PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION

FOR

LIFESPRINGS/EMMANUEL COLLEGE

EMPLOYEE HEALTH BENEFIT PLAN

G - 4857

PLAN EFFECTIVE DATE:
JANUARY 1, 2008

Lifesprings/Emmanuel College hereby establishes a self-funded health care plan for the benefit of eligible Employees and their eligible Dependents.

The purpose of the Lifesprings/Emmanuel College Employee Health Benefit Plan (the "Plan") is to provide reimbursement for covered charges incurred as a result of Medically Necessary treatment for Illness or Injury of the Company's eligible Employees and their eligible Dependents.

The Company caused this instrument to be executed by its duly authorized officers effective as of the 1st day of January 2008.

LIFESPRINGS/EMMANUAL COLLEGE

By: _____

Title: _____

Date: _____

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FOREWORD

TO ALL EMPLOYEES:

We are all aware of the financial disaster that a family may experience as a result of a serious or prolonged Illness or Accident. The medical benefits available under the Lifesprings/Emmanuel College Employee Health Benefit Plan (the Plan) and described in this Plan document and summary plan description (SPD) are designed to provide some protection for you and your family against such a disaster.

In sponsoring this Plan, the Company has attempted to provide the best coverage possible within the financial limits of both the Company and you. In keeping with this goal, we periodically review the Plan to ensure we maintain an adequate and reasonably priced program. The cost of this Plan is in direct proportion to the Claims paid. Therefore, it is important that all Employees and their families use the Plan wisely so the cost will remain affordable to all of us. In addition, the amount of your contribution to the Plan is subject to change at the discretion of the Company.

The Company has selected **iPROCERT**, a health benefit management service, to provide pre-hospitalization and continued stay review for all persons covered by the Plan. A Covered Person must contact **iPROCERT** at **(800) 319-9416** at least 72 hours prior to any scheduled admission for a medical condition, Mental and Nervous Disorder, or Chemical Dependency treatment. In case of an emergency Hospital admission or emergency surgery, **iPROCERT** must be notified within two working days following admission. Except in certain cases concerning childbirth, as described more fully in this Plan, all Covered Persons must use the **iPROCERT** pre-hospitalization and continued stay review service to obtain full benefits under this Plan.

The administration of the Plan may include pre-admission reviews, length of stay reviews, utilization reviews, retrospective reviews, audits, and managed care; each and all of which to such extent as is appropriate to ensure that neither Covered Persons nor the Company incur avoidable hospitalization or other costs in obtaining quality, appropriate medical care covered by the Plan.

Payment of covered charges will be withheld if pre-certification for treatment is based on a diagnosis for which treatment is covered, but the treatment is actually undertaken for a condition which is not covered by the Plan. In no event will pre-certification guarantee payment of any Claims.

In addition to describing your benefits, this Plan document and SPD explain other important procedures such as how you become eligible and how to file a claim for benefits.

IMPORTANT: If, at any time, you have questions about the Plan, please contact the Plan's Administrative Service Agent, Group Resources®, for assistance. Group Resources® is always available to assist you with your questions.

We are pleased to offer the benefits under this Plan for you and your covered family members as an expression of our appreciation for your efforts on behalf of our Company.

LifeSprings/Emmanuel

PRIVACY OF MEDICAL INFORMATION

We understand that your medical information is private, and we are committed to maintaining the privacy of your medical information. The Plan will follow the policies below to help ensure that your medical information remains private.

Each time you submit a claim to the Plan for reimbursement, and each time you see a health care Provider who is paid by the Plan, a record is created. The record may contain your medical information. In general, the Plan will only use or disclose your medical information without your authorization for the specific reasons detailed below. Except in limited circumstances, the amount of information used or disclosed will be limited to the minimum necessary to accomplish the intent of the use or disclosure.

The Plan does not operate by itself but rather is operated and administered by the Company acting on the Plan's behalf. As a result, medical information used or disclosed by the Plan (as discussed below) necessarily means that the Company is using or disclosing the medical information on behalf of the Plan. As a result, references to the Plan in "PRIVACY OF MEDICAL INFORMATION" shall also be construed as references to the Company to the extent necessary to carry out the actions of the Plan.

PERMITTED USES AND DISCLOSURES. The following categories describe different ways that the Plan may use or disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

Treatment. The Plan may use or disclose your medical information to facilitate medical treatment or services by Providers. The Plan may disclose your medical information to Providers, including doctors, nurses, technicians, pharmacists, medical students, or other hospital personnel who are involved in your care. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

Payment. The Plan may use and disclose your medical information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care Providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care Provider about your medical history to determine whether a particular treatment is Experimental/Investigational, or Medically Necessary or to determine whether the Plan will cover the treatment. The Plan may also share medical information with a utilization review or pre-certification service Provider. Likewise, the Plan may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

Health Care Operations. The Plan may use and disclose your medical information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

Family Members, Relatives, Close Personal Friends. The Plan may disclose your medical information to your family members, relatives, or close personal friends, or any other person identified by you, if the medical information is directly relevant to the family member's, relative's or friend's involvement with your care or payment for your care.

Requirement by Law. The Plan will disclose your medical information when required to do so by federal, state, or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

Aversion of a Serious Threat to Health or Safety. The Plan may use or disclose your medical information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose your medical information in a proceeding regarding the licensure of a physician.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release your medical information as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release your medical information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Plan may disclose your medical information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, the Plan may disclose your medical information in response to a court or administrative order. The Plan may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release your medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- if you are, or are suspected to be, the victim of a crime, under certain limited circumstances, and the Plan Administrator is unable to obtain your agreement;
- about a death the Plan Administrator believes may be the result of criminal conduct;
- about criminal conduct on the Company's premises; or
- in emergency circumstances to report a crime, the location of the crime or victims , or the identity, description, or location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Department of Health and Human Services. The Plan will disclose your medical information to the U.S. Department of Health and Human Services when requested for purposes of determining the Plan's compliance with applicable regulations.

Coroners, Medical Examiners, and Funeral Directors. The Plan may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your medical information to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

DISCLOSURES TO THE COMPANY. The Plan will disclose your medical information to the Company for Plan administration purposes only upon receipt of a certification from the Company that the Plan sets forth the permitted uses and disclosures of medical information by the Company on behalf of the Plan, and that the Company has agreed to the following assurances:

- The Company shall not further use or disclose medical information about you other than as permitted or required by the Plan documents or as required by law;

- The Company shall ensure that any agents, including subcontractors, to whom it provides medical information received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such information;
- The Company shall not use or disclose the medical information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;
- The Company shall report to the Plan any use or disclosure of the medical information that is inconsistent with the permitted uses and disclosures of which it becomes aware;
- The Company shall make its internal practices, books, and records relating to the use and disclosure of medical information received from the Plan available to the Department of Health and Human Services for purposes of determining whether the Plan is complying with applicable regulations;
- The Company shall, if feasible, return or destroy all medical information received from the Plan about you and retain no copies of the information when it is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, to limit further uses or disclosures to those purposes that make such return or destruction infeasible;
- The Company shall ensure that there is adequate separation between the Plan and the Company (as described below);
- The Company shall make your medical information available to you (as described below);
- The Company shall make your medical information available to you for amendment and incorporate any amendment into your medical information (as described below); and
- The Company shall make available the information required to provide you an accounting of disclosures (as described below).

ACCESS TO MEDICAL INFORMATION. The Plan will make your medical information available to you for inspection and copying upon your written request to the Plan Administrator. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

AMENDMENT OF MEDICAL INFORMATION. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. Your request must be made in writing and submitted to the Plan Administrator. In addition, you must provide a reason that supports your request.

The Plan Administrator may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan Administrator may deny your request if you ask the Plan Administrator to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

ACCOUNTING OF DISCLOSURES. If you wish to know to whom medical information about you has been disclosed for any purpose other than (1) treatment, payment, or health care operations, (2) pursuant to your written authorization, and (3) for certain other purposes, you may make a written request to the Plan Administrator.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan Administrator may charge you for the costs of providing the list. The Plan Administrator will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

The accounting will not include disclosure for the purposes of treatment, payment, or health care operations. In addition, the accounting will not include disclosures which you have authorized in writing.

SEPARATION BETWEEN THE PLAN AND THE COMPANY. Only Employees of the Company who are involved in the day-to-day operation and administrative functions of the Plan will have access to your medical information. In general, this will only include individuals who work in the Company's Human Resources or Employee Benefits departments. These individuals will receive appropriate training regarding the Plan's privacy policies. In the event an individual fails to comply with the Plan's provisions regarding the protection of your medical information, the Company will take appropriate action in accordance with its established policy for failure to comply with the Plan's privacy provisions.

OTHER USES OF MEDICAL INFORMATION. Any other uses and disclosures of medical information will be made only with your written authorization. If you provide the Plan authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please note that the Plan is unable to take back any disclosures it has already made with your authorization, and that the Plan is required to retain records of the care provided to you.

HIPAA SECURITY STANDARDS

"HIPAA SECURITY STANDARDS" is intended to bring the Lifesprings/Emmanuel College Employee Group Health Plan (hereinafter "Plan") into compliance with the requirements of 45 C.F.R. § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as "HIPAA SECURITY STANDARDS") by establishing Plan sponsor's obligations with respect to the security of Electronic Protected Health Information. The obligations set forth below are effective on April 21, 2006.

The Plan Documents of the Lifesprings/Emmanuel College Plan are hereby amended as follows:

Electronic Protected Health Information. The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

Plan. The term "Plan" means the Lifesprings/Emmanuel College Employee Health Benefit Plan.

Plan Documents. The term "Plan Documents" means the group health plan's governing documents and instruments (*i.e.*, the documents under which the group health plan was established and is maintained), including but not limited to the Lifesprings/Emmanuel College Group Health Plan Document.

Plan sponsor. The term "Plan sponsor" means the entity as defined at section 3(16)(B) of ERISA, 29 U.S.C. § 1002(16)(B). The Plan sponsor is LifeSprings/Emmanuel.

Security Incidents. The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

PLAN SPONSOR OBLIGATIONS. Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan sponsor on behalf of the Plan, the Plan sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

Plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates, receives, maintains, or transmits on behalf of the Plan.

Plan sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures.

Plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information, agrees to implement reasonable and appropriate security measures to protect such Information.

Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

- Plan sponsor shall report to the Plan within a reasonable time after Plan sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information.

- Plan sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter or more frequently upon the Plan's request.

MEDICAL BENEFITS

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Benefits under this Plan are paid according to the provisions, exclusions and limitations described in this Plan, subject to the schedule outlined below.

COINSURANCE

PPO	50%
NON-PPO	40%

Non-PPO Providers will be paid at the PPO rate under the following circumstances:
1) When radiology, anesthesiology, or pathology services are rendered by a Non-PPO Provider at a PPO facility;
2) When no appropriate specialist or facility is available within the PPO network; or
3) When a Non-PPO Provider/facility is used in a Medical Emergency situation.

OUT-OF-POCKET MAXIMUM (Includes prescription drug charges)

PPO	
Single	$2,500
Family	$5,000
NON-PPO	
Single	$6,000
Family	$12,000

Eligible expenses are applied to both the PPO and Non-PPO Out-of-Pocket. The maximum Out-of-Pocket will never exceed the amount of the Non-PPO Out-of-Pocket. After the Out-of-Pocket Maximum has been satisfied, all eligible charges subsequently incurred during that Calendar Year will be paid at 100%. However, penalties, non-covered charges, and charges incurred for the Outpatient treatment of Mental or Nervous Disorders or Chemical Dependency do not apply to the Out-of-Pocket Maximum.

ALLERGY TESTING/INJECTIONS/SERUM

PPO	50%
NON-PPO	40%

AMBULANCE SERVICES

PPO	50%
NON-PPO	40%

BEREAVEMENT COUNSELING

PPO	50%
NON-PPO	40%
Lifetime Maximum	Six visits

BIRTHING CENTERS

PPO	50%
NON-PPO	40%

CHEMICAL DEPENDENCY TREATMENT

Outpatient

PPO 50%
NON-PPO 40%
Maximum Visits Per Calendar Year $2,000

Inpatient

PPO 50%
NON-PPO 40%
Maximum Days Per Calendar Year $2,500
Lifetime Maximum ..... One treatment

Lifetime Maximum $10,000

CHEMOTHERAPY/RADIATION/DIALYSIS

PPO 50%
NON-PPO 40%

CHIROPRACTIC CARE (See Spinal Manipulation)

DIAGNOSTIC LAB & X-RAY

PPO 50%
NON-PPO 40%

DURABLE MEDICAL EQUIPMENT/PROSTHETICS/ORTHOTICS

PPO 50%
NON-PPO 40%

EMERGENCY ROOM SERVICES

PPO 50%
NON-PPO 40%

HOME HEALTH CARE

PPO 50%
NON-PPO 40%
Maximum Per Calendar Year $5,000

HOSPICE CARE

PPO 50%
NON-PPO 40%
Lifetime Maximum ..... 180 days

IMPOTENCE TREATMENT (Includes care, supplies, prescriptions, and services for the diagnosis and treatment of impotence)

PPO 50%
NON-PPO 40%
Lifetime Maximum $3,000

INFERTILITY TREATMENT (Includes care, supplies, prescriptions, and services for the diagnosis and treatment of infertility)

PPO 50%
NON-PPO 40%
Lifetime Maximum $3,000

INPATIENT HOSPITAL SERVICES (Must be pre-certified or a penalty will apply)

PPO 50%
NON-PPO 40%

The Maximum Eligible Charge for Room and Board in a Hospital will be:
a) for a semi-private room, the average semi-private room rate of the Hospital;
b) for a private room, the average semi-private room rate of the Hospital; and
c) for intensive care, coronary care, and neonatal intensive care, the actual amount charged.

LIFETIME MAXIMUM BENEFIT $2,000,000

MATERNITY SERVICES

PPO 50%
NON-PPO 40%

MENTAL AND NERVOUS DISORDERS TREATMENT

Outpatient

PPO 50%
NON-PPO 40%
Maximum Visits Per Calendar Year ..... 30 visits

Inpatient

PPO 50%
NON-PPO 40%
Maximum Days Per Calendar Year ..... 30 days

OCCUPATIONAL THERAPY

PPO 50%
NON-PPO 40%
Maximum Per Calendar Year $2,000

ORTHOTICS/PROSTHETICS

PPO 50%
NON-PPO 40%

OUTPATIENT HOSPITAL SERVICES

PPO 50%
NON-PPO 40%

OUTPATIENT SURGERY
- **PPO** 50%
- **NON-PPO** 40%

PENALTY FOR FAILURE TO PRE-CERTIFY HOSPITAL ADMISSIONS $400

PHYSICAL THERAPY
- **PPO** 50%
- **NON-PPO** 40%
- **Maximum Per Calendar Year** $2,000

PHYSICIAN'S SERVICES
- **PPO** 50%
- **NON-PPO** 40%

PRE-ADMISSION TESTING
- **PPO** 50%
- **NON-PPO** 40%

PRIVATE DUTY NURSING
- **PPO** 50%
- **NON-PPO** 40%
- **Maximum Per Calendar Year** $2,500

SECOND SURGICAL OPINION
- **PPO** 50%
- **NON-PPO** 40%

SKILLED NURSING FACILITY CARE
- **PPO** 50%
- **NON-PPO** 40%
- **Maximum Days Per Calendar Year** ..... 120 days

SPEECH THERAPY
- **PPO** 50%
- **NON-PPO** 40%
- **Maximum Visits Per Calendar Year** ..... 30 visits

SPINAL MANIPULATION TREATMENT
- **PPO** 50%
- **NON-PPO** 40%
- **Maximum Per Calendar Year** $750

TEMPOROMANDIBULAR JOINT DISORDER

PPO	50%
NON-PPO	40%
Lifetime Maximum	$15,000

WELLNESS EXPENSE (Includes immunizations, flu shots, mammogram, (annually for Covered Persons age 40 and over) pap smear, prostate exam, routine exam, routine lab and x-ray, bone density testing, routine colonoscopy, Well Child Care, hearing and vision exams (birth through age 24))

PPO	50%
NON-PPO	40%
Maximum Per Calendar Year	$500

WOMEN'S HEALTH AND CANCER RIGHTS ACT. Pursuant to the Women's Health and Cancer Rights Act of 1998, this Plan provides benefits for Covered Persons for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema). For further details, please see subsection 22 of "ELIGIBLE CHARGES."

PRESCRIPTION DRUG PROGRAM

CVS/CAREMARK PRESCRIPTION DRUG PROGRAM. CVS/CareMark is able to provide many prescriptions for Covered Persons at a discounted price. Prescriptions may be purchased through the CVS/CareMark prescription drug program in two ways. Short-term prescriptions may be filled at local CVS/CareMark Network Pharmacies which will charge a flat fee for up to a 34-day supply of medication. CVS/CareMark home delivery pharmacy service is a mail order prescription drug service which charges a flat fee for a 90-day supply of prescription maintenance drugs, such as birth control pills, ulcer medication, insulin, thyroid medication, etc. When using the mail order option, Employees will need to request two prescriptions from their Physician, one for a two or three week supply to be filled by their local CVS/CareMark pharmacy, and another which can be mailed to the CVS/CareMark home delivery service for the remainder of their 90-day supply. Regardless of whether the Covered Person uses the drug card or mail order option, the Covered Person will be responsible for the actual prescription cost.

PRESCRIPTION DRUG CARD PROGRAM (PPO Out-of-Pocket applies)

Cost For Each Prescription or Refill (30-day supply)

Name Brand	50% of prescription cost
Generic Drugs	50% of prescription cost

MAIL ORDER DRUG PROGRAM (PPO Out-of-Pocket applies)

Cost For Each Prescription or Refill (90-day supply)

Name Brand	50% of prescription cost
Generic Drugs	50% of prescription cost

Prescriptions not purchased through the mail order or drug card program may be filed with Group Resources® and may be reimbursed at 40% subject to the Non-PPO Out-of-Pocket. The per prescription cost is not eligible for reimbursement under the Plan.

Some drug expenses which are not covered:

* Any drug or device that prevents implantation of a fertilized egg;
* Any charge for the administration of a covered prescription drug;
* Any drug that is consumed or administered at the place where it is dispensed;
* Devices of any type, even though such devices may require a prescription. These include, but are not limited to therapeutic devices, artificial appliances, braces, support garments, or any similar device;
* Drugs which are Experimental/Investigational (see "EXCLUSIONS AND LIMITATIONS" for further details);
* Any drug not approved by the FDA;
* FDA approved drugs that are prescribed for non-FDA approved uses;
* Immunization agents or biological sera;
* Infertility medication (Covered under "MEDICAL BENEFITS" up to the stated limit);
* Charges excluded under "EXCLUSIONS AND LIMITATIONS";
* Prescription drugs which may be properly received without charge under local, state, or federal programs;

* Drugs that can legally be bought without a written prescription. This does not apply to injectable insulin;
* Weight loss medication;
* Growth hormones or any other drugs which enhance physical growth, athletic performance, or appearance;
* Impotence medication (Covered under "MEDICAL BENEFITS" up to the stated limit);
* Cosmetic medication, such as anabolic steroids, Retin A, or medications for hair growth or removal;
* Drugs that are to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs on its premises;
* Vitamins or dietary supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride;
* Any refill that is requested more than one year after the prescription was written;
* Any refill that is more than the number of refills ordered by the Physician; and
* Smoking cessation products (i.e. nicotine gum and patches).

This is not a complete list of drugs that are excluded. Please contact CVS/CareMark at (800) 519-8374 to determine specific drug coverage.

ORGAN AND/OR TISSUE TRANSPLANT

Pre-Authorization Requirement for Organ Transplant. Expenses incurred in connection with any organ or tissue transplant listed in this provision will be covered subject to referral to and pre-authorization by the Plan Administrator's authorized review specialist. (Cornea transplants are not subject to the pre-authorization provision, but will be considered on the same basis as any other medical expense coverage under this Plan.) Transplant coverage is offered under this Plan through a preferred Provider network of specialized professionals and facilities. Coverage is also provided for Transplant services obtained outside of the preferred network, at a reduced benefit level.

As soon as reasonably possible, but in no event more than ten days after a Covered Person's attending Physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or his Physician should contact the Plan Administrator for referral to the network's medical review specialist, for evaluation and pre-authorization. A comprehensive treatment plan must be developed for this Plan's medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e. name and address of the Hospital), any secondary medical complications, a five year prognosis, two qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment (One or both confirming second opinions may be waived by the Plan's medical review specialist). Additional attending Physician's statements may also be required. The Covered Person may provide a comprehensive treatment plan independent of the preferred Provider network, but this will be subject to medical appropriateness review and may result in non-network benefit coverage. All potential transplant cases will be assessed for their appropriateness for Large Case Management.

Failure to pre-authorize a transplant procedure will result in the application of a $5,000 deductible to all covered expenses incurred as a result of the transplant. This deductible is in addition to any other Plan deductible and co-payment requirements that would normally be applicable to the transplant procedure.

Organ Transplant Network. As a result of the pre-authorization review the Covered Person will be asked to consider obtaining transplant services from a participating Outcome-Based Transplant Network facility arranged by the Plan Administrator. The purpose of designating Outcome-Based Transplant Networks is to perform necessary transplants in the most appropriate setting for the procedure, to improve the quality and probability of a successful outcome, and reduce the average cost of the procedures.

There is no obligation for the patient to use a participating transplant network facility. However, benefits for the transplant and its related expenses may vary depending on whether services are provided in or out of the transplant network.

If a transplant is performed out of network, but the Covered Person has received approval for the Plan's medical review specialist for out of network services, then network benefits will apply to the transplant and its related expenses. If services are provided out of network without approval from the medical review specialist, then out of network benefits will apply.

Transplant Benefit Period. Covered transplant expenses will accumulate during a Transplant Benefit Period, and will be charged toward the transplant benefit period maximums, if any, shown in the Transplant Schedule of Benefits. The term "Transplant Benefit Period" means the period beginning on the date of the initial evaluation and ending on the date twelve consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is re-infused is considered the date of the transplant.)

Covered Transplant Expenses. The term "covered expenses" with respect to transplants includes the Reasonable and Customary expenses for services and supplies which are covered under this Plan (or which are specifically identified as covered only under this provision) and which are Medically Necessary and appropriate to the transplant, including:

1) Charges incurred in the evaluation, screening, and candidacy determination process.

2) Charges incurred for organ transplantation.

3) Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits.

   Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving, and transporting the organ.

   Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care.

   If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the Covered Person's bone marrow (autologous) or the donor's marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, and treatment and storage cost of the marrow, up to the time of reinfusion. (The harvesting of the marrow need not be performed within the transplant benefit period.)

4) Charges incurred for follow up care, including immuno-suppressant therapy.

5) Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two other individuals. In addition, all reasonable and necessary lodging and meal expenses incurred during the transplant benefit period will be covered up to a maximum of $10,000 per transplant period.

Re-transplantation. Re-transplantation will be covered for up to two re-transplants, for a total of three transplants per person, per lifetime. Each transplant will be subject to the Pre-Authorization Requirement for Organ Transplant. Each transplant and re-transplant will have a new benefit period and a new maximum benefit, subject to the Plan's overall per-person maximum lifetime benefit.

Accumulation of Expenses. Expenses incurred during any transplant period for the recipient and for the donor will accumulate towards the recipient's benefit and will be included in the Plan's overall per-person maximum lifetime benefit.

Donor Expenses. Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a participant under this Plan are limited to a maximum of $10,000 per transplant benefit period when the transplant services are provided out of network. This does not include the donor's transportation and lodging expenses.

Pre-Existing Conditions Limitation. Transplant charges will be subject to this Plan's pre-existing conditions limitation.

CENTERS OF EXCELLENCE NETWORK BENEFITS. Network for "ORGAN AND/OR TISSUE TRANSPLANT" is Centers of Excellence, call Group Resources® at (770) 623-8383.

Transplant Procedure	Network Benefits	Non-Network Benefits
Heart	100% of eligible charges	100% of eligible charges, up to an overall maximum of $110,000 including a Physician's maximum of $20,000.
Lung	100% of eligible charges	100% of eligible charges, up to an overall maximum of $155,000 including a Physician's maximum of $20,000.
Bone Marrow	100% of eligible charges	100% of eligible charges, up to an overall maximum of $130,000 including a Physician's maximum of $20,000.
Liver	100% of eligible charges	100% of eligible charges, up to an overall maximum of $130,000 including a Physician's maximum of $20,000.
Heart/Lung	100% of eligible charges	100% of eligible charges, up to an overall maximum of $150,000 including a Physician's maximum of $20,000.
Pancreas	100% of eligible charges	100% of eligible charges, up to an overall maximum of $70,000 including a Physician's maximum of $20,000.
Kidney	100% of eligible charges	100% of eligible charges, up to an overall maximum of $55,000 including a Physician's maximum of $20,000.
Kidney/Pancreas	100% of eligible charges	100% of eligible charges, up to an overall maximum of $95,000 including a Physician's maximum of $20,000.

SECOND SURGICAL OPINION PROGRAM

Certain Surgical Procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the "SECOND SURGICAL OPINION PROGRAM" fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective Surgical Procedure. An elective Surgical Procedure is one that can be scheduled in advance that is not an emergency or of a life-threatening nature.

The Covered Person may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available:

1) Appendectomy;
2) Hernia surgery;
3) Spinal surgery;
4) Cataract surgery;
5) Hysterectomy;
6) Surgery to knee, shoulder, elbow, or toe;
7) Tonsillectomy and adenoidectomy;
8) Mastectomy surgery;
9) Cholecystectomy (gall bladder removal);
10) Deviated septum (nose surgery);
11) Prostate surgery;
12) Tympanotomy (inner ear);
13) Hemorrhoidectomy;
14) Salpingo-oophorectomy (removal of tubes/ovaries); and
15) Varicose vein ligation.

DEFINITIONS

As used in this Plan, the following words and phrases shall have the meanings indicated:

ACCIDENT means an incident resulting in Injury that occurs from external forces under unexpected circumstances, and which is in no way the fault of the victim. Injuries to teeth resulting from chewing or biting; as well as sprains and strains resulting from overexertion, excessive use, or overstretching will not be considered Accidental Injuries for purposes of medical benefit determination.

ADMINISTRATIVE SERVICE AGENT means the firm providing administrative services to the Plan Administrator in connection with the operation of the Plan, such as maintaining current eligibility data, billing, processing and payment of Claims and providing the Plan Administrator with any other information deemed necessary.

BIRTHING CENTER means any freestanding health facility, place, professional office, or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse, (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

CALENDAR YEAR means each period of time beginning on January 1 and ending on December 31 of the same year.

CHEMICAL DEPENDENCY means a physical, emotional, or physiological dependency on alcohol or drugs (whether legal or illegal) or any type of substance abuse.

COINSURANCE means the percentage of an eligible charge that is paid by the Plan on behalf of the Covered Person.

COMPANY means Lifesprings/Emmanuel College or any affiliate which is participating in the Plan with the permission of LifeSprings/Emmanuel College.

COSMETIC TREATMENT means treatment performed for the purpose of improving appearance rather than for restoring bodily function.

COVERED PERSON means an Employee or a Dependent for whom the coverage provided by this Plan is in effect. A Covered Person may be covered under this Plan as an Employee or as a Dependent, but not both at the same time.

DEPENDENT means a person who meets the requirements of both (1) and (2):

1) is the Employee's spouse or meets the definition of a Dependent of an Employee under the provisions of Section 152 of the Internal Revenue Code of 1986, as amended (determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof); and
2) is an Employee's:
   a) spouse who resides in the United States (unless the spouse is legally separated or divorced from the Employee) and is the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship;
   b) unmarried child less than 19 years of age;
   c) unmarried child less than 24 years of age and a Full-Time Student; or
   d) unmarried child meeting all of the following conditions:
      i) subject to a physical or mental impairment which can be expected to result in death or which has lasted or is expected to last for a continuous period of not less than 12 months; and
      ii) is unable to engage in any substantial gainful activity due to such physical or mental impairment; and
      iii) for whom proof of such physical or mental impairment is submitted to the Plan Administrator within 31 days of the date coverage would have ended as a result of the child's age.

The Plan Administrator may also require at reasonable intervals during the two years following a disabled and/or handicapped Dependent reaching the limiting age, subsequent proof of the child's disability and dependency. After a two-year period, the Plan Administrator may require subsequent proof not more than once each year.

The term "child" includes a natural child, an adopted child at time of placement, a child placed with a Covered Person in anticipation of adoption, a child for whom the Employee or Employee's spouse is Legal Guardian, and a stepchild (if the natural parent remains married to the Employee and resides in the Employee's household) who:

1) has the same principal place of abode as the Employee for more than one-half of the year; and
2) does not provide over one-half of his or her own support for the year.

Notwithstanding the above, the term "child" also includes a child of the Covered Person whose coverage is ordered under a qualified medical child support order (QMCSO).

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records, or iniation of legal proceedings severing parental rights.

The phrase "child placed with a Covered Person in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as to the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child.

Coverage of these pre-adoptive children is required by the federal Omnibus Budget Reconciliation Act of 1993 and no Pre-Existing Conditions provisions are applied to this coverage. This child must be available for adoption and the legal process must have commenced.

For purposes of continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, "Dependent" shall also include any child born to or placed for adoption with a Covered Person during the period of continuation coverage.

In the case of an individual whose parents are divorced, the individual shall be considered the "child" of the parent for whom an exemption is allowed under Section 152(e) of the Internal Revenue Code of 1986, as amended.

The term "Dependent" does not include the legally separated or divorced former spouse of the Employee, any person serving in the armed forces of any country, any person covered under the Plan as an Employee, or any other individual living in the Employee's home who is not eligible as defined. If a husband and wife are both Employees, their children may be considered Dependents of either the husband or wife but not of both.

DURABLE MEDICAL EQUIPMENT means equipment which is:

1) able to withstand repeated use;
2) primarily and customarily used to serve a medical purpose;
3) not generally used by a person in the absence of Illness or Injury; and
4) suitable for use in the home.

EMPLOYEE means any person employed on a regular basis by the Company in the conduct of the Company's regular business, who is regularly scheduled to work at least 30 hours per week, and who is classified by the Company, pursuant to its regular administrative practices, as a common law Employee, excluding any person who (a) is a leased Employee under Code Section 414 (n) or (b) is covered under a collective bargaining agreement which is the subject of good faith bargaining, unless the agreement provides for participation in the Plan.

The term "Employee" shall exclude any individual classified by the Company, in its sole discretion, in a designation which would exclude the person from being considered as an Employee under the Company's customary worker classification procedures, regardless of whether such classification is in error.

FULL-TIME STUDENT means a person who, during each of five calendar months during the year is enrolled in and regularly attending an accredited high school, junior college, college, university, or a licensed trade school for the minimum number of credit hours required by that junior college, college, university, or a licensed trade school in order to maintain Full-Time Student status.

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

HOME HEALTH CARE means the following services and supplies furnished in the home by a Home Health Care agency in accordance with a Home Health Care plan, provided that the Physician certifies that Hospital confinement would otherwise be required:

1) part-time or intermittent nursing care by a Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.) under the supervision of a Registered Nurse (R.N.);
2) Occupational Therapy, Speech Therapy, and Physical Therapy which are provided by a Home Health Care Agency;
3) medical supplies and medications prescribed by a Physician and laboratory services of a Hospital if such items would have been covered while confined in a Hospital.

Home Health Care is provided to a Covered Person in accordance with a Home Health Care plan only if:

1) the Covered Person was confined in a Hospital for at least three consecutive days and the Home Health Care begins within 14 days following this period of Hospital confinement; and
2) the Home Health Care is given for the same or related condition for which the Covered Person was hospitalized.

The term "Home Health Care" does not include:

1) services or supplies not included in the Home Health Care plan;
2) services of a person who ordinarily resides in a Covered Person's home or is a member of the Covered Person's family or the Covered Person's spouse's family;
3) custodial care consisting of services and supplies which are provided to the Covered Person primarily to assist in the activities of daily living;
4) care received in any period during which the Covered Person is not under the continuing care of a Physician; or
5) transportation.

HOSPICE means a public agency or private organization which meets all of the following requirements:

1) is primarily engaged in providing care to terminally ill patients;
2) provides 24-hour care to control the symptoms associated with terminal Illness;
3) has on its staff an interdisciplinary team which includes at least one Physician, one Registered Nurse (R.N.), one social worker and one counselor;
4) is a licensed organization whose standards of care meet those of the National Hospice Organization;
5) maintains central clinical records on all patients;
6) provides appropriate methods of dispensing drugs and medicines; and
7) offers a coordinated program of home care and Inpatient care for the terminally ill patient and the patient's family.

The term "Hospice" does not include an organization or part thereof which is primarily engaged in providing:
1) custodial care;
2) care for drug addicts and alcoholics; or
3) domestic services.

The term "Hospice" does not include an organization or part thereof which is primarily:
1) a place of rest;
2) a place for the aged; or
3) a hotel or similar institution.

HOSPITAL means a place which meets all of the following requirements:
1) is accredited as a general hospital by the Joint Commission on Accreditation of Hospitals;
2) is open at all times;
3) is operated chiefly for the treatment of sick or injured persons as Inpatients;
4) has a staff of one or more Physicians available at all times;
5) provides 24 hour nursing services by Registered Nurses (R.N.'s);
6) includes areas designed for diagnosis and major Surgical Procedures.

The term “Hospital” also includes:
1) a facility operating legally as a mental health Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates; and
2) a facility operating primarily for the treatment of Chemical Dependency if it meets these tests:
    a) maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients;
    b) has a Physician in regular attendance;
    c) continuously provides 24-hour a day nursing service by a registered nurse (R.N.);
    d) has a full-time psychiatrist or psychologist on the staff; and
    e) is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Chemical Dependency.

The term "Hospital" does not include a convalescent facility, nursing home, rest home, Skilled Nursing Facility or a facility chiefly operated for treatment of the aged.

ILLNESS means a disorder of the body or mind, a disease, or pregnancy. All Illnesses which are due to the same cause or to a related cause or causes will be deemed to be one Illness.

INJURY means bodily Injury caused by an Accident and which results directly from the Accident and independently of all other causes.

INPATIENT means an individual confined as a registered bed patient in a Hospital, Skilled Nursing Facility or Hospice.

INTENSIVE CARE/CORONARY CARE/ACUTE CARE UNIT/BURN UNIT means a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This area must have:

1) facilities for special nursing care not available in regular rooms and wards of the Hospital;
2) special life saving equipment which is immediately available at all times;
3) at least two beds for the accommodation of the critically ill; and
4) at least one Registered Nurse (R.N.) in continuous and constant attendance 24 hours a day.

LEGAL GUARDIAN means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

LIFETIME means the maximum benefit while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

MAXIMUM BENEFIT means the maximum amount payable for the period indicated for a Covered Person for all eligible charges incurred while covered under the Plan.

MEDICAL EMERGENCY means a sudden and unexpected onset of a medical condition requiring medical care which the patient secures immediately after the onset and, as a general rule, is a condition which would be life threatening or would cause serious impairment if immediate care were not received. Examples include, but are not limited to heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, or other such acute medical conditions. **Colds, flu, sore throat, or earaches are not Medical Emergencies.**

MEDICALLY NECESSARY means health care services, supplies, or treatment which is:

1) recommended, approved, or ordered by a Physician or Dentist;
2) consistent with the patient's condition or accepted standards of good medical and dental practice;
3) not performed for the convenience of the patient or the Provider of medical and dental services;
4) not conducted for research purposes; and
5) is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

MENTAL OR NERVOUS DISORDER means an Illness, including, but not limited to, a neurosis, psychoneurosis, psychopathy, psychosis, personality disorder, ADD, ADHD, bulimia, anorexia, or any other Illness, the layman's understanding of which is a mental or nervous disorder. Mental or Nervous Disorder does not include Chemical Dependency or any condition resulting therefrom. In the event of any dispute as to the interpretation of this term, the decision of the Plan Administrator shall prevail.

MORBID OBESITY means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables (or similar actuarial tables) for a person of the same height, age and mobility as the Covered Person.

OCCUPATIONAL THERAPY means a program of care which focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks. The therapist evaluates the patient's ability to use his fingers and hands (fine motor skills), perceptual skills, cognitive functioning and eye-hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment.

OUT-OF-POCKET MAXIMUM means the maximum amount that a covered Employee or Dependent will have to pay for covered expenses under the Plan. This does not include non-covered items, penalties, and remaining Coinsurance for the Outpatient treatment of Mental and Nervous Disorders or Chemical Dependency.

OUTPATIENT means an individual receiving medical services, but not confined as a registered bed patient in a Hospital, Skilled Nursing Facility, or Hospice.

OUTPATIENT SURGICAL CENTER means any public or private establishment which:
1) has a staff of Physicians;
2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; and
3) provides continuous Physician and nursing services while patients are in the facility.

PHYSICAL THERAPY means a plan of care provided to return a patient to the highest level of motor functioning possible. The physical therapist extensively evaluates the patient's muscle tone, movement, balance, endurance, ability to ambulate, ability to plan motor movements, strength and coordination. If the patient requires special equipment (such as a wheelchair, walker or splint), the therapist evaluates the patient's ability to use the equipment and determines the correct size and type of equipment for the specific patient. The therapist constructs a program of exercises and movements to maximize the patient's motor skills.

PHYSICIAN means a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.), a Doctor of Podiatry (D.P.M.), a Doctor of Chiropractic (D.C.), an Audiologist, a Certified Registered Nurse Anesthetist (C.R.N.A.), a Licensed Physical Therapist (L.P.T.), a Midwife, an Occupational Therapist, an Optometrist (O.D.), a Physiotherapist, a Psychiatrist, a Psychologist (Ph.D.), a Speech and Language Pathologist, a Licensed Clinical Social Worker (L.C.S.W.), a Master of Social Work (M.S.W.), a Licensed Professional Counselor (L.P.C.), and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency, and who is acting within the scope of his or her license, to the extent that his or her services are covered under this Plan.

Psychiatrists (M.D.), Masters of Social Work (M.S.W.), and Psychologists or counselors (Ph.D.) may bill the Plan directly for Mental and Nervous Disorders and Chemical Dependency services. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

The term "Physician" does not include a person who:
1) is the Covered Person receiving treatment; or
2) is a relative by blood or marriage of the Covered Person receiving treatment.

PRE-ADMISSION TESTING means x-ray and laboratory examinations which:
1) are performed on an Outpatient basis;
2) are performed within seven days of a scheduled surgery which is performed within 48 hours following the Covered Person's admission to the Hospital; and
3) are related to the Illness or Injury that caused Hospital confinement or the need for surgery.

PREFERRED PROVIDER ORGANIZATION (PPO) means the Plan has retained the services of a Preferred Provider Organization in order to provide quality medical care to participants who are within the PPO's area of operation, at lower cost to both the Plan and participants. PPOs vary among the type of services to be provided. Utilization of PPO network Providers will usually result in an increase in the amount of benefits paid on eligible expenses. A list of the Providers included in the PPO will be furnished automatically, without charge, and is also available on the internet at www.beechstreet.com.

PROVIDER means a Hospital, Physician, or any other person, company, or institution furnishing to a Covered Person an item of service or supply listed as a covered expense in the Plan.

REASONABLE AND CUSTOMARY CHARGE means the ordinary charge made by a person, group, or other entity which provides the services, treatments, or materials in question. It does not include any charge which the Plan Administrator finds to be more than the general level of charges made:
1) by others who provide such services, treatments, or materials;
2) for an Illness or Injury of comparable severity and nature to the Illness or Injury being treated; or
3) to persons in the area where the Covered Person normally resides. The term "area" means a county or such greater area as is determined to be appropriate by the Plan Administrator to obtain a typical cross section of others who provide such services, treatments, or materials.

ROOM AND BOARD means the Hospital's charge for:
1) room and linen service;
2) dietary service, including meals, special diets, and nourishments; and
3) general nursing service.

SKILLED NURSING CARE means those charges incurred for:
1) visiting nurse care by an R.N. or L.P.N. The term "visiting nursing care" means a visit of not more than two hours for the purposes of performing specific Skilled Nursing tasks; and
2) private duty nursing by an R.N. or L.P.N. if the patient condition requires Skilled Nursing services and visiting nurse care is not adequate.

The term "Skilled Nursing Care" does not include:
1) that part or all of any nursing care that does not require the skills of an R.N.; or
2) any nursing care given while the person is an Inpatient in a health care facility that could safely and adequately be furnished by the facility's general nursing staff if it were fully staffed.

SKILLED NURSING FACILITY means a place, or a distinct part of a place, which meets all of the following criteria:
1) is licensed according to state or local laws;
2) provides as its chief purpose Skilled Nursing treatment to patients who are recovering from an Illness or Injury;
3) includes areas for medical treatment;
4) provides 24-hour-a-day nursing services under the full-time supervision of a Physician or a Registered Nurse (R.N.);
5) maintains daily health records for each patient;
6) has an agreement which provides for the services of a Physician;
7) has a suitable method for providing drugs and medicines to patients;
8) has an arrangement with one or more Hospitals for the transfer of patients;
9) has an effective utilization review plan;
10) develops functions with the advice and review of a skilled group which includes at least one Physician; and
11) is not solely a place for:
    a) rest, rehabilitation or custodial care;
    b) the aged;
    c) drug addicts;
    d) alcoholics; or
    e) those who are mentally handicapped or who have mental disorders.

SOUND NATURAL TEETH means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

SPEECH THERAPY means a program of care which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his social interaction skills such as the ability to maintain eye contact and initiate conversation.

SPINAL MANIPULATION/CHIROPRACTIC CARE means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

SURGICAL PROCEDURE includes, but not limited to, incision and excision, sutures, debridement of tissue, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electocauterizing, paracentesis, applying plaster casts, endoscopy, injecting sclerosing solution, arthroscopic procedures, lithotripsy, catheterization, and injections into a joint.

TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME means a jaw/joint disorder causing pain, swelling, clicking, and difficulties in opening and closing the mouth; and complications including arthritis, dislocation, and bite problems of the jaw.

TOTAL DISABILITY or TOTALLY DISABLED means an Injury or Illness which:

1) with respect to an Employee, prevents the Employee from performing the main duties of the Employee's occupation with the Company; and
2) with respect to a Dependent, prevents the Dependent from performing the normal activities of a healthy person of the same age and sex.

WELL CHILD CARE means preventative medical care, i.e., periodic checkups and immunizations as recommended by the AMA Board of Pediatrics.

WHEN COVERAGE BEGINS

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Any change in benefits as a result of a change in the classification will be effective on the date the change in class occurs.

A Covered Person will not receive benefits:
1) for which such person is not eligible; or
2) in excess of the maximum amount provided under any benefit for which the person is covered.

ELIGIBILITY CLASSIFICATION - DESCRIPTION OF ELIGIBLE CLASSES:

All Employees in an eligible class.

No benefits are provided for retired Employees or their Dependents.

REQUIRED EMPLOYEE CONTRIBUTIONS:

Employees do contribute toward the cost of Employee and Dependent coverage.

The amount that Employees contribute is calculated by the Plan Administrator and is a portion of the cost of coverage under the Plan.

ELIGIBILITY FOR EMPLOYEE COVERAGE. An Employee becomes eligible for coverage provided by this Plan on the later of:
1) the effective date of the Plan; or
2) the first day of the month following date of hire.

OPEN ENROLLMENT means the period from December 1 through December 31 during which individuals who are currently enrolled or eligible to enroll in this Plan or any other healthcare plan sponsored by the Company may make changes to their coverage. Coverage under any newly elected option will take effect on January 1 provided the individual is in full-time service on that date, and the enrollment requirements of this Plan have been met. If an Employee does not complete and return a new election form prior to January 1 of each year, the previous year's coverage will remain in effect.

SPECIAL ENROLLMENT RIGHTS. If an Employee declines enrollment for himself or his Dependents (including spouse) because of other health insurance or group health plan coverage, the Employee may in the future be able to enroll himself or his Dependents in this Plan if the Employee or his Dependents lose eligibility for that other coverage (or if an employer stops contributing towards the Employee's or his Dependent's other coverage), provided that the Employee requests enrollment within 31 days after the other coverage ends (or within 31 days after an employer stops contributing towards the other coverage). In addition, if the Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee may be able to enroll himself and his Dependents, provided that the Employee requests enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. The subsection entitled "SPECIAL ENROLLMENT PERIOD" below describes the procedures for Special Enrollment.

SPECIAL ENROLLMENT PERIOD. Notwithstanding any other provisions in the Plan to the contrary, Employees and their Dependents shall be eligible to enroll in the Plan upon the occurrence of one of the following:

1) the Employee or Dependent loses other health coverage and meets the following conditions:
   a) the individual had other health coverage at the time he became eligible for the Plan;
   b) the Employee stated in writing that he was declining to enroll himself and/or his Dependents in the Plan because of the other coverage;
   c) coverage being lost was (i) COBRA coverage that was exhausted, (ii) other coverage for which the individual is no longer eligible (for example, by reason of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or incurring a claim that would meet or exceed a lifetime limit on all benefits under the other coverage), or (iii) provided by another employer which ceased to pay for it. (However, loss of coverage due to a failure to pay premiums will not trigger a Special Enrollment period; nor will loss of coverage for cause [such as making a fraudulent claim or an intentional misrepresentation] trigger a Special Enrollment period); and
   d) the individual makes a request for enrollment under the Plan within 31 days after losing the other coverage.

   If an Employee fails to provide the written statement required under b) above, the Plan may not provide special enrollment to the Employee or any of his Dependents.
2) the Employee marries, has a child, adopts a child, or has a child placed for adoption, and makes a request for enrollment under the Plan within 31 days of such event.

EFFECTIVE DATE FOR EMPLOYEE COVERAGE. Except as stated in "Delayed Effective Date for Employee Coverage" below, coverage for an Employee becomes effective as follows:

1) for a Special Enrollment:
   a) in the case of a loss of coverage, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested;
   b) in the case of marriage, the date which is the first day following date of marriage, provided that special enrollment is timely requested; and
   c) in the case of a Dependent's birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption, respectively, provided that special enrollment is timely requested; and
2) for all other enrollments, the date which is the later of:
   a) the date the Employee becomes eligible for coverage; or
   b) the date the Employee makes written application and written election to pay for coverage provided said application is made within 31 days of the eligibility date.

DELAYED EFFECTIVE DATE FOR EMPLOYEE COVERAGE. If an Employee fails to make written application for coverage within 31 days of his initial eligibility under the Plan (or, fails to request enrollment within 31 days of the occurrence of an event which would entitled him to Special Enrollment, if applicable), he shall be deemed a "Late Enrollee" and he may not apply for coverage until the earlier of (1) the next Open Enrollment period, or (2) a Special Enrollment period.

REHIRED EMPLOYEES. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements, with the exception of an Employee returning to work directly from COBRA coverage. This Employee does not have to satisfy the employment waiting period or pre-existing conditions provision.

EMPLOYEES ON MILITARY LEAVE. Employees going into or returning from military services will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 24 months of extended health care coverage. In cases where leave is for more than 31 days, they cannot be required to pay any more than 102 percent of the full premium. If the Employee performs services for less than 31 days, they cannot be required to pay more than the normal Employee share for such coverage. Regardless of whether extended health care coverage is elected or declined, the Employee is entitled to immediate coverage under the Plan with no pre-existing condition exclusions applied, upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service. Plan exclusion and waiting periods may be imposed for an Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

ELIGIBILITY FOR DEPENDENT COVERAGE. An Employee becomes eligible for Dependent Coverage on the later of:

1) the date the Employee becomes eligible for coverage; or
2) the date the Employee first acquires a Dependent.

EFFECTIVE DATE FOR DEPENDENT COVERAGE. Except as stated in "Delayed Effective Date for Dependent Coverage" below, coverage for a Dependent becomes effective as follows:

1) for a Special Enrollment:
   a) in the case of a loss of coverage, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested;
   b) in the case of marriage, the date which is the first day following date of marriage, provided that special enrollment is timely requested; and
   c) in the case of a Dependent's birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption, respectively, provided that special enrollment is timely requested; and
2) for all other enrollments, the date which is the later of:
   a) the date the Employee becomes eligible for Dependent coverage; or
   b) the date the Employee makes written application and written election to pay for Dependent coverage, provided said application is made within 31 days of the eligibility date.

DELAYED EFFECTIVE DATE FOR DEPENDENT COVERAGE. If an Employee fails to make written application for coverage of the Dependent when the Dependent first becomes eligible (or during a Special Enrollment period, if applicable), the Dependent shall be deemed a "Late Enrollee" and the Employee may not apply for coverage for the Dependent until the earlier of (1) the next Open Enrollment period or (2) a Special Enrollment period.

NEWBORNS. The Employee's newborn child will be covered from the date of birth only if the newborn is properly enrolled as outlined under "Special Enrollment Period." If the newborn is not enrolled within 31 days of the date of birth, enrollment cannot be made until (1) the next Open Enrollment period or (2) a Special Enrollment period.

Inpatient nursery charges for a newborn child will be applied tot eh Covered parent's Out-of-Pocket for the first four days of life. Charges thereafter will be subject to the newborn child's own Out-of-Pocket.

STATUS CHANGE. If a Covered Person changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during, and after the change in status, credit will be given for Out-of-Pockets and for all amounts applied to maximums.

NO MULTIPLE STATUS. You may not have multiple status under the Plan (*i.e.*, you may not receive benefits under this Plan as both an Employee and as a Dependent).

WHEN COVERAGE ENDS

EMPLOYEE COVERAGE. An Employee's coverage will terminate on the earliest of:
1) the date this Plan is terminated;
2) the end of the period for which the last required Employee contribution for the Employee's coverage has been paid;
3) the date the covered Employee ceases to be in a class eligible for coverage under the Plan; or
4) the date on which the covered Employee's employment with the Company terminates.

Ceasing active work is deemed termination of employment unless:
1) the covered Employee is Totally Disabled due to Illness or Injury. In that event, coverage may be continued up to six months during the disability provided required Employee contributions, if any, are made by such covered Employee; or
2) cessation of work is due to an approved leave of absence. In that event, coverage may be continued for up to 12 weeks, in compliance with the Family and Medical Leave Act of 1993. Required contributions, if any, must be made by the covered Employee in accordance with the agreement reached between the Employee and Employer prior to the leave of absence becoming effective.

A covered Employee's coverage for any specific benefit will terminate on the earlier of:
1) the date coverage under the Plan for such benefit ends; or
2) the date the covered Employee ceases to be eligible for that benefit.

DEPENDENT COVERAGE. Dependent coverage will cease for any Dependent on the earliest of:
1) the date the covered Employee's coverage terminates;
2) the date this Plan is terminated;
3) the date Dependent coverage is discontinued under this Plan;
4) the date the covered Employee ceases to be in a class eligible for Dependent coverage;
5) the end of the period for which the last required Employee contribution for Dependent coverage has been paid;
6) the date the covered Employee no longer has any Dependents; or
7) the date the individual ceases to qualify as a Dependent under this Plan.

FULL-TIME STUDENT DEPENDENT COVERAGE. The Full-Time Student Dependent is no longer eligible for medical or dental coverage on the earliest of:
1) the date of graduation;
2) the date he or she turns 24;
3) the date he or she marries;
4) the date he or she voluntarily stops attending school full-time as defined by the institution; or
5) the last day of attendance in any quarter or semester by a Dependent who is a Full-Time Student, unless he or she is off for the summer with intent to resume Full-Time Student status as of the next available quarter or semester.

If the covered Full-Time Student Dependent is unable to attend school full-time because of Illness or Accidental Injury, coverage will terminate on the first day of the next regular semester or quarter, unless he or she has resumed attendance before then.

LIMITED CONTINUATION OF COVERAGE. As described below, and in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), Covered Persons may be able to continue their coverage under this Plan in certain limited circumstances. A Covered Person may elect to continue coverage under this Plan for up to 18 months if his coverage terminates because:

1) the covered Employee's employment is terminated (for reasons other than gross misconduct); or
2) the covered Employee's number of hours of employment is reduced such that he is no longer eligible for coverage under this Plan.

The 18 months of continuation coverage may be extended in two situations: (1) if a Covered Person is determined to be disabled, or (2) another event occurs which would cause a covered Employee's covered Dependent to lose coverage, provided certain notices are timely provided to the Plan Administrator. See the paragraphs below titled "Notice: Disability Extension" and "Notice: Second Qualifying Events."

A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if such Dependent's coverage terminates because:

1) the covered Employee dies;
2) the covered Employee is divorced or legally separated;
3) the covered Employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
4) a child covered under the Plan ceases to be a Dependent.

NOTICE: GENERAL. Covered Person's Responsibility. A Covered Person must notify the Plan Administrator of a divorce or legal separation or when a child ceases to be a Dependent within 60 days of such event. Failure to do so will result in the loss of coverage under this Limited Continuation of Coverage provision. A Covered Person must give this notice prior to the qualifying event or as soon as possible thereafter, and not later than 60 days after the qualifying event occurs. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator.

The "COBRA Notification Form" must be sent, along with applicable documentation indicated on the form (such as a divorce decree, separation order, death certificate, birth certificate, or other documentation verifying a Dependent child's age), to the Plan Administrator at the address listed under "PLAN INFORMATION." When the Plan Administrator receives this notice, it or its designee will notify the applicable Covered Persons (individually or jointly) of the right to elect COBRA coverage.

If a Covered Person fails to provide the Plan Administrator with timely notice when one of these qualifying events occurs, the right to COBRA coverage will be waived. A Covered Person who elects COBRA coverage will have the same annual enrollment rights that apply to active employees.

Company's Responsibility. For other qualifying events (a covered Employee's end of employment or reduction of hours of employment, death of a covered Employee, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both)), the Company will notify the Plan Administrator. When the Plan Administrator receives this notice, it or its designee will notify the applicable Covered Persons (individually or jointly) of the right to elect COBRA coverage.

NOTICE: DISABILITY EXTENSION. If a Covered Person is Totally Disabled under the Social Security definition at the time of a reduction in hours or termination of employment, or becomes disabled within 60 days of beginning COBRA coverage, all Covered Persons with respect to the disabled individual may extend the continuation coverage period an additional 11 months for up to a total of 29 months.

To extend coverage beyond the 18-month period, a Covered Person must notify the Plan Administrator of the Social Security Administration's ("SSA's") determination within 60 days after the later of: (1) the date of the SSA's determination, or (2) the date on which the qualifying event occurs under this Plan, and in all cases before the end of the 18-month period of COBRA coverage. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator, and must be sent, along with a copy of the SSA's disability determination, to the Plan Administrator at the address listed under "PLAN INFORMATION."

If a Covered Person is determined by the SSA to no longer be disabled, the Covered Person must notify the Plan Administrator of that fact within 30 days of the SSA's determination. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator, and which must be sent along with a copy of the SSA's disability determination, to the Plan Administrator at the address listed under "PLAN INFORMATION."

Upon receipt of this notice, COBRA coverage extended beyond the maximum that would otherwise apply will be terminated on the first day of the month which is 30 days after the determination that the Covered Person is no longer disabled.

NOTICE: SECOND QUALIFYING EVENTS. If a covered Dependent experiences another qualifying event while already on COBRA coverage due to the covered Employee's employment termination or reduction in hours, the covered Dependent may elect to extend the period of COBRA coverage for up to 36 months from the date of the employment termination or reduction in hours. For example, assume that the covered Employee and his covered Dependents elect COBRA coverage because of the covered Employee's employment termination.

If the covered Employee dies during the first 18 months of COBRA coverage, the covered Dependents could elect to continue COBRA coverage for up to 36 months from the covered Employee's date of employment termination.

A Covered Person must notify the Plan Administrator of the second qualifying event within 60 days of the second qualifying event. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator and must be sent, along with applicable documentation, to the Plan Administrator at the address listed under "PLAN INFORMATION."

ELECTION. A Covered Person is entitled to an election period of 60 days in which to elect to continue coverage under the Plan. The 60-day election period begins on the date the Covered Person would lose Plan coverage because of one of the events described above, and ends on the later of 60 days following such date or the date the Covered Person is sent a notice about eligibility to elect to continue coverage.

If a Covered Person elects continuation coverage within the 60-day election period, continuation coverage will generally begin on the date regular Plan coverage ceases. If a Covered Person waives continuation coverage, but within the 60-day election period revokes the waiver, continuation coverage will begin on the date the waiver is revoked. A Covered Person may not revoke a waiver after the end of the 60-day election period.

If a Covered Person who is certified as eligible for Trade Adjustment Assistance ("TAA") elects continuation coverage during the second election period described below, continuation coverage will begin on the first day of the second election period.

If a Covered Person does not choose continuation coverage within the 60-day election period, eligibility for continuation coverage under the Plan ends at the end of that period.

However, if a Covered Person fails to make an election during the 60-day election period, and is certified as TAA-eligible under the Trade Act of 2002, the TAA-eligible Covered Person may elect continuation coverage during the 60-day period that begins on the first day of the month in which the individual is certified to be eligible for TAA benefits, but only if the election is made no later than six months after the date of the TAA-related loss of coverage under the Plan (the "second election period").

COST OF CONTINUATION COVERAGE. To receive continuation coverage, the Covered Person, or any third party, must pay the required monthly premium plus a two percent administrative charge. If a Covered Person is eligible for an extension of coverage due to disability, then the cost of continuation coverage will be 150 percent of the normal required monthly premium for all months after the 18th month of continuation coverage.

Each monthly premium for continuation coverage is due on the first day of the month for which coverage is being continued. However, the first such monthly premium is not due until 45 days after the date on which the Covered Person initially elects continuation coverage.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the health Coverage Tax Credit Customer contact center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

BENEFITS UNDER CONTINUATION COVERAGE. If a Covered Person chooses continuation coverage, the coverage is identical to the coverage then being provided under the Plan to similarly situated Employees, their spouses, and their Dependent children who have not experienced a qualifying event. If their coverage changes, continuation coverage will change in the same way.

PAYMENT OF CLAIMS. No claim will be payable under this Limited Continuation of Coverage provision until the Plan Administrator receives the applicable premium.

TERMINATION. A Covered Person's Coverage under this Limited Continuation of Coverage provision will terminate on the earliest of:

1) the date on which the Company ceases to provide a group health plan to any Employee;
2) the date the Covered Person first becomes covered under any other group health plan after electing continuation coverage, provided that applicable law precludes any pre-existing condition exclusion in the new plan from affecting the Covered Person's coverage under the new plan;
3) the date the Covered Person becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
4) the date the required monthly premium is due, if the Covered Person fails to make payment within 30 days after the due date; or
5) the end of the applicable continuation coverage period described above.

In no case will coverage extend beyond 36 months from the original qualifying event, even if a second qualifying event occurs during the continuation coverage period.

ELIGIBLE CHARGES

BENEFITS. Eligible charges will be paid subject to exclusions, limitations and other terms of the Plan. The amount payable for any Eligible Charge will generally be equal to the percentage of the Reasonable and Customary Charge or PPO allowance as described in "MEDICAL BENEFITS."

MAXIMUM BENEFITS. The benefits paid for a Covered Person's Illnesses and Injuries will not exceed the maximum for a Covered Person shown in "MEDICAL BENEFITS." Only charges incurred by a Covered Person while covered under this Plan may be considered "eligible charges." An eligible charge is considered to be incurred on the date a service is provided, and not when the Covered Person is formally billed or pays for the service. Other eligible charges are incurred when the purchase is made. Eligible charges are the Reasonable and Customary Charges or PPO allowance incurred for an Illness or Injury for one or more of the following:

1) Room and Board and routine nursing services for each day of confinement in a Hospital;
2) Intensive or cardiac care Room and Board if Medically Necessary;
3) Medical services and supplies furnished by a Hospital;
4) Anesthetics and their administration by a Physician (see "DEFINITIONS");
5) Fees of Physicians for medical treatment including, but not limited to, fees for Surgical Procedures. When two or more Surgical Procedures occur during the same operative session, the eligible expense is calculated as follows:
   a) if bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Reasonable and Customary Charge or PPO allowance that is allowed for the primary procedure. 50% of the Reasonable and Customary Charge or PPO allowance will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental, and no benefits will be provided for such procedures;
   b) if multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Reasonable and Customary Charge or PPO allowance for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Reasonable and Customary Charge or PPO allowance for that procedure; and
   c) if an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Reasonable and Customary Charge or PPO allowance.
6) Services of a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.) for private duty nursing:
   a) charges incurred for Inpatient care are covered only when Medically Necessary or not custodial in nature and the Hospital's intensive care unit is filled or the Hospital has no intensive care unit; and
   b) charges incurred for Outpatient care are covered only when Medically Necessary and not custodial in nature, and only under the Home Health Care provisions of this Plan. Outpatient care on a 24-hour-shift basis and not billed by a Home Health Care Provider must be pre-certified;
7) Physical Therapy by a licensed physical therapist. Therapy must be in accord with a Physician's exact orders as to type, frequency and duration, and for conditions which are subject to significant improvement through short-term therapy;

8) Speech Therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either surgery for correction of a congenital condition of oral cavity, throat, or nasal complex (other than a frenectomy) of a person, an Injury, or an Illness that is other than a learning or Mental and Nervous Disorder;
9) Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result form an Illness or Injury and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy;
10) Cardiac rehabilitation as deemed Medically Necessary, provided services are initiated within 12 weeks after other treatment for the medical condition ends, and are rendered:
    a) under the supervision of a Physician;
    b) in connection with a myocardial infarction, coronary occlusion, or coronary bypass surgery; and
    c) in a Hospital or Skilled Nursing Facility;
11) Charges for Outpatient skeletal adjustment, adjunctive therapy, vertebral manipulation, and services for the care or treatment of dislocations or subluxations of the vertebrae by an M.D., D.O., or D.C.;
12) X-rays (other than dental), laboratory tests, and other diagnostic services which:
    a) are performed as a result of definite symptoms of an Illness or Injury; or
    b) reveal the need for medical treatment;
13) X-ray and radiation therapy, chemotherapy, and dialysis;
14) Local Medically Necessary professional land or air ambulance service. A charge for this item will be a covered charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary;
15) Medical supplies as follows:
    a) drugs and medicines (including diabetic supplies):
        i) which are approved by the Food and Drug Administration;
        ii) which require the written prescription of a Physician; and
        iii) which must be dispensed by a licensed pharmacist or Physician;
    b) blood and blood derivatives that are not donated or replaced, marrow, or other fluids;
    c) artificial limbs and eyes to replace natural limbs and eyes;
    d) initial purchase, fitting, repair, and adjustment of prosthetic devices, when Medically Necessary;
    e) contact lenses or lenses for standard glasses only if required promptly after, and because of, cataract surgery;
    f) casts, splints, trusses, braces, crutches, and surgical dressings; and
    g) rental or purchase, if less expensive, of Hospital-type equipment including, but not limited to wheelchairs, Hospital beds, and oxygen equipment;
16) Charges for services performed in an Outpatient Surgical Center or Birthing Center;
17) Charges for each day of confinement in a Skilled Nursing Facility if the confinement:
    a) follows a Hospital confinement for which at least three straight days of Hospital Room and Board charges were included as eligible charges under the Plan;
    b) begins within 14 days after the Covered Person is released from such Hospital confinement;
    c) is for treatment of the same Illness or Injury which resulted in such Hospital confinement; and

d) is one during which a Physician is present and consults with the Covered Person at least once every seven days;

18) Second surgical opinion;

19) Routine Inpatient newborn care for a newborn child who is either a Covered Person at the time of birth or is enrolled in the Plan within 31 days of his birth. Routine newborn care includes:
   a) Hospital charges for Room and Board, services, and supplies;
   b) charges related to circumcision; and
   c) fees from Physicians for routine Inpatient pediatric care;

20) Hospice care for a Covered Person who is a terminally ill patient and for members of the Covered Person's family who are also Covered Persons under this Plan. A terminally ill patient is someone who has a life expectancy of six months or less as certified in writing by the Physician who is in charge of the Covered Person's care and treatment. Hospice care expenses for a Covered Person will be limited to the following:
   a) Hospice care in a Hospital-based Hospice, an extended care Hospice facility or nursing home Hospice;
   b) care received from an interdisciplinary team of professionals for Hospice and home care; or
   c) bereavement counseling during the six months following the death of the terminally ill patient, up to a limit of six sessions by a licensed social worker or a licensed pastoral counselor;

21) Home Health Care provided by a Home Health Care Provider if:
   a) on an intermittent basis, the Covered Person requires nursing services, therapy, or other services provided by a Home Health Care Provider;
   b) the Covered Person is Totally Disabled and is essentially confined to the home;
   c) the Covered Person would otherwise have been confined as an Inpatient in a Hospital or Skilled Nursing Facility;
   d) the Covered Person is examined by the attending Physician at least once every 60 days; and
   e) the plan of treatment including Home Health Care is:
      i) established in writing by the attending Physician prior to the commencement of such treatment; and
      ii) certified by the attending Physician at least once every month;

   Eligible Home Health Care services will not include:
   a) custodial care;
   b) meals or nutritional services;
   c) housekeeper services;
   d) services or supplies not specified in the Home Health Care plan;
   e) services of a relative of the Covered Person;
   f) services of any social worker;
   g) transportation services;
   h) care for tuberculosis;
   i) care for Chemical Dependency;
   j) care for the deaf or blind; or
   k) care for senility, mental deficiency, retardation or mental Illness;

22) For Covered Persons undergoing covered mastectomies, and upon consultation with the Covered Person's Physician:
    a) reconstruction of the breast on which the mastectomy has been performed;
    b) surgery or reconstruction of the other breast to produce a symmetrical appearance; and
    c) prostheses and physical complications of all stages of a mastectomy, including lymphedemas;
23) Services related to organ transplants when the Covered Person is the recipient for the following procedures:

a)	cornea;	d)	pancreas;	g)	heart/lung;
b)	heart;	e)	liver;	h)	bone marrow; and
c)	lung;	f)	kidney;	i)	kidney/pancreas.

    See "ORGAN AND/OR TISSUE TRANSPLANT" for guidelines;
24) Charges for Accidental Injury to or care of mouth, teeth, gums, and alveolar processes, but only if that care is for:
    a) excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    b) emergency repair due to Injury to Sound Natural Teeth. Repair must be made within 12 months from date of Accident;
    c) surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth;
    d) excision of benign bony growths of the jaw and hard palate;
    e) external incision and drainage of cellulitis;
    f) incision of sensory sinuses, salivary glands or ducts;
    g) removal of impacted teeth; or
    h) reduction of dislocations and excision of temporomandibular joints (TMJs).

    No charge will be covered under "MEDICAL BENEFITS" for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, or preparing the mouth for the fitting of or continued use of dentures; and
25) Charges incurred for Chemical Dependency and Mental and Nervous Disorders treatment for a semi-private Hospital room and board, miscellaneous facility charges on days a room and board charge is covered, individual psychotherapy, group psychotherapy, psychological testing, family counseling, and convulsive therapy treatment;
26) Diagnosis and treatment of impotence;
27) Diagnosis and treatment of infertility;
28) Maternity expenses incurred by an Employee, spouse, or Dependent;
29) Charges for tubal ligation and vasectomy; and
30) Routine services as outlined in "MEDICAL BENEFITS."

EXCLUSIONS AND LIMITATIONS

ABORTION. No benefits will be paid for services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest. This includes any drug or device that prevents implantation of the fertilized egg.

BREAST SURGERY. No benefits will be paid for that portion of breast surgery which involves the implanting or injecting of any substance into the body for restoring breast shape. Charges will, however be covered as part of the treatment plan for a Medically Necessary mastectomy due to Illness, as set forth in "ELIGIBLE CHARGES." Charges related to the removal of a prosthesis due to medical complications will be covered; however no benefits will be allowed for the replacement of a prosthesis which was originally inserted as a part of a voluntary breast augmentation.

COMPLICATIONS OF NON-COVERED TREATMENT. Except for abortion and breast surgery as outlined above, no benefits will be paid for care, services, or treatment required as a result of complications from a treatment not covered under this Plan.

COSMETIC TREATMENT. No benefits will be paid for Cosmetic Treatment, except for that which:
1) results from an Illness or Injury; or
2) is indicated because of congenital birth defects.

COURT MANDATED. No benefits will be paid for services that are provided due to a court order except as required in the ERISA Requirements section under "MISCELLANEOUS PLAN PROVISIONS."

CUSTODIAL CARE. No benefits will be paid for services which are custodial in nature or primarily consist of bathing, feeding, homemaking, moving the patient, giving medication, or acting as a companion or sitter.

DRUGS - POISON. To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for any Illness or Injury to Covered Persons over the age of seven, which is due to:
1) the voluntary and intentional taking of drugs except those taken as prescribed by a Physician;
2) the voluntary and intentional taking of poison; or
3) the voluntary and intentional inhaling of gas.

However, this exclusion shall not apply to Injuries resulting from an act of domestic violence or a medical condition (physical or mental).

EDUCATIONAL/RECREATIONAL/BIOFEEDBACK. No benefits will be paid for any services or supplies deemed to be educational in nature, or for any services or supplies related to self-care or self-help training and any related diagnostic training.

EXERCISE PROGRAMS. No benefits will be paid for exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, Occupational Therapy, or Physical Therapy covered by this Plan.

EXPERIMENTAL/INVESTIGATIONAL. Benefits will not be paid for any services or supplies which are experimental/investigational in nature. A drug, device, or medical treatment or procedure is experimental/investigational:

1) if the drug or device 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 drug or device is furnished;
2) if reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
   a) maximum tolerated dose;
   b) toxicity;
   c) safety;
   d) efficacy; and
   e) efficacy as compared with the standard means of treatment or diagnosis; or
3) if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
   a) maximum tolerated dose;
   b) toxicity;
   c) safety;
   d) efficacy; and
   e) efficacy as compared with the standard means of treatment or diagnosis.

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

FOOT CARE LIMITATION. No benefits will be paid for any medical services or supplies furnished for the treatment of (a) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, or (b) corns, calluses or toenails, except for surgery performed for a condition listed in (a) or removal of nail roots, and treatment of a condition listed in (b) because of any metabolic or peripheral vascular disease.

GOVERNMENT AGENCIES. No benefits will be paid for Hospital confinement, services, treatments or supplies furnished by the United States or a foreign government or any agency of either, unless federal laws dictate that the Plan is primary.

HAIR LOSS. No benefits will be paid for the care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

HEARING AIDS. No benefits will be paid for examinations to determine the need for, or for the fitting or purchase of hearing aids.

HOSPITAL EMPLOYEES. No benefits will be paid for professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

HOSPITAL WEEKEND ADMISSIONS. No benefits will be paid for the initial Friday or Saturday Room and Board charges incurred in connection with a Hospital confinement which begins on Friday or Saturday except for emergency Hospital admissions or scheduled surgery within the 24 hours immediately following Hospital admission.

ILLEGAL ACTIVITY. No benefits will be paid for any Illness or Injury which is incurred while taking part in an illegal activity, including but not limited to felonies, misdemeanors, or an attempt to commit a crime.

JAW AND JAW JOINTS. No benefits will be paid for osteotomy, orthognathic surgery, or maxillo facial or dental facial orthopedics.

LEARNING/BEHAVIOR DISORDERS. No benefits will be paid for special education, treatment, or training for learning or behavior disorders.

LEGAL DUTY. Coverage is provided only for services and supplies for which the Covered Person has a legal duty to pay.

MARRIAGE COUNSELING. No benefits will be paid for marital or pre-marital counseling.

MEDICALLY NECESSARY. No benefits will be paid for charges which are not Medically Necessary.

NO CHARGE. No benefits will be paid for care and treatment for which there would not have been a charge if no coverage had been in force.

NON-MEDICAL CHARGES. No benefits will be paid for sales tax, interest, charges made for completion of claim forms or for providing supplemental information, or expenses incurred for failure to keep a scheduled appointment.

OTHER. Benefits will not be paid for charges not listed under "ELIGIBLE CHARGES."

OUTSIDE THE UNITED STATES. No benefits will be paid for charges incurred outside the United States if the Covered Person traveled to such location for the sole purpose of obtaining medical services, drugs or supplies or to obtain those services, drugs, and supplies that are unavailable or illegal in the United States.

PERSONAL COMFORT ITEMS. No benefits will be paid for personal comfort items or other equipment such as, but not limited to air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription medications, first-aid supplies, and non-hospital adjustable beds.

PHYSICIAN'S DIRECT CARE. Benefits will be paid only for eligible charges incurred by a Covered Person under the direct care of a Physician.

PRE-EXISTING CONDITIONS. If charges are incurred as a result of an Illness or Injury which the Plan Administrator finds to be pre-existing, payment for such charges will be limited in accordance with "PRE-EXISTING CONDITIONS."

PRESCRIPTIONS/MEDICATIONS. No benefits will be paid for any prescriptions or medications which are excluded under the "PRESCRIPTION DRUG PROGRAM."

REASONABLE AND CUSTOMARY. No benefits will be paid for charges which are more than the Reasonable and Customary charge.

RELATIVE PERFORMING SERVICE. No benefits will be paid for charges for the services of a Physician or any other Provider of services:

1) who usually resides in the same household with the Covered Person; or
2) who is related by blood, marriage or legal adoption to the Covered Person or to the Covered Person's spouse.

REPLACEMENT BRACES. No benefits will be paid for replacement braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

REVERSAL OF STERILIZATION. No benefits will be paid for the reversal of sterilization.

RIOT – CIVIL DISTURBANCE. No benefits will be paid for any Illness or Injury which is incurred while taking part in a riot or civil disturbance.

SELF-INFLICTED. To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for an Illness or Injury which is intentionally self-induced or self-inflicted. However, this exclusion shall not apply to Injuries resulting from an act of domestic violence or a medical condition (physical or mental).

SERVICES BEFORE OR AFTER COVERAGE. No benefits will be paid for care, treatment, or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

SEXUAL DYSFUNCTION. No benefits will be paid for sex change surgery or any treatment of gender identity disorders, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment, except as stated in "MEDICAL BENEFITS."

SLEEP DISORDERS. No benefits will be paid for the treatment of sleep disorders, unless deemed Medically Necessary.

SMOKING CESSATION. No benefits will be paid for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.

TELEPHONE CONSULTATIONS. No benefits will be paid for telephone consultations or for any other charges by a Physician who is not physically present when consulting with the Covered Person.

TREATMENT OF TEETH AND GUMS. Except as described in "ELIGIBLE CHARGES," no benefits will be paid for teeth, gums, alveolar process, or supplies used in such treatment, or for dental appliances.

VISION CARE. Except as outlined in "MEDICAL BENEFITS," no benefits will be paid for:

1) treatment of refractive errors including, but not limited to, eye glasses or contact lenses or the fitting of them, eye exercises, visual therapy, fusion therapy, visual aids or orthoptics, or any related examinations; or
2) Surgical Procedures to eliminate the need for eyeglasses or to correct refractive errors of the eye (such as radial keratotomy, LASIK (laser in-situ keratomileusis) or any other vision enhancement surgery solely to correct nearsightedness, farsightedness or astigmatism), including any confinement, treatment, services, or supplies given in connection with or related to the surgery.

This exclusion does not apply to surgery for cataracts or replacement of the lens of the eye following cataract surgery. This exclusion also does not apply to soft lenses or scleral shells used as corneal bandages.

WAR. No benefits will be paid for any Illness or Injury which is due to revolt, war or any act of war, whether declared or not.

WEIGHT CONTROL. No benefits will be paid for the treatment of, or services or supplies related to, obesity, Morbid Obesity, weight control, or diet, including but not limited to surgery, treatment of complications or adverse reactions to any prior surgery, nutritional counseling, food products, and medications. Medical conditions which may be considered a result of obesity, such as diabetes, high blood pressure, or heart conditions are subject to regular plan benefits.

WORK RELATED ILLNESS OR INJURY. No benefits will be provided for an Illness or Injury:

1) which arises out of or in the course of employment for any employer which is eligible to obtain coverage for its employees under workers' compensation or occupational disease or similar law; or
2) for which the Covered Person is eligible or paid benefits under workers' compensation or occupational disease or similar law.

PRE-EXISTING CONDITIONS

Except as stated below, this Plan does not pay benefits for "pre-existing conditions." However, benefits may be paid for eligible charges related to pre-existing conditions up to $1,000 during the first 12 months. A "pre-existing condition" is any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the individual's enrollment date; provided, however, Genetic Information shall not be treated as a "pre-existing condition" in the absence of a diagnosis of the condition related to such information.

Notwithstanding any other provision of "PRE-EXISTING CONDITIONS" to the contrary, in no event shall a pre-existing condition exclusion apply to the following:

1) pregnancy;
2) a newborn, an adoptee under the age of 18, or a child under the age of 18 placed for adoption with the Employee, so long as the child is enrolled in the Plan within 31 days after birth, adoption, or placement for adoption, whichever is applicable, provided the child is enrolled pursuant to the provisions set forth in "WHEN COVERAGE BEGINS"; and
3) prescription drugs purchased through the “PRESCRIPTION DRUG PROGRAM.”

For purposes of this pre-existing condition section, "enrollment date" means the first day of coverage under the Plan or, if earlier, the first day of the waiting period under the Plan.

An individual covered under the Plan will be subject to these pre-existing condition limitations for the duration of the pre-existing condition exclusion period. For purposes of this Plan, the "pre-existing condition exclusion period" is the 12-month period (18 months for late enrollees) following the enrollment date, as reduced by any period of "creditable coverage."

For purposes of this section, "creditable coverage" means coverage under any of the following:

1) a group health plan;
2) health insurance coverage;
3) coverage under Medicare;
4) coverage under Medicaid (other than coverage consisting solely of the program for distribution of pediatric vaccines);
5) medical coverage for members of the uniformed services and their dependents;
6) medical care programs of the Indian Health Service or other tribal organizations;
7) a state health benefits risk pool;
8) the Federal Employees Health Benefits Program;
9) a public health plan (as defined in federal regulations);
10) health coverage under the Peace Corps Act; and
11) health coverage under the State Children’s Health Insurance Program.

For purposes of this section, the pre-existing condition exclusion period shall be reduced by the days of creditable coverage, excluding any creditable coverage incurred prior to a "break in coverage."

"Break in coverage" means a period of more than 63 days during which an individual has no type of creditable coverage. A break in coverage will not include any Waiting Periods under the Plan or any other plan or insurance coverage.

However, if a Covered Person is certified as eligible for Trade Adjustment Assistance, a break in coverage will not include the period between the loss of health coverage and the beginning of the new special COBRA election period (see 'Cost of Continuation Coverage' under "WHEN COVERAGE ENDS").

To demonstrate evidence of creditable coverage, individuals must present to the Plan Administrator a Certificate(s) of Group Health Plan Coverage, issued by the prior plan(s) or insurance carrier(s), or, in the absence of such Certificate(s), such other evidence of health coverage as may be required by the Plan Administrator, including but not limited to, copies of claim forms, explanations of benefits, pay stubs reflecting premium payments, and summary plan descriptions. If necessary, the Plan Administrator will assist an individual in obtaining the Certificate(s) of Group Health Plan Coverage.

Upon enrollment in the Plan, each individual will be required to provide evidence of creditable coverage to the Plan Administrator. Upon receipt of the evidence of creditable coverage, the Plan Administrator shall review the evidence and will provide to each individual a notice regarding to what extent any pre-existing condition limitation exclusion shall apply to the individual. The notice will contain the name of the Plan, the period to which the pre-existing condition exclusion applies (including the last day of the pre-existing condition exclusion period), the basis for the determination of the exclusion period (including the source and substance of any information on which the Plan relied), an explanation of the right to submit additional evidence of creditable coverage, and notice of the right to appeal the Plan Administrator's decision. Each individual who receives a determination regarding the imposition of a pre-existing condition exclusion period shall have the right to appeal the determination directly to the Plan Administrator and to present additional evidence of prior creditable coverage. For information on appeals procedures, refer to "FILING A CLAIM."

PRE-CERTIFICATION/CONTINUED STAY REVIEW. A Covered Person must call iPROCERT at least 72 hours prior to Hospital admission for a medical condition, Mental and Nervous Disorder, or Chemical Dependency treatment, and in case of an emergency hospitalization, must call within two working days following admission. The number for **iPROCERT** is **(800) 319-9416**.

The Covered Person must provide iPROCERT with the name, address, and birth date of the patient, the names, addresses, and telephone numbers of the Physician and Hospital, and the reason for hospitalization or surgery. The Covered Person is responsible for informing the attending Physician of the requirements of the pre-hospitalization review procedure. Continued stay review is also conducted by iPROCERT.

The iPROCERT medical care counselor will contact the Physician to discuss the proposed admission and treatment plan. If the diagnosis and treatment meet the criteria for Inpatient Hospital care, the counselor and the Physician will discuss the length of time required in the Hospital, as well as any care appropriate for recovery.

If the Covered Person fails to follow the Plan's procedures for pre-admission or continued stay review, the pre-certification penalty described in “MEDICAL BENEFITS” will be applicable.

Payment of covered charges will be withheld if pre-certification for treatment is based on a diagnosis for which treatment is covered, but the treatment is actually undertaken for a condition which is not covered by the Plan.

Pre-certification by iPROCERT does not guarantee coverage or Preferred Provider Organization benefits. It is the Employee's responsibility to verify that the medical facility and Physicians are members of their PPO and that the proposed service is covered by this Plan.

MOTHERS AND NEWBORNS. Notwithstanding any other provision of this "MANAGED CARE " section, the Plan shall not:

1) restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child following (a) a normal vaginal delivery, to less than 48 hours, or (b) a cesarean section, to less than 96 hours, unless discharged earlier by a Physician after consultation with the mother; or
2) require any Covered Person or Provider to obtain authorization under the pre-certification features of this section in conjunction with any such stay that does not exceed the number of hours set forth in 1) above.

CASE MANAGEMENT PROGRAM. The case management program is a special program designed for Covered Persons who are suffering from a complex Illness requiring continued medical care.

Alternate forms of treatment or alternate treatment facilities may be recommended as part of the case management program.

Subject to the Administrative Service Agent's approval, expenses for such alternative forms will be payable under this Plan on the same basis as the treatment or facilities for which they are substituted.

The Administrative Service Agent will have the authority to implement the alternate forms of care and treatment recommended by the case management program.

Case management is a voluntary service. There are no reductions of benefits or penalties if the Covered Person chooses not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

ALTERNATIVE CARE. The Plan may elect to offer benefits for services furnished by any Provider pursuant to an alternative treatment plan for a Covered Person whose condition would otherwise require Hospital care.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost effective, and that the total benefits paid for such services will not exceed the total benefits to which the Covered Person would otherwise be entitled under this Plan in the absence of such alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the right to administer this Plan thereafter in strict accordance with its express terms.

COORDINATION OF BENEFITS

To prevent duplicate benefit payments if a Covered Person is covered under more than one plan, the Coordination of Benefits (COB) provision of this Plan is included to coordinate all the benefits provided by this Plan with benefits payable under any other medical plan or policy.

In this section, the term "plan" means any health care arrangement which provides medical or dental care benefits on an insured or uninsured basis. It includes, but is not limited to:

1) group, blanket, or individual insurance;
2) Hospital or medical service pre-payment plans;
3) labor-management trustee plans, union welfare plans, employer or employee organization plans;
4) government plans or programs;
5) coverage required or provided by law;
6) no fault auto insurance; and
7) third party liability insurance.

COORDINATION PROCEDURES. The procedure hereinafter described will be used to determine the amount of benefits payable under this Plan for a Covered Person when the Covered Person is covered under any other plan. In that event, one plan is the primary plan, and all other plans are secondary, in the order described below.

The primary plan pays its benefits first, without taking other plans into consideration. The secondary plan then pays benefits up to the extent of its liability, after taking into consideration the benefits provided by the other plan. Benefits under any other plan include benefits which the Covered Person could have received if such benefits had been claimed.

If the benefits paid by the secondary plan are less than the Plan would have paid as primary, the unused benefits will be set aside as COB savings. COB savings may be used to pay any benefits which are not covered by the normal payments of the primary and secondary plans, as long as the expense is allowable under one of the plans. COB savings is accrued on a Calendar Year basis and can only be used in the Calendar Year in which it has accrued.

No more than 100% of allowable expenses will be paid by the combination of this Plan, COB savings and any other plan(s). “Allowable expense” means any eligible charges which are Reasonable and Customary, Medically Necessary, and covered under at least one of the Plans. When this Plan is secondary (i.e., when this Plan pays after another Plan), “allowable expense” will include any Coinsurance not paid by the other plan. “Allowable expense” will not include any PPO, HMO, or other Provider discounts. An “allowable expense” will not include an expense incurred when coverage is not in effect under this Plan.

1) If a plan has no COB provision, it is automatically the primary plan;
2) If all the plans have COB provisions, a plan is primary if it covers the person as an employee, and secondary if it covers the person as a Dependent;
3) If a person is covered as a Dependent child under more than one plan:
    a) the plan of the parent whose birthday falls earlier in the year is the primary plan;
    b) if the father and mother share the same birthday, the Plan covering the parent longer is the primary plan;

c) if the other plan coordinates benefits according to the sex of the parents, then the plan that covers the person as a Dependent of a male is the primary plan;
d) if parents are separated or divorced, the following applies:
the plan which covers a child as a Dependent of the parent with legal custody of the child is the primary plan, unless a court decree outlines the obligation for medical expenses for the child in which case the plan which covers the child as a Dependent of the parent with such obligation for medical expenses is primary;

4) When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary;
5) If a plan is no fault auto insurance, required by law, or third party liability insurance, it is the primary plan; and
6) If the primary plan is still not established by the rules above, then the plan that has covered such person for the longest continuous period of time will be the primary plan.

COORDINATION WITH HEALTH MAINTENANCE ORGANIZATION (HMO) OR PREFERRED PROVIDER ORGANIZATION (PPO) PLANS. This Plan will not consider any charges in excess of what an HMO or PPO Provider has agreed to accept as payment in full. When an HMO is the primary plan and the Covered Person did not use the services of an HMO Provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

AUTOMOBILE LIMITATIONS. When medical payments are available under vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan will always be considered the secondary carrier regardless of the Covered Person's election under PIP (Personal Injury Protection) coverage with the auto carrier.

RIGHT TO EXCHANGE DATA. The Plan Administrator has the right to exchange benefit information with any plan, insurance company, organization or person to determine benefits payable using this COB provision. Any such data may be exchanged without the consent of, or notice to, any person. Any person who Claims benefits under this Plan must provide the Plan Administrator with data it requires to apply this provision. Notwithstanding the preceding, the Plan Administrator will comply with applicable federal regulations regarding the privacy of medical information on and after the effective date of such regulations.

PAYMENT AND OVERPAYMENT. If payments have been made under any other plan which should have been made under this Plan, this Plan will have the right to reimburse such other plan to the extent necessary to satisfy the intent of this COB provision. This Plan also has the right to recover any overpayment made because of coverage under another plan. This Plan may recover this overpayment from any insurance company, organization or person to whom or for whom this Plan paid benefits.

GOVERNMENT BENEFITS. Except as set forth below, no benefits will be paid for any services, treatment, or supplies, to the extent that the services, treatment, or supplies were furnished by the United States, a state, a municipality, or a foreign government or any agency thereof, unless federal law dictates that the Plan is primary.

EFFECT OF MEDICARE ON BENEFITS. A covered Employee who reaches age 65, and his spouse, may remain covered by the Plan unless the Employee or spouse makes an election to waive coverage under this Plan and chooses Medicare as the primary payer of benefits. In the event that an Employee or spouse waives coverage under this Plan and thereby elects Medicare as the primary source of benefits, no benefits will be payable under this Plan. If an Employee or spouse who is entitled to Medicare does not waive coverage under the Plan, Medicare will be the secondary payer of benefits.

Notwithstanding the above, Medicare shall be the primary payer of benefits for an individual after the individual's first 30 months of entitlement to Medicare due to end stage renal disease.

SUBROGATION AND REIMBURSEMENT

WHEN THIS PROVISION APPLIES. You or your Dependent(s) (hereinafter "beneficiary") may incur medical or dental expenses because of Illness or Injuries for which benefits are paid by the Plan but which were caused by another party. The beneficiary may therefore have a claim against the other party for payment of the medical or dental expenses incurred. In these instances, the Plan has no duty or obligation to pay claims related to this Illness or Injury. However, if the Plan chooses to pay benefits, it has both a right of Subrogation and a right of Reimbursement. Each right is separate and the waiver of one right by the Plan shall not be deemed to waive the other right. Under the Plan's right of Subrogation, the Plan is subrogated to all of the rights the beneficiary may have against that other party. This right of Subrogation also applies when a beneficiary has a right to recover under an uninsured or underinsured motorist's plan, homeowner's plan, renter's plan, or any other insurance policy under which the beneficiary is insured. The Plan also retains a right of first lien against any monies received by the beneficiary from the other person. Any monies received by a beneficiary or his attorney to which this Plan has a right of Subrogation or Reimbursement shall be held in trust for the benefit of the Plan. Under this right of Reimbursement, the beneficiary will be required to reimburse the Plan out of any monies the beneficiary receives from the other person or on behalf of the other person as a result of judgment, settlement, or otherwise, without regard as to whether the recovery has been apportioned between medical and other damages, and without regard as to whether full or complete recovery of damages has occurred. The Plan specifically rejects the "make-whole doctrine" and the "common-fund doctrine" with respect to its rights of Subrogation and Reimbursement. The Plan will not be responsible for expenses or attorney's fees incurred by a beneficiary in connection with any recovery. Accordingly, beneficiaries must pay their own legal fees. Furthermore, the Plan is subrogated to attorney's fees and expenses in enforcing its rights.

The beneficiary may be required to execute a Subrogation Reimbursement Agreement and/or a Trust Agreement to receive benefits under the Plan. Failure to execute these documents upon request by the Plan Administrator may result in the non-payment of any related Claims. Further, if the beneficiary fails to return signed copies of these documents within the time period specified by the Plan Administrator, the Plan may refuse to pay Claims incurred with respect to the Illness or Injury from the date of your Injury or Illness through the date the Plan Administrator receives the signed documents. If the documents are received after the deadline established by the Plan Administrator, the Plan will pay eligible Claims incurred subsequent to its receipt of the signed documents.

AMOUNT SUBJECT TO SUBROGATION OR REIMBURSEMENT. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or dental benefits paid for the Illness or Injuries under the Plan.

The beneficiary is required to provide information and assistance including testimony or the execution of documents to enforce the Plan's rights of Subrogation and Reimbursement. In addition, the beneficiary must notify the Plan Administrator of any action, judgment, settlement or other recovery for which the Plan has rights of Subrogation and Reimbursement. Further, the beneficiary will do nothing to prejudice the right of the Plan to Subrogation or Reimbursement. The Plan also reserves the right to initiate an action in the name of the Plan or in the name of the beneficiary to recover the Plan's subrogation and/or reimbursement interest.

The beneficiary shall be entitled to recover payment for benefits under the Plan only once. In the event a beneficiary becomes entitled to recovery from the Plan Administrator for a work-related Illness or Injury, and the amount of such recovery includes amounts for medical benefits previously paid by the Plan, the Plan Sponsor shall be entitled to offset the amount of such recovery by the amount of benefits previously paid by the Plan.

DEFINED TERMS

1) **"Recovery"** means monies paid to the beneficiary by way of judgment, settlement, claim, or otherwise by the other party to compensate for the Illness or Injuries sustained;
2) **"Subrogation"** means the Plan's right to pursue the beneficiary's Claims for medical or dental charges against the other party and to be compensated in accordance with appropriate laws and regulations; and
3) **"Reimbursement"** means repayment or reimbursement to the Plan of medical or dental benefits that it has paid toward care and treatment of the beneficiary's Illness or Injuries.

RIGHTS OF RECOVERY. Whenever payments have been made by the Plan with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Plan shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

FILING A CLAIM FOR BENEFITS

To receive benefits under the Plan as quickly as possible, complete the claim forms clearly and accurately.

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a Covered Person or by a representative of a Covered Person, that complies with the Plan's procedure for making benefit Claims.

HOW TO MAKE A CLAIM:

To assist the Administrative Service Agent in processing your Claim, please follow the steps listed below in the order in which they appear.

Step 1) You must provide the Administrative Service Agent with current information regarding other coverage you may have. This information is requested on your enrollment form and must be furnished each year.

Step 2) Also on the enrollment form is an important authorization request, which requires your signature. Your signature allows the Administrative Service Agent to request the necessary information from your Physician, in order to process your Claims for payment. If you have a spouse covered under the Plan, they must also sign this authorization to release information.

Step 3) If items 1 and or 2 above are not on file with the Administrative Service Agent, a Claim form will be requested, which may result in a delay in the processing of your Claim.

Step 4) In the case of Hospital confinement, a form provided by the Hospital must be completed by the Hospital and submitted directly to the Administrative Service Agent.

Step 5) Other bills or receipts relating to a covered expense may be submitted directly to the Administrative Service Agent. All bills must show the following:

a) the employer's name, or group number;
b) the Employee's name;
c) the Employee's social security number;
d) the patient's name;
e) the Physician's name;
f) the type of service rendered;
g) an itemization of the charges;
h) the condition for which the service was incurred;
i) the date of service; and
j) Accident/Injury detail, if applicable (can be provided by the Covered Person on a separate document).

Step 6) A receipt for a prescription drug must show the following:
a) the employer's name, or group number;
b) the Employee's name, or social security number;
c) the name of the drug being prescribed;
d) the prescribing Physician;
e) the prescription number;
f) an itemization for each separate prescription item; and
g) the date of purchase.

Step 7) Forward all related bills and receipts to the Administrative Service Agent for processing.

Step 8) Provide any additional information that may be requested by the Plan or Administrative Service Agent.

TYPES OF CLAIMS AND TIME PERIOD FOR PROCESSING. There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator. A period of time begins at the time the Claim is filed. "Days" means calendar days.

URGENT CARE CLAIM. A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care decision could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or, in the opinion of the attending or consulting Physician, would subject the Covered Person to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

In the case of the Claim involving Urgent Care, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to Covered Person of benefit determination (adverse or not)	72 hours
If there is insufficient information on the Claim, or the Covered Person has failed to follow the Plan's procedure for filing a Claim:	
Notification to Covered Person of deficiency, orally or in writing	24 hours
Response by Covered Person, orally or in writing	Not less than 48 hours
Benefit determination, orally or in writing	48 hours after receipt of additional information or expiration of Covered Person's time to respond
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours
Review of adverse benefit determination	72 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the Covered Person. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Covered Person by telephone, facsimile, or other similarly expeditious method.

PRE-SERVICE CLAIM. A Pre-Service Claim means any Claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification or mandatory second opinions. Please see "MANAGED CARE" for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to Covered Person of benefit determination (adverse or not)	15 days
Extension due to matters beyond the control of the Plan	15 days
If there is insufficient information on the Claim:	
Notification to Covered Person of deficiency	15 days
Response by Covered Person	At least 45 days
Notification, orally or in writing, of failure to following the Plan's procedures for filing a Claim	5 days
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	15 days
Determination as to extending course of treatment	15 days
Review of adverse benefit determination	30 days

POST-SERVICE CLAIM. A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim. In other words, a claim that is a request for payment under the Plan for covered medical services already received by the Covered Person for which no prior approval was required. In the case of a Post-Service Claim, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to Covered Person of benefit determination (adverse or not)	30 days
Extension due to matters beyond the control of the Plan	15 days
If there is insufficient information on the Claim:	
Notification to Covered Person of deficiency	15 days
Response by Covered Person	At least 45 days
Review of adverse benefit determination	60 days

NOTICE OF ADVERSE BENEFIT DETERMINATIONS. Except with Urgent Care Claims (in which event the notification may be given orally followed by written or electronic notification within three days of the oral notification), the Plan Administrator will provide written or electronic notification of any adverse benefit determination. The notice will set forth:

1) the specific reason(s) for the adverse determination;
2) reference to the specific Plan provision(s) on which the determination was based;
3) a description of any additional material or information necessary for the Covered Person to perfect the Claim and an explanation of why such material or information is necessary;
4) a description of the Plan's review procedures and the time limits applicable to such procedures, including any expedited review procedures for urgent care Claims, as well as any other statements required under the law; and
5) a statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

In addition, if the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the Covered Person upon request.

Further, if the adverse benefit determination is based on the fact that the treatment was not Medically Necessary or the Experimental/Investigational exclusion or similar exclusion or limit was applied, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

APPEAL OF ADVERSE BENEFIT DETERMINATION. When a Covered Person receives an adverse benefit determination, the Covered Person has 180 days following receipt of the notification in which to appeal the decision. A Covered Person may submit written comments, documents, records and other information relating to the Claim. If the Covered Person so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The review will take into account all comments, documents, records, and other information submitted by the Covered Person relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the fiduciary will consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

NOTICE OF ADVERSE DETERMINATION ON APPEAL. The Plan Administrator will provide written or electronic notification of an adverse benefit determination on appeal. The notice will set forth:

1) the specific reason(s) for the adverse determination;
2) reference to the specific Plan provision(s) upon which the determination was based;
3) a statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of all document, records, and other information relevant to the Covered Person Claim for benefits; and
4) any other information required by law.

In addition, if the determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included in the notice of adverse determination that such rule, guideline, or protocol was relied on in making the adverse benefit determination and a copy will be provided free of charge upon request.

Further, if the adverse benefit determination was based on Medical Necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided free of charge upon request will be included in the notice of adverse determination.

QUESTIONS ON CLAIMS CALL:

GROUP RESOURCES® AT: (770) 623-8383
MONDAY THROUGH FRIDAY, BETWEEN 8:30 AM AND 5:00 PM EST.
OR VISIT OUR WEBSITE AT: www.groupresources.com

PRE-ADMISSION CERTIFICATION CONTACT:

iPROCERT AT: (800) 319-9416
THIS SERVICE IS AVAILABLE 24 HOURS A DAY, SEVEN DAYS A WEEK.

PROOF OF LOSS. A Claim must be made no later than one year from the date of service unless the Covered Person was legally incapacitated. The Plan Administrator may require, as part of the proof, authorization to obtain medical and non-medical information.

PHYSICAL EXAMINATIONS. The Plan Administrator, at its expense, may have a Covered Person examined as often as reasonably necessary while any Claim is pending.

TIME BAR TO LEGAL ACTION. No legal action may be commenced or maintained against the Plan prior to the Covered Person's exhaustion of the claims procedures. In addition, no legal action may be commenced or maintained against the Plan more than 90 days after the Plan Administrator's decision on review.

MISCELLANEOUS PLAN PROVISIONS

AMENDMENT OR TERMINATION. The continued maintenance of the Plan is completely voluntary on the part of the Company and neither its existence nor its continuation shall be construed as creating any contractual right to or obligation for its future continuation. While the Company intends to continue the Plan indefinitely, it reserves the right at any time and for any reason, in its sole and absolute discretion, through the procedure of an execution of a document by any officer who is authorized, to curtail benefits under, or otherwise amend or terminate the Plan or any portion thereof, including, without limitation, those portions of the Plan outlining the benefits provided or the classes of Employees or Dependents eligible for benefits under the Plan.

PLAN ADMINISTRATOR DISCRETION. The Plan Administrator shall have the sole discretionary authority to construe the terms of the Plan and all facts surrounding Claims for benefits under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, those concerning eligibility for benefits. Accordingly, benefits under this Plan shall be paid only if the Plan Administrator decides at its discretion that an applicant is entitled to them. All determinations of the Plan Administrator shall be conclusive and binding on all parties.

ERISA REQUIREMENTS. Notwithstanding anything in the Plan to the contrary, the Plan will comply with the following requirements of ERISA Section 609:

1) Medical Child Support Orders. The Plan will comply with the requirements of any "qualified medical child support order" as defined in ERISA Section 609(a)(2)(a). The Plan Administrator will develop procedures to determine whether a medical child support order is qualified and for complying therewith. A Covered Person may obtain, without charge, a copy of these procedures upon request to the Plan Administrator;
2) Rights of States where Covered Persons are eligible for medical benefits. The Plan Administrator will comply with the requirements set forth in ERISA Section 609(b) regarding:
    a) assignments of rights;
    b) enrollment and provision of benefits without regard to Medicaid eligibility; and
    c) acquisition by states of rights of third parties;
3) Coverage of Dependent Children in Cases of Adoption. The Plan Administrator will comply with the requirements set forth in ERISA Section 609(c) regarding:
    a) the effective date of insurance for adopted Dependent children; and
    b) the prohibition of restrictions based on pre-existing conditions at the time of placement for adoption.

COMPLIANCE WITH FEDERAL LAWS. The terms of the Plan shall be construed and administered in a manner calculated to meet the requirements of the following laws, as the laws are applicable to this Plan:

1) Americans With Disabilities Act of 1990;
2) Family and Medical Leave Act of 1993;
3) Uniformed Services Employment and Reemployment Rights Act of 1994, as amended;
4) Health Insurance Portability and Accountability Act of 1996, as amended;
5) Personal Responsibility and Work Opportunity Reconciliation Act of 1996;
6) The Newborns' and Mothers' Health Protection Act of 1996;

7) The Mental Health Parity Act of 1996, as amended;
8) The Women's Health and Cancer Rights Act of 1998;
9) The U.S. Trade Promotion Authority Act of 2002; and
10) The Working Families Tax Relief Act of 2004 (H.R.1308).

To the extent a Plan provision is contrary to or fails to address the minimum requirements of these laws, the Plan shall provide the coverage or benefit necessary to comply with the minimum requirements thereof.

NON-DISCRIMINATION. Notwithstanding anything in the Plan to the contrary, the Plan may not discriminate against any individual or a Dependent of that individual with respect to health coverage on the basis of a health factor.

GOVERNING LAW. The Plan shall be governed by ERISA and the regulations promulgated thereunder. Any assignee of a Covered Person under this Plan shall be treated as the Covered Person with respect to any claim or request for payment of expenses for medical services submitted to the Plan, the Plan Administrator, the Plan Sponsor, the Third Party Administrator, or any agent or Employee thereof. Any Claims or causes of action asserted by any Covered Person or assignee shall be subject to ERISA, and no state law Claims or causes of action shall be applicable with respect to any expenses related to the provision of health care services.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s) and defraying reasonable expenses of administering the Plan. These are duties that must be carried out:
1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is a fiduciary named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibilities to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:
1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

ADMINISTRATIVE SERVICE AGENT IS NOT A FIDUCIARY. The Administrative Service Agent is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT. The Plan is not to be construed as a contract for or of employment. Nothing contained in the Plan gives an Employee the right to be retained in the service of the Employer, or to interfere with the right of the Employer to discharge an Employee at any time, with or without cause (subject only to the provisions of any relevant collective bargaining agreement), regardless of the effect that discharge will have upon the Employee's rights under the Plan.

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

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

SEVERABILITY. If any provision, or any portion thereof, contained in this Plan is held to be unconstitutional, illegal, invalid, or unenforceable, the remainder of this Plan shall not be affected and shall remain in full force and effect.

ASSIGNABILITY. Amounts payable at any time may be used to make direct payments to health care Providers. Except as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge, or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge, or otherwise encumber any such amount, whether presently or hereafter payable, shall be void. The Plan shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable under the Plan, or any part thereof.

No appeal rights granted to the Covered Person in this Plan may be assigned, transferred, or in any way made over to another party by a Covered Person. Nothing contained in the written description of the medical coverage shall be construed to make the Plan liable to any third-party to whom a Covered Person may be liable for medical care, treatment, or services.

NATIONAL CORRECT CODING INITIATIVE. Where not otherwise specified, this Plan follows National Correct Coding Initiative ("NCCI") for coding, modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The Plan Administrator has full discretionary authority to select guidelines and/or vendors to assist in determinations.

FINAL DISCRETIONARY AUTHORITY. The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to construe the terms of the Plan and all facts surrounding claims for benefits under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, those concerning the determination of the Reasonable and Customary Charge and eligibility for benefits. Accordingly, benefits under this Plan shall be paid only if the Plan Administrator decides at its discretion that an applicant is entitled to them. All determinations and any construction of the terms of this Plan and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

PLAN INFORMATION

Name of the Plan: LifeSprings/Emmanuel College
Employee Health Benefit Plan

Name, address, and telephone number of the Plan Sponsor and Plan Administrator:

LifeSprings/Emmanuel College
PO Box 9
Franklin Springs, GA 30639
(706) 245-7272

The Plan Administrator is responsible for the administration of the Plan and is the "Named Fiduciary" under the Employee Retirement Income Security Act of 1974, as amended.

Employer Identification Number (EIN): 58-0612610

Plan Number: 501

Type of Plan: Self-Funded welfare benefit plan providing health and hospitalization benefits. Claims under the Plan are paid solely from the general assets of the Company. While the Company may obtain insurance to limit its losses under the Plan, no insurance protects any of the benefits or Claims under this Plan.

Name, address, and telephone number of the Administrative Service Agent:

Group Resources®
3080 Premiere Parkway
Suite 100
Duluth, GA 30097-4904
(770) 623-8383

The designated agent for service of legal process is:

LifeSprings/Emmanuel College
PO Box 9
Franklin Springs, GA 30639

Service of legal process may also be served upon the Plan Trustee or the Plan Administrator.

Names and addresses of the Plan's Trustees:

LifeSprings/Emmanuel College
PO Box 9
Franklin Springs, GA 30639

Claims Administration: The plan is administered by the Plan Administrator, with Group Resources®, an Administrative Service Agent, acting as Claims paying agent.

Plan Funding: Company and Employee contributions cover the cost of the Plan. Company contributions and any Employee pre-tax contributions withheld by way of payroll deduction are held by the Company and used to pay Plan benefits. All Employee contributions to the Plan shall be withheld from the Employee's paycheck on a pre-tax basis unless the Employee requests, in writing to the Plan Administrator, that the required contributions be withheld on an after-tax basis. Any after-tax Employee contributions may be held in trust by the trustee. The amount of all such contributions is actuarially determined where necessary.

The Plan fiscal year ends on: December 31

STATEMENT OF ERISA RIGHTS

As a participant in the Lifesprings/Emmanuel College Employee Health Benefit Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan participants shall be entitled to the following:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

CONTINUE GROUP HEALTH PLAN COVERAGE. Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if you have creditable coverage from another health plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

ENFORCE YOUR RIGHTS. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court subsequent to exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court subsequent to exhausting the Plan's claim procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Miscellaneous Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of Employee Benefits Security Administration at (866) 444-3272.