by the participant, and include all the information required in our Authorized Representative Form. This form is available from the Company. In a medically urgent situation the treating health care practitioner may act as the participant's authorized representative without completion of the Authorized Representative Form. An assignment of benefits, release of information, or other similar form that the participant may sign at the request of his/her health care provider does not make that provider an authorized representative. The participant can revoke the authorized representative at any time, and may authorize only one person as his/her representative at a time.

DEFINITIONS

"ACCIDENTAL INJURY" means an injury, independent of disease or bodily infirmity of any other cause, which happens by chance and requires immediate medical attention.

"ACTIVE DUTY" means full-time duty in the active military service of the United States. Such term includes full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned. Such term does not include full-time National Guard duty.

"ACTIVELY AT WORK " means an employee must work for his/her employer at his usual place of work or such other place or places as required by his/her employer in the course of such work for the full number of hours and full rate of pay, as set by the employment practices of the employer.

"ACUTE CARE" refers to inpatient twenty-four (24)-hour hospital care where physician and nursing observations and care are required on a minute-to-minute, hour-to-hour basis.

"ADMISSION" is the formal acceptance of a patient into a hospital or other health care institution for a medical, surgical, or obstetrical condition.

"ADOPTED CHILD(REN)" means 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.

"ADVERSE BENEFIT DETERMINATION" means a denial, reduction, or termination of a benefit.

"ALLOWABLE EXPENSES" mean the portion of an eligible expense actually payable by this Plan, after taking into account co-pay, deductible, and coinsurance amounts, any applicable benefit maximum or maximums, and any other limitation or exclusion provided for under this Plan.

"ALTERNATE RECIPIENT" means any child of a participant who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment in this Plan with respect to such participant.

"AMBULATORY/OUTPATIENT SURGERY FACILITY" provides surgical services on an

outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed.

"AMENDMENT" means a formal document that changes a provision of this Plan, duly signed by the authorized person or persons as designated by the Plan Sponsor.

"BENEFIT SERVICES ADMINISTRATOR" means First Administrators, Inc., an Iowa corporation.

"BENEFITS" mean those medically necessary services and supplies that qualify for payment under this Plan.

"BIRTHING CENTER" provides obstetrical care and related services on an outpatient basis.

"BRACES" include rigid and semi-rigid appliances and devices commonly used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Braces do not include elastic stockings, elastic bandages, garter belts, arch supports, orthodontic devices and other similar items.

"BRAND NAME PRESCRIPTION DRUG" means the pharmaceutical products manufactured and sold under the name assigned by the developer/manufacturer.

"BUSINESS ASSOCIATE" means a person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. A business associate can also be a covered entity in its own right. (Also see Part II, 45 Code of Federal Regulations Part 160.103).

"CALENDAR YEAR" means the twelve (12) month period commencing January 1st and ending the next following December 31st.

"CERTIFIED REGISTERED NURSE " is a registered nurse (RN) certified by a national certifying organization. A CRN is in an independent practice and is not an employee of another provider.

"CERTIFIED REGISTERED NURSE ANESTHETIST" is a registered nurse (RN) licensed and certified to administer anesthesia by the Council of Certification of Nurse Anesthetists.

"CHEMICAL DEPENDENCY" means any condition resulting from dependency on or abuse of a psychoactive substance as described in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised*, (DSM-III-R), published by the American Psychiatric Association or subsequent revisions to DSM-III-R.

"CHEMICAL DEPENDENCY FACILITY" is a licensed, free-standing facility approved by this Plan to provide treatment for chemical dependency conditions.

"CHILD(REN)" means natural children, adopted children (as defined), stepchildren, foster children and grandchildren or children for whom the employee has legal guardianship of a covered employee.

"CLAIM" means any request for a Plan benefit made by a participant or a representative of a participant that complies with the Plan's reasonable procedure for making benefit claims.

"COMMON ACCIDENT DEDUCTIBLE" is a single deductible amount the participant is responsible for when two or more family members receive covered services for injuries suffered in the same accident.

"COMMUNITY MENTAL HEALTH CENTER" or "MENTAL HEALTH CLINIC" means a facility established for the purpose of providing consultation, diagnosis, and treatment in connection with a mental health disorder, and approved as such by a state department or agency having authority over such facilities.

"COMPANY" means Manatts, Inc.

"COMPLICATIONS OF PREGNANCY" refers to a cesarean section which was not planned, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible. Also covered are conditions requiring inpatient hospital admission (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

"CONTINGENCY OPERATION" means designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force.

"CO-PAY" means the predetermined amount paid by the participant on a per item or per service basis.

"COINSURANCE" means the percentage(s) of eligible expenses allocable to the participant and the Plan Sponsor after any applicable co-pays, calendar year deductibles, or non-compliance penalties have been applied.

"COSMETIC SERVICES" means treatment or surgical procedures intended to improve physical appearance, but which do not treat

illness, restore, or materially improve a deficiency in normal physiological function. Cosmetic services performed to alleviate psychological distress are not covered by the Plan

"COVERED DENTAL EXPENSES" mean expenses incurred which are dentally/medically necessary that are not specifically excluded from coverage elsewhere in this Plan.

"COVERED DEPENDENT" means a spouse or a dependent child who has satisfied the definition of dependent and the eligibility requirements specified under **Dependent Eligibility**.

"COVERED EMPLOYEE" means any employee who is eligible for benefits as specified under **Employee Eligibility**.

"COVERED EXPENSES" mean those expenses covered by this Plan, including the hospital, surgical, and medical care expenses described in this booklet. A covered expense does not include any expense expressly excluded from coverage under this Plan. Thus, for example, but not by way of limitation, a covered expense does not include an expense which is listed as a type of expense otherwise covered under this Plan, but which is not medically necessary, or which is experimental or investigational in nature, nor does it include the *portion* of an otherwise covered expense which exceeds the maximum amount considered by this Plan for the service or supply. See also the definitions of eligible expenses and allowable expenses.

"COVERED SERVICEMEMBER" means a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

"CREDITABLE COVERAGE" means coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance, including COBRA continuation coverage, or short-term "bridge" policy), Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefit risk pool, the Federal Employees Health Benefits Plan (FEHBP), a public health plan as defined in subsequent Centers for Medicare and Medicaid Services regulations, state Children's Health Insurance Program (S-Chip), public health plans provided by a foreign country or a political subdivision and any health benefit plan under Peace Corps Act 5(e).

"Creditable Coverage" does **not** include accident or disability income, liability, workers' compensation, automobile medical insurance, health coverage for limited benefits, such as limited scope dental or vision benefits or long-term care plans, or plans under which health benefits are secondary or incidental.

"CUSTODIAL CARE" helps a participant with his/her daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding and other forms of assistance with normal bodily functions, preparation of special diets; and supervision of medication which usually can be self-administered. Custodial care is not a benefit under this Plan.

"DEDUCTIBLE" is the amount for covered services a participant pays before this Plan begins paying benefits.

"DEPENDENT" means any one or more of the following:

- (a) the spouse of an employee (see the definition of spouse);
- (b) unmarried children of an employee under the age of nineteen (19), including natural children, adopted children (as defined), stepchildren and foster children, who normally reside in the employee's household in a parent-child relationship and/or who are principally dependent upon the employee or covered spouse for support and maintenance, as defined by the Internal Revenue Service for tax purposes;
- (c) unmarried children of an employee, including natural children, adopted children (as defined), stepchildren, and foster children who have attained age nineteen (19) but who have not attained age twenty-six (26) and who are full-time students, as defined, in an accredited educational institution; and
- (d) unmarried children of an employee, including natural children, adopted children (as defined), stepchildren, foster children and grandchildren or children for whom the employee has legal guardianship, who are principally dependent upon the employee or covered spouse for support and maintenance and who are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of the termination age for dependent children

specified under this Plan and such children were covered prior to attainment of such termination age and continuously thereafter under this Plan or a predecessor plan; and

- (e) unmarried children and grandchildren of an employee for whom the employee has legal guardianship, who normally reside in the employee's household in a parent-child relationship and/or who are principally dependent upon the employee or covered spouse for support and maintenance, as defined by the Internal Revenue Service for tax purposes are covered to age eighteen (18) unless disabled.

The residency requirement cited above shall be deemed satisfied as to dependent children temporarily residing away from the employee's home for full-time educational purposes.

The primary maintenance and support requirement cited above will be waived if a covered employee or covered spouse is assigned responsibility for medical and dental expenses or for providing medical and dental coverage for a child in a divorce decree, and is also waived for dependents who qualify for benefits based on full-time student status.

A spouse age sixty-five (65) or older of an active employee who makes a written election to be covered by Medicare instead of this Plan may not, by law, be considered a dependent under this Plan.

"DISABLED" means the temporary inability of a covered employee to perform each and every regular duty pertaining to his/her occupation or employment for compensation or profit, or the temporary inability of a covered dependent to engage in the normal activities of a person in good health of like age and sex.

"DOMICILIARY CARE" means inpatient institutional care provided to the participant not because it is medically necessary, but because care in the home setting is not available, is unsuitable, or members of the patient's family are unwilling to provide care. Institutionalization because of abandonment constitutes domiciliary care. Domiciliary care is not a benefit under this Plan. Some examples of domiciliary care for which benefits are not payable:

- (a) home care is not available, such as where institutionalization is primarily because parents work or where a hospital stay is extended beyond what is medically necessary because the patient lives alone;
- (b) home care is not suitable, such as where a child is institutionalized because a parent(s) is an alcoholic who is not responsible

enough to care for the child or because someone in the home has a contagious disease; or

- (c) the family is unwilling to care for a person in the home, such as where a family does not want to handle a child who is difficult to manage.

"DURABLE MEDICAL EQUIPMENT" means medical equipment not otherwise excluded, which is designed for repeated use, is primarily and customarily used to serve a medical purpose, and is not useful to a person in the absence of an injury or illness. For the purpose of determining whether a piece of equipment constitutes durable medical equipment for coverage under this Plan, First Administrators, Inc. may consult the equipment list compiled from time to time for use in the administration of the Medicare program. Examples of durable medical equipment include, but are not limited to, wheelchairs, hospital beds, and respirators. Air conditioners, humidifiers, dehumidifiers, air purifiers, and other similar convenience items are not considered durable medical equipment.

"EFFECTIVE DATE" means the first day that benefits under this Plan would be in effect, after satisfaction of the waiting period, if applicable, and any other provisions or limitations contained herein.

"ELECTIVE SURGICAL PROCEDURE" means a non-emergency surgery that can be scheduled at any time without risking the patient's life or risking serious impairment to the patient's bodily functions.

"ELIGIBLE EXPENSE" means the portion of a covered expense which is considered for payment under this Plan. Where a participant incurs a covered expense for treatment of a condition, the treatment of which is normally covered by this Plan, but the course or manner of treatment of such condition is excluded from coverage because it is expressly so excluded, is not medically necessary, or is experimental, investigational, or otherwise not considered efficacious by the Plan Administrator for treatment of the condition, or because of any reason described in this Plan, the expense incurred for such course or manner of treatment is not an eligible expense. See the definition of allowable expense for a description of how this Plan computes the portion of an eligible expense which it will pay.

"EMERGENCY" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of health and medicine, could

reasonably expect absence of immediate medical attention to result in one of the following:

- (a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
- (b) serious impairment to bodily function; or
- (c) serious dysfunction of any bodily organ or part.

"EMERGENCY ADMISSION" means an admission that must take place immediately or serious disability or death may result.

"EMPLOYEE" means any individual who is employed by an employer participating in the Manatts, Inc. Group Health Plan Trust.

"ENROLLMENT DATE" or **"DATE OF ENROLLMENT"** means the first day of a participant's waiting period under this Plan (typically, the date the employee's employment begins). The enrollment date for anyone who enrolls during a special enrollment period, is the first day of coverage under this Plan.

"ERISA" means the Employee Retirement Income Security Act of 1974, a federal law protecting a participant's rights under this Plan.

"EXPERIMENTAL OR INVESTIGATIONAL SERVICES OR SUPPLIES" mean that one or more of the following is true:

- (a) the device, drug or medicine cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished;
- (b) the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, if federal law requires such review and approval, and furthermore, that the treating facility's Institutional Review Board is reviewing such drug, device treatment or procedure as being experimental or investigational;
- (c) reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as

compared with the standard means of treatment or diagnosis; and/or

- (d) reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

In addition, no reimbursement is available for payments of any: (1) treatments, services or supplies that are educational or provided primarily for research; or (2) treatments, procedures, devices, drugs or medicines or other expense relating to transplants of nonhuman organs.

"FACILITY" means a licensed, certified, and/or accredited facility that provides inpatient and outpatient services. An example of a facility is a hospital.

"FEE SCHEDULE" means a contractually specified amount payable for physician's services within the PPO area.

"FOSTER CHILD" means a child whom the employee is raising as his/her own, who resides in the employee's home, who is chiefly dependent on the employee for support and for whom the employee has full parental responsibility and control. A foster child must have been placed in the employee's home by the appropriate governing authority.

"FULL-TIME STUDENT" means a covered dependent who meets the age requirements of this Plan and is enrolled in a full-time course of study in an approved institution of higher learning. A covered dependent who is enrolled in the required number of credit hours for graduation during the last semester of study will be considered to be enrolled full time;

"GENERIC PRESCRIPTION DRUGS" mean the pharmaceutical products manufactured and sold under their common chemical or non-proprietary name. The generic equivalent of a brand name drug must meet the same

standards for safety, purity, strength, and effectiveness as the brand name drug. Both have the identical chemical composition and therapeutic effect.

"HIPAA" means the Health Insurance Portability and Accountability Act, a Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives Health and Human Services (HHS) the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans) and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. (Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191).

"HOME HEALTH AGENCY" is a Medicare approved association or organization which provides skilled nursing care in the participant's home.

"HOME HEALTH SERVICES" are health care services performed in the participant's home by a home health agency.

"HOME INFUSION THERAPY" means treatment provided in the home involving the administration of nutrients, antibiotics, and other drugs and fluids intravenously or through a feeding tube.

"HOSPICE" provides care (usually in the home) for patients who are terminally ill and have a life expectancy of six (6) months or less. The hospice must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), be Medicare approved, and/or be licensed by the state in which it operates.

"HOSPICE SERVICES" include home health care plus respite services.

"HOSPITAL" is an institution that primarily provides diagnostic and therapeutic services for surgical and medical diagnosis, treatment and care of injured or ill persons. The facility must be licensed as a hospital under applicable laws.

"HOSPITAL CONFINEMENT" means being registered for a minimum of eighteen (18) hours as a bed patient in a hospital, nursing facility or chemical dependency facility upon the recommendation of a physician or as a patient in a hospital because of a surgical operation or

receiving emergency care in a hospital for an injury within forty-eight (48) hours after the injury is received.

"ILLNESS" means any bodily disorder, bodily injury, disease or mental health condition including pregnancy and complications of pregnancy.

"IMMEDIATE FAMILY" means a participant's legal spouse, parents, children, grandparents and siblings (brothers and/or sisters). This includes such persons whether related by blood or marriage (in-laws).

"IMMUNIZATION" is an injection with a specific antigen to promote antibody formation to make a person immune to a disease or less susceptible to a contagious disease.

"INFERTILITY" means the inability or diminished ability to produce offspring.

"INJURY" means a physical condition which is the result of an accident caused by an external force and occurring while this Plan is in effect, with respect to that participant, and which results in loss covered by this Plan; 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; the condition must be an instantaneous one, rather than one which continues, progresses or develops.

"INPATIENT" means being confined in a hospital or a nursing facility as a resident patient and subject to at least one day's room and board charges by the hospital, nursing facility or chemical dependency facility.

"INTENSIVE CARE UNIT" means a unit exclusively reserved for critically and seriously ill or injured patients requiring constant audio-visual observation as prescribed by the attending physician which provides room and board, specialized registered nurse (RN) and other nursing care, and special equipment or supplies immediately available on a stand-by basis segregated from the rest of the hospital's facilities.

"LEGEND DRUGS" mean those drugs classified within any of the five categories for drugs that come under the jurisdiction of the most recent Controlled Substance Act and which may only be dispensed by a licensed pharmacist upon the written prescription of a physician. Compounded medications of which at least one ingredient is classified as noted above shall be included.

"LICENSED PRACTICAL NURSE" means an individual who has received specialized nursing

training and practical nursing experience and who is licensed to perform nursing services by the state in which he/she performs such services, other than one who ordinarily resides in the participant's home or who is a member of the participant's immediate family.

"LICENSED PUBLIC HEALTH NURSE" means a professional nurse who has the right to use the title registered nurse (RN), other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family, and who has extended their study in the public health field.

"LIFETIME" means the period of time a person is actually a participant under this Plan, commencing with the original effective date, and is not intended to imply or suggest benefits beyond an individual's termination date or this Plan's termination date as herein specified.

"LOCAL AIR AND GROUND AMBULANCE" means medically necessary transportation to an appropriate inpatient or outpatient 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 participant is an inpatient or outpatient and the point of destination is the nearest one with adequate and appropriate methods of care.

"MAINTENANCE DRUG" means the prescription drugs and medications which are prescribed to treat a chronic medical condition, such as hypertension, diabetes, and certain heart conditions. "Maintenance drug" includes diabetic supplies such as hypodermic syringes, needles, and blood-sugar testing supplies.

"MAXIMUM ALLOWABLE FEE" means an amount established, using various methodologies, for covered services and supplies. The settlement amount is based on the lesser of the covered charge for a service or supply or the maximum allowable fee.

Information regarding the calculation and determination of the maximum allowable fee is available to you. Upon receiving your request for such information, First Administrators, Inc. or your group health plan sponsor will provide the following:

- the frequency of the determination of the maximum allowable fee

- a general description of the methodology used to determine the maximum allowable fee, including geographic locations
- the percentile that determines the maximum benefit that we will pay for any procedure, if the maximum allowable fee is determined by taking a sample of fees submitted on actual claims and then determining the benefit by selecting a percentile of those fees.

"MAXIMUM LIFETIME BENEFIT" means the highest dollar amount of allowable expenses that could be paid to or on behalf of any participant during the participant's lifetime, subject to the terms of this Plan.

"MEDICALLY NECESSARY" means that a procedure, service or supply is all of the following:

- appropriate and necessary for the diagnosis and treatment of a participant's injury or illness;
- consistent with professionally recognized standards of health care determined within the state in which the participant resides and given at the right time and in the right setting;
- not more costly than alternative services that would be effective for diagnosis and treatment of the participant's condition; and
- enables the patient to make reasonable progress in treatment.

"MEDICARE" is the federal government's health insurance program established under Title XVIII of the Social Security Act for people age sixty-five (65) and older and people of any age entitled to monthly disability benefits under the Social Security or Railroad Retirement Program. It is also available for those with chronic renal disease who require hemodialysis or kidney transplant.

"MENTAL HEALTH DISORDER" means any disorder classified in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised* (DSM-III-R), or subsequent revisions to DSM-III-R, and includes behavioral or psychological conditions not attributable to a mental disorder that are the focus of professional attention or treatment, but only to the extent services for such conditions are otherwise considered to be benefits under this Plan.

"NEXT OF KIN" means the nearest blood relative of an individual.

"NEWBORN CARE" means all physician services provided to a baby during the mother's hospitalization.

"NON-PPO MEMBER" or "NON-PPO PROVIDER" means any health care provider who

is not a contracting member of a preferred provider organization utilized by this Plan.

"NOTIFICATION OF DECISION" means delivery or furnishing of information by the Plan to an individual regarding decision of the claim for benefits. Information is considered delivered or furnished as of the date it is mailed by or verbally provided by the Plan.

"NURSING FACILITY" provides continuous skilled nursing services as ordered and certified by the attending physician. A registered nurse (R.N.) must supervise services and supplies on a twenty-four (24) hour basis. A nursing facility must also be licensed under the laws of the state in which it operates.

"ORAL SURGEON" means a dentist licensed to perform diagnosis and treatment of oral conditions requiring surgical intervention.

"OUT-OF-POCKET MAXIMUM" is a specified amount that a participant must pay for covered services, out of his/her pocket, in a calendar year. The out-of-pocket amount is satisfied as indicated on the benefit summary. Once the out-of-pocket maximum has been met, this Plan pays one hundred percent (100%) of the approved charges for covered services.

"OUTPATIENT" means a participant who receives treatment at a hospital, clinic or dispensary or other medical care facility but is not confined to continuous twenty-four (24) hour inpatient care.

"PARTICIPANT" means any covered employee and any covered dependent.

"PHYSICIAN" means a provider of medical services legally licensed to practice medicine and surgery or any other legally licensed practitioner of the healing arts rendering, within the scope of the individual's license, services which are covered under this program and for which benefits are required to be provided by law when rendered by such a practitioner. In no event will the term "physician" include a resident physician, intern, or other individual in training, or a member of the participant's family.

"PLAN" means the Manatts, Inc. Group Health Plan, as set forth herein, and as from time to time amended, which is administered by First Administrators, Inc., the Benefit Services Administrator.

"PLAN ADMINISTRATOR" means the Manatts, Inc. Group Health Plan Trust.

"PLANNED ADMISSION" means an admission that can be scheduled in advance because the condition, illness or injury is not immediately life-threatening.

"PLAN SPONSOR" means an entity that sponsors a health plan. This can be an employer, a union or some other entity. (Also see Part II, 45 Code of Federal Regulations Part 164.501).

"PLAN YEAR" means the twelve (12) consecutive month period commencing on January 1st and ending on the next following December 31st.

"POSTOPERATIVE CARE" means care given following a surgical operation.

"POSTPARTUM" means the period of time following childbirth.

"POST-SERVICE CLAIM" means any claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims for services already received by the participant.

"PPO AREA" means the area encompassing the contracted PPO providers.

"PPO MEMBER" or "PPO PROVIDER" means a contracted health care provider who is a member of a preferred provider organization utilized by this Plan.

"PRE-EXISTING CONDITION" means any limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day.

"PREFERRED PROVIDER ORGANIZATION" or "PPO" means an organization composed of a group of health care providers who have contracted to offer their services at a discount rate in accordance with the formal agreement between the Plan Sponsor and the preferred provider organization.

"PREOPERATIVE CARE" means care occurring, performed, or administered before, and usually close, to a surgical operation.

"PRESCRIPTION DRUG" means covered legend drugs, medicines or medications prescribed by a physician and dispensed by a licensed pharmacist necessary to treat an injury or illness.

"PRE-SERVICE CLAIM" means any claim for a benefit under this Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

"PRIVATE DUTY NURSING" means 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 inpatient setting.

"PROCUREMENT COSTS" mean 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.

"PROSTHESIS" or "PROSTHETIC APPLIANCE" means a device used as an artificial substitute to replace a limb or an eye, used to improve, aid or augment the performance of a natural function. In no event will the term "prosthesis" include devices such as eyeglasses, hearing aids, orthopedic shoes, arch supports, orthotic devices, trusses, or examinations for the prescription or fitting thereof.

"PROTECTED HEALTH INFORMATION (PHI)" means individually identifiable health information (any health information that can be tied back to an individual). (See Part II, 45 Code of Federal Regulations Part 164.501).

"PSYCHOLOGIST" means a person who holds a Ph.D. in clinical psychology, is recognized by the American Board of Examiners in Professional Psychology and who is licensed in and performs such services in accordance with the laws of the state in which such services are provided.

"QUALIFIED BENEFICIARY" means a participant 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)" means a judgment, decree or order (including judicially approved settlement agreements having the effect of an order) which provides for child support with respect to a child of a participant under this Plan or provides health benefit coverage to such a child, and qualifies with the requirements set forth in this Plan. The QMCSO must be a judgment or decree issued by a court of competent jurisdiction or a state agency that administers child support enforcement programs.

"REGISTERED NURSE" means a professional nurse who has the right to use the title registered nurse (RN), other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

"REHABILITATION INSTITUTION" means a legally constituted and operated institution (other than a hospital) established to provide medical treatment for patients who require inpatient care for chemical dependency, but do not currently require continuous hospital services for such condition, and which has permanent facilities for inpatient medical care on the premises, including twenty-four (24) hour nursing service under the supervision of a full-time

registered nurse (R.N.), 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.

"REINSURER" means the insurance company providing the excess risk insurance maintained by the Plan Sponsor.

"ROOM AND BOARD" means all charges commonly made by a hospital for room and meals and for all general services and activities essential to the care of registered bed patients.

"SECOND SURGICAL OPINION" means a consultation with another physician which the Plan may allow to determine the appropriateness of a surgical procedure as the preferred course of treatment as recommended by the attending physician.

"SPECIAL CARE UNIT" means 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 illnesses;
- (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) and other specially trained hospital personnel.

"SPOUSE" means 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. **NOTE:** Effective June 1, 2006, an employee's spouse is a person legally recognized by the state as indicated in Chapter 595 of the Iowa Code. The Plan Administrator may require documentation proving a legal marital status.

"STEPCHILD" means any unmarried biological or adopted child of the spouse of an employee who has not reached the age of nineteen (19), and any unmarried biological or adopted child of the spouse of an employee who has not yet reached the age of twenty-six (26) and is a full-time student in an accredited school.

"SUBCUTANEOUS IMPLANT" means a medication which is surgically placed beneath the skin to release the drug in the bloodstream. An example is the Norplant contraceptive.

"SURGICAL PROCEDURE" means cutting, suturing, treatment of burns, correction of fractures, reduction of dislocations, manipulation of joints under general anesthesia, electro-cauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopy, the injection of sclerosing solutions, and obstetrical procedures.

"TERMINALLY ILL" means having a life expectancy of six (6) months or less due to an illness from which the participant is not expected to recover. This is usually a chronic illness or condition for which there is no known cure.

"TOTAL DISABILITY" and "TOTALLY DISABLED" mean:

- (a) In the case of the covered employee, due to illness or injury, he or she is wholly and continuously prevented from performing the normal duties of his or her regular occupation, including any occupation for which the employee is reasonably qualified by reason of education, training or experience;
- (b) In the case of a covered dependent, due to illness or injury, he or she is wholly and continuously prevented from engaging in substantially all of the normal and customary activities of a person of the same gender and age who is in good health.

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

"VISIT" means each attendance to the covered participant by a physician or medical practitioner (i.e., consultation or treatment).

"WAITING PERIOD" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the Plan can become effective.

"WELL-BABY CARE" or "WELL-CHILD CARE" means pediatric preventive services appropriate to the age of a child as defined by current Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

Group plans which provided coverage for pediatric vaccines as of May 1, 1993, may not reduce or eliminate this coverage. Failure to

comply will result in an excise tax penalty equal to the penalty for plans that fail to provide COBRA coverage.

STATEMENT OF RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). These rights are provided to you below, as required by federal law and regulation.

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office, all plan documents, including insurance contracts, bargaining agreements and copies of all documents such as annual reports (Form 5500) filed by this Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under this Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Plan Description on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under this Plan, if you have creditable coverage from another plan. You should be provided 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 twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of this employee benefit Plan. These persons are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused this Plan.

The employer of a Plan participant may not fire or discriminate against that participant to prevent him or her from obtaining or exercising his or her rights under ERISA.

Enforce Your Rights

If a participant is denied a benefit in full or in part, he or she has a right to know why this was done, to obtain copies of the documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in full or in part, you may file suit in a state or Federal court. In addition, if a participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in Federal court. If Plan fiduciaries are misusing this Plan's money, or if a participant is discriminated against for asserting his or her rights, a participant has the right to file a suit in a Federal court or request assistance from the U.S. Department of Labor. If the participant is successful in the lawsuit, the court may require the other party to pay the participant's legal costs, including attorney's fees. If the participant is unsuccessful, the court may require the participant to pay these costs and fees, for example if it finds the claim was frivolous.

Assistance with your Questions

If a participant has any questions about this Plan, the participant should contact the Plan Administrator. If the participant has any questions about this statement or about his or her rights under ERISA, or if the participant needs assistance in obtaining documents from the Plan Administrator, the participant should contact the nearest office of the Employee Benefits Security Administration, U.S.

Department of Labor, listed in their telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

INFORMATION REQUIREMENTS OF ERISA

Named Fiduciary/
Plan Sponsor: Manatts, Inc. Group Health Plan Trust
1771 Old 6 Road
P.O. Box 535
Brooklyn, IA 52211
641-522-9206

Trust Identification #: 42-1450400

Plan Number: 501

First Administrator's Inc.
Group Number: 50500-50595

Plan Year Ends: December 31

Participants: Active full-time employees, and their dependents, of employers participating in the Manatts, Inc. Group Health Plan Trust

Plan Administrator and
Agent for Legal Process
of Plan: Manatts, Inc. Group Health Plan Trust
1771 Old 6 Road
P.O. Box 535
Brooklyn, IA 52211

Trust Name: Manatts, Inc. Group Health Plan Trust

Trustees: Dan Boyer, Human Resources Director
1771 Old 6 Road
P.O. Box 535
Brooklyn, IA 52211
Frank Heinen, Benefits Coordinator, Manatts, Inc.
1771 Old 6 Road
P.O. Box 535
Brooklyn, IA 52211

Plan Costs: The participating employers and the employees pay the costs of this Plan.

Type of Plan: Group Health Plan

Type of Administration: Contract Administration

Third Party Administrator: First Administrators, Inc.
P.O. Box 8150
Rapid City, SD 57709-8150

Authority to Amend Plan: An officer of Manatts, Inc.

Administration and Plan
Administrator Authority: The Plan is administered through the local offices of the Plan Administrator to which the participant is associated. The Plan Administrator has retained the services of an Independent Benefit Services Administrator experienced in claims processing.

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

The Plan Administrator has the full and final authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including the construction of the language of the Summary Plan Description, and any writing, decision, benefit eligibility and determination, instrument or accounts in connection with same and with the operation of this Plan or otherwise, which shall be binding upon all persons dealing with this Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in their sole discretion, that their original decision was in error or to the extent such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matters.

If the Company or the trust is unable to fund this Plan, the participant may be financially responsible for any incurred and unpaid claims. The Benefit Services Administrator assumes no financial liability.

NOTES