Health Benefit Plan 2
Summary Plan Description

To All Employees:

At Lauren, we highly value the health and well being of our employees and their dependents. Accordingly, we have designed a health benefit plan that provides valuable coverage for routine health maintenance, as well as for serious or prolonged illnesses or accidents.

This document has been prepared to furnish you with information regarding the benefits you and your eligible dependents have access to under the health benefit program in which you have enrolled. The “Employee Retirement Income Security Act of 1974” (ERISA) requires that all participants be furnished a summary description of their benefit plan. A general outline of the plan and details of your benefits are covered in this booklet.

In an effort to control plan costs without sacrificing quality of coverage, we have elected to adopt a self-insured plan design. In essence, this means that Lauren is the insurance provider. Under this type of plan design, we must understand that the cost of the 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 costs will remain affordable to all participants.

If you have any questions concerning the plan or the information and provisions of this coverage booklet, please consult with the Human Resources department at any time.

Sincerely,

Cleve Whitener, CEO-Chairman

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CLASSIFICATION

Benefits for a Covered Person are determined by the Covered Person's classification and by the terms of this Plan. Any change in benefits as a result of a change in class 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 maximum amounts provided under any benefit for which such person is covered.

DESCRIPTION OF ELIGIBLE CLASSES:

ALL ACTIVE FULL-TIME ADMINISTRATIVE/SALARIED EMPLOYEES
All active full-time administrative/salaried employees working a minimum of thirty (30) hours per week and their eligible dependents.

ADMINISTRATIVE/SALARIED EMPLOYEE'S WAITING PERIOD
A period beginning on the first day of active employment and ending upon completion of zero (0) days of continuous Active Work.

ALL ACTIVE FULL-TIME CRAFT EMPLOYEES
All active full-time craft employees working a minimum of thirty (30) hours per week and their eligible dependents.

CRAFT EMPOLOYEE'S WAITING PERIOD
New Hires
If this is the first time you have been employed with The Lauren Corporation, you are eligible for our employee benefits program on the **first day** of the calendar month following completion of **thirty (30) days** of continuous Active Work**.**

Rehires
A. When an employee has worked for The Lauren Corporation in the past and did complete the waiting period:

    1. If the break in service is less than 13 weeks, the employee may enroll into the plan on the first day of the calendar month following the date of rehire
    2. If the break in service is greater than 13 weeks, the employee must complete the entire New Hire Waiting Period.

B. When an employee has worked for The Lauren Corporation in the past 13 weeks and did not complete the waiting period:

    1. If the employee is rehired **before** thirty (30) days from his/her last termination date, the employee may continue with prior time in the waiting period counting toward meeting the current waiting period.
    2. If the employee is rehired thirty (30) days or longer from his/her last termination date, the employee must complete the entire New hire Waiting Period.

REQUIRED EMPLOYEE CONTRIBUTION

Employees do not contribute toward the cost of Employee Coverage.
Employees do not contribute toward the cost of Dependent Coverage.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

An EMPLOYEE is a person:

(1) whose employment with the Company is:
  (a) on a permanent full-time basis;
  (b) the person's principle occupation; and
  (c) for regular wage or salary.
(2) who is regularly scheduled to work at such occupation at least thirty (30) hours each week;
(3) who is a member of an employee class which is eligible for coverage under this Plan; and
(4) who is eligible to work in the United States pursuant to the Immigration Reform and Control Act of 1986.

Employee does not include a person who:

(1) performs service of a recognized profession, including but not limited to, an attorney or an accountant; and
(2) is paid on a basis other than regular wage or salary.

EMPLOYEE COVERAGE. An Employee becomes eligible for coverage provided by this Plan on the later of:

(1) the Plan's Effective Date; and
(2) completion of the waiting period.

Former Employees whose coverage under the Plan has terminated are required to satisfy the Waiting Period to determine their date of eligibility under this Plan.

A DEPENDENT is a person who:

(1) Meets the definition of the a Dependent or a Spouse under the provisions of the Internal Revenue Code of the United States; and

(2) is a Covered Employee's:
  (a) Spouse (unless the spouse is legally separated from the Covered Employee);
  (b) Child less than 26 years of age;
  (c) unmarried Child over 26 years of age meeting all of the following conditions:
    i. totally and permanently disabled and unable to earn a living (proof of such disability must be submitted to the Company within 30 days of the date coverage would have ended due to the child's age);
    ii. dependent on the Covered Employee for principle support; and
    iii. covered under the Plan on a day prior to the day coverage would have ended due to the child's age.

Spouse
A Spouse is defined as a member of the opposite sex who is legally married (certificate of matrimony) to the employee.

Child
A Child is a Covered Employee's:
(a) son, daughter, stepson, stepdaughter; or
(b) a child legally adopted by the employee or legally placed for adoption; or
(c) an eligible foster child who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Proof of Dependent Eligibility
New Employees and Employees seeking new coverage for their previously non-covered Dependents are required to prove dependent eligibility by supplying the following required documentation:

Dependents	**Documentation Required**
Spouse	Photocopy of marriage certificate
Children	
Natural Child	Photocopy of birth certificate showing name of employee as parent
Step Child	Photocopy of birth certificate showing name of employee's spouse as parent, and a photocopy of marriage certificate showing the names of the employee and spouse
Adopted and Foster Children	Photocopies of Affidavits of Dependency, Final Court Orders with the presiding judge's signature and seal, or Adoption Final Decree with the presiding judge's signature and seal

Documentation must be provided within 30 days of dependent's expected eligibility date for coverage, or the dependent must wait until the next Open Enrollment Period to join the plan.

Michelle's Law
A dependent child age 19 to 26 being covered under the Plan due to their status as a full-time student at an accredited school may continue coverage for up to one year, or until such time as coverage would have otherwise terminated under the terms of the Plan (i.e. reaching the age of 26; parents terminating coverage, etc.), if such continuation is due to a medically necessary leave of absence.
For the purpose of implementing Michelle's Law, a medically necessary leave of absence means a leave of absence of such child from a postsecondary educational institution, or any change of enrolment that:
(a) commences while such child is suffering from a serious illness or injury;
(b) is medically necessary; and
(c) causes such child to lose student status for purposes of coverage under the terms of this Plan.
You must provide the Plan with written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.
At any time, the Company may require proof that a child continues to qualify as a Dependent. In addition to natural and legally adopted children, the word "child" includes a Covered Employee's stepchild if the child:
(1) resides in the Covered Employee's household; and
(2) is dependent on the Covered Employee for principle support.

The term Dependent **does not** include any person serving in the armed forces of any country, a legally separated or divorced former Spouse of the Employee, or any child born to a Dependent child of the Employee.
If a husband and wife are both Covered Employees, their Dependents if any, may be considered as Dependents of either the husband or the wife but not of both. A Covered Person may either be a Covered Employee or a Dependent of a Covered Employee, but not both at the same time.

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

(1) the date the Employee becomes eligible for coverage; and
(2) the date the Employee first acquires a Dependent.
An Employee will again become eligible for Dependent Coverage on the date coverage for the Employee's Dependents under another health care plan is terminated due to an involuntary termination of the spouse's employment.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE COVERAGE. Coverage for an Employee becomes effective on the latest of:

(1) the date the Employee becomes eligible for coverage; or
(2) the date the Employee signs a payroll deduction order, if any part of the cost for this Plan is paid by Covered Employees, and makes written application for coverage.

You will be considered a Late Enrollee, and must wait until the next Open-Enrollment Period to apply for coverage if:

(1) written application for coverage is made more than thirty (30) days after the Employee became eligible for coverage; or
(2) coverage is elected after the Employee has requested;
    (a) termination of coverage; or
    (b) cancellation of payroll deduction.

DEPENDENT COVERAGE. Coverage for an Employee's Dependent will become effective on the latest of:

(1) the date the Employee becomes eligible for Dependent Coverage; or
(2) the date the Employee makes written application for Dependent Coverage and signs a payroll deduction order.

If an Employee acquires a new Dependent while covered for Dependent Coverage, coverage for this Dependent will become effective on the date the Dependent is acquired.

Each Employee's Dependent will be considered Late Enrollee(s), and must wait until the next Open-Enrollment Period to apply for Coverage if the Employee:

(1) makes application for Dependent Coverage more than thirty (30) days after the date such Employee becomes eligible for Dependent Coverage; or
(2) elects to be covered for Dependent Coverage after such Employee has requested:
    (a) termination of the Dependent Coverage; or
    (b) cancellation of the payroll deduction.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A child of a Covered Person who is an alternate recipient under a Qualified Medical Child Support Order (QMSCO) shall be considered as having a right to Dependent coverage under this Plan. You may obtain a copy, free of charge, of the Plan's procedures governing QMSCO's from the Plan Administrator.

GINA

In compliance with the Genetic Information Nondiscrimination Act of 2008, this Plan does not request or require any covered person to undergo genetic testing; and will not base eligibility, premium or contribution amounts or other underwriting decisions on genetic information.

HIPAA ELIGIBILITY PROVISIONS

You and/or your eligible dependents will be considered a Special Enrollee under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) if:

(1) You and/or your eligible Dependent(s) originally declined coverage under this plan because of other health insurance coverage, and you or your Dependents other coverage has ended, but not as a result of a failure to pay premium or for cause (such as making a fraudulent claim); and you and/or your dependent(s) request enrollment under this plan within 30 days after your other coverage ends; or

(2) You and/or your eligible Dependent(s) originally declined coverage under this plan because of coverage under a Medicaid or Children's Health Insurance Plan (CHIP) and you or your dependents coverage has ended; and you and/or your dependent(s) request enrollment under this plan within 60 days after your other coverage ends.

(3) You and/or your eligible Dependent(s) have been determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan; and you and/or your Dependent(s) request enrollment under this plan within 60 days after the eligibility determination date.

(4) You have a new Dependent by birth, marriage, adoption or placement for adoption, and you request enrollment for yourself and/or your Dependents under this plan within thirty (30) days following the birth, marriage, adoption or placement for adoption.

A Special Enrollee is not required to provide evidence of good health in-order for coverage to become effective.

The Plans' Waiting Period will not apply to a Special Enrollee who has been a full-time employee of the Company for a period of time which is equal to or greater than the waiting period, therefore, your enrollment date will be the first date of coverage.

You and/or your Eligible dependents will be considered Late Enrollee(s) if you enroll in the plan at a time other than at the first time you and/or your dependents are eligible to enroll or during a special enrollment period as described above. A Late Enrollee(s) is required to wait until the next Open Enrollment Period to apply for coverage (see the section entitled "Special Limitations and Provisions")

HIPAA NON-DISCRIMINATION STATEMENT

In accordance with HIPAA, and except for late enrollees, eligibility and premium amounts paid under this plan are not based on any of the following factors:

(1) health Status
(2) medical condition
(3) claims experience
(4) medical history
(5) genetic information
(6) evidence of insurability
(7) disability

QUALIFYING EVENTS ALLOWING CHANGES DURING THE PLAN YEAR

The following describes the circumstances under which you may be allowed to add or drop your eligible spouse or dependent children to/from your medical and/or dental insurance under this plan other than during the annual open enrollment period or your initial enrollment period. The spouse or dependent with the qualifying event is **not** the only individual who can make a change or be enrolled as a result of a qualifying event. You have 30 days from the date of the "qualifying" event (or sixty (60) days if the qualifying event is the loss of coverage under Medicaid or SCHIP or becoming eligible for payment assistance under Medicaid or SCHIP) to make an eligible change to your medical or dental coverage. If you make a change during the 30-day period allowed, the change to your coverage will be effective on the later of the first of the month following receipt of the change form **or** the date of the qualifying event, with the following exceptions:

1. Coverage for loss of dependent eligibility will end the last day of the month in which the dependent loses eligibility.
2. The effective date for adding a dependent child due to birth, placement for adoption or adoption will be the date of birth, placement for adoption or adoption, as long as the change form is received in Human Resources within the 30-day period allowed to make a change.
3. Coverage will be reinstated on the day an employee returns to work in an eligible position following leave as allowed under FMLA, USERRA, or unpaid leave of absence.

Evidence of the qualifying event is required. If you do not submit the required information within the time period allowed, you will have to wait until the next open enrollment period to make the change, you may be subject to a pre-existing condition limitation and you may be required to continue payment of premiums under the Flexible Benefits Plan which are not refundable, and for which no benefit may be received under the medical and dental plans.

Please be aware that if you have dependent children covered under your plan and acquire a new dependent child, you MUST enroll the new dependent in the plan within 30 days of acquiring that dependent. Coverage for the additional child is not automatic.

Qualifying Events (Change in Status):

1. A change in legal marital status (marriage, divorce, legal separation, annulment, death of spouse).
2. A change in the number of dependents (birth, adoption, placement for adoption, death). Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.
3. Change in employment status for you, your spouse or dependent (termination or commencement of employment, strike or lockout, commencement or return from an unpaid leave of absence).
4. Change in dependent status (events that cause a dependent to satisfy or cease to satisfy eligibility requirements for coverage).
5. Initial, or change in, legal judgment, court decree or court order that requires coverage for a child who is a dependent of the employee.
6. Change in entitlement to Medicare or Medicaid.
7. Significant cost or coverage changes under another employer's plan (Including a change made by your spouse or dependent during another employer's open enrollment period that differs from the Lauren Corporation's open enrollment period).
8. Loss of coverage under a State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act.
9. Special requirements relating to the Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA).
10. Special enrollment rights allowed under the Health Insurance Portability and Accountability Act of 1996.

TERMINATION OF COVERAGE

If your coverage terminates under this Plan, you may be eligible to continue your benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). See the section entitled "Limited Continuation of Coverage" for details. This plan complies with all provisions of Continuation of Coverage (COC/COBRA).

EMPLOYEE COVERAGE. An Employee's Coverage will terminate on the earliest of:

(1) the date this Plan is terminated;
(2) at 12:00 am Central Standard time on the last day of the Calendar month such Covered Employee ceases to be in an employee class eligible for coverage under the Plan; or
(3) at 12:00 am Central Standard time on the last day of the Calendar month during which such Covered Employee's employment with the Company terminates.

Ceasing Active Work is deemed termination of employment unless:

(1) the Covered Employee is disabled due to Illness or Injury. In that event, coverage may be continued up to six (6) months during the disability provided required Employee contributions are made by such Covered Employee; or
(2) cessation of work is due to a temporary lay-off or approved leave of absence, or a reduction in hours due to business conditions. In that event, coverage may be continued six (6) months after the lay-off or leave began, provided required Employee contributions are made by such Covered Employee.
(3) the Covered Employee is taking leave under the Family Medical Leave Act.

The Company will not discriminate unfairly among Employees in similar situations.

A Covered Employee's coverage for any specific benefit will terminate on the earlier of:

(1) the date coverage for such benefit ends; or
(2) the date the Covered Employee ceases to be eligible for such benefit.

Military Leave

Employees going into or returning from military service will have Plan rights mandated by the Uniform Services Employment and Reemployment Rights Act. These rights include up to 18 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no pre-existing conditions exclusions applied in the Plan upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

DEPENDENT COVERAGE. A Covered Employee's Dependent Coverage will cease for all of the Covered Employee's Dependents 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 last day of the Calendar month during which the Covered Employee ceases to be in an employee class eligible for Dependent Coverage;
(5) the date the Covered Employee no longer has any Dependents;
(6) the date a Dependent ceases to be a Dependent as defined in this Plan; and
(7) the date the Dependent enters the armed forces of a any country as a full-time member if active duty is to exceed thirty (30) days.

Special Notice Regarding Employee Contributions

Employees are responsible for requesting termination of coverage for dependents that lose eligibility within 30 days of the qualifying event. Failure to notify the Human Resources Department in a timely manner could result in payment of premiums under the Flexible Benefits Plan that are not refundable and for which no benefits may be received under the medical and dental plans (Section 125 IRS regulations). Due to IRS regulations, we cannot process a change to the Flexible Benefit Plan that is requested more than 30 days after the event, or loss of coverage due to the event, and the next opportunity to end deductions will be at the next Open Enrollment period.

Certificate of Coverage (HIPAA)

After termination of coverage, upon request, you will be issued a certificate of coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The certificate will show how long you were covered under the Plan and the date your coverage under the Plan ended.

PLAN 2 - SCHEDULE OF MAJOR MEDICAL BENEFITS

MAXIMUM LIFETIME BENEFIT PER PERSON WHILE COVERED UNDER THIS PLAN	Unlimited (applies In- and Out-of-Network)

PHYSICIAN OFFICE VISITS	**IN-NETWORK**	**OUT-OF-NETWORK**
	Deductible applies, Then Plan pays 80%, Employee pays 20%	Deductible applies, then Plan pays 60% Employee pays 40%

HOSPITAL EMERGENCY ROOM	**IN-NETWORK**	**OUT-OF-NETWORK**
	Deductible applies, Then Plan pays 80%, Employee pays 20%	Deductible applies, then Plan pays 80% Employee pays 20%

MINOR EMERGENCY CLINIC	**IN-NETWORK**	**OUT-OF-NETWORK**
	Deductible applies, Then Plan pays 80%, Employee pays 20%	Deductible applies, then Plan pays 60% Employee pays 40%

A $150 penalty will apply to any Non-emergency use of the Emergency Room or Minor Emergency Clinic.

DEDUCTIBLE AMOUNTS PER CALENDAR YEAR

	IN-NETWORK	**OUT-OF-NETWORK**
Individual Deductible	$2,500	$3,000
Family Deductible	$4,500	$6,000

This Plan utilizes an aggregate deductible. If you cover any dependents, the family deductible will be applied to all claims incurred by covered family members. The coinsurance will not apply until the Family deductible has been met. One member of the family could have the entire family deductible applied to their claims

The Deductible is waived for Eligible Charges:

a. for Pre-admission Testing;
b. made by Physicians for Second and Third Surgical Opinions;
c. for Emergencies;
d. for Diabetic Supplies and Insulin
e. for covered Preventive Care Benefits

MAXIMUM OUT-OF-POCKET PER CALENDAR YR.	**IN-NETWORK**	**OUT-OF-NETWORK**
Individual	$6,450	$13,000
Family	$12,900	$26,000

The Plan will pay the Benefit Percentage(s) of Eligible Charges (described below) in excess of the deductible, until Out-of-Pocket Maximum's are met, at which time the Plan will pay 100% of the remainder of Eligible Charges incurred during the current Calendar Year. All deductibles and coinsurance accrue towards the Maximum Out-of-Pocket; penalties of any kind, and reductions in benefits due to usual, reasonable and customary guidelines, do not accrue toward the Out-of-Pocket maximum.

Once the Out-of-Pocket maximum is met, the 100% payment of Eligible Charges (charged either IN or OUT-OF-NETWORK) does not apply to charges for Cost containment penalties, and/or any other penalties

Any Out-of-Network claim that is negotiated and receives a discount will be paid at the In-Network provider benefit level.

PRESCRIPTION DRUGS

	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Payment percentage for eligible Prescription Drugs (Applies to Retail and Mail-Order)	80% after deductible	60% after deductible
Retail Pharmacy		
Generic Birth Control Prescription Medications Approved by the Food and Drug Administration	$0	60% after deductible
Generic Breast Cancer Preventive Medications such as Tamoxifen and Raloxifene for women with an increased risk of developing Breast Cancer	$0	60% after deductible
Generic Drug per prescription	80% after deductible	60% after deductible
Brand Name Drugs on Preferred Drug List*		
Brand Name Drug per prescription when a generic substitute is not available	80% after deductible	60% after deductible
Brand Name Drug per prescription when a generic substitute is available	80% after deductible	60% after deductible
Brand Name Drugs **not** on Preferred Drug List		
Brand Name Drug per prescription when **not** on Preferred Drug List	80% after deductible	60% after deductible
Mail-Order Pharmacy		
Generic Drug per prescription	80% after deductible	60% after deductible
Brand Name Drugs on Preferred Drug List*		
Brand Name Drug per prescription when a generic substitute is not available	80% after deductible	60% after deductible
Brand Name Drug per prescription when a generic substitute is available	80% after deductible	60% after deductible
Brand Name Drugs **not** on Preferred Drug List		
Brand Name Drug per prescription when **not** on Preferred Drug List	80% after deductible	60% after deductible

Each retail prescription purchased with the prescription drug card is limited to the greater of a 30-day supply or a 100-unit dose. Mail-order prescriptions are limited to the greater of a 90-day supply or a 300-unit dose, and three (3) refills.

A Current Participating Pharmacy listing and a detailed description of the current Preferred Drug listing are available through the Human Resources Department.

The Mail-Order program is designed to provide maintenance medications in a convenient, low-cost manner; and is made available if you complete the enrollment form attached to the brochure detailing the Mail-Order program. The brochure is available through the Human Resources Department.

***Preferred Drug List**
The preferred drug list is a menu of preferred medications within selected drug categories. A committee of practicing physicians and pharmacists evaluated all of the medications in these categories. These “preferred drugs” are the most cost effective medications in their class. The purpose of this preferred drug list is to provide you and your healthcare providers with a guide to obtain the highest quality of drugs at the best price.

By selecting generic products or preferred brand name drugs you may reduce your out-of-pocket expense and save money for your health plan. If you’ve been prescribed or you are currently taking a non-preferred brand name drug, you may want to ask your physician if a "preferred" product is right for you.

BENEFIT PERCENTAGE PAID BY PLAN FOR ELIGIBLE CHARGES

HOSPITAL SERVICES

	IN-NETWORK	**OUT-OF-NETWORK**
Room and Board, ICU, Inpatient Surgery, Outpatient Surgery and Facility Charges, Radiology, Anesthesiology and other eligible inpatient and outpatient charges.	80% after deductible	60% after deductible

USE OF OUT-OF-NETWORK RESOURCES

You have the option to use an Out-of-Network medical provider, although your out-of-pocket expenses will be higher and you will not receive the discounted service rates available through In-Network providers. In addition, Out-of-Network providers may charge fees exceeding usual, reasonable and customary rates that are not covered by this Plan and become additional expenses to you.

If a Covered person requires medical care from a provider that is Out-of-Network and there is not an In-Network provider within a 120 mile radius, the benefit level will be out-of-Area. Out-of-Area benefits are subject to the In-Network deductible and maximum out-of-pocket and then pay at 80% not to exceed usual, reasonable and customary limits.

ANCILLARY SERVICES
Under the following circumstances, the In-Network Provider benefit payment will be made for certain Out-of-Network services:

If a covered Person receives services by an Out-of-Network Provider (e.g. anesthesiologist, radiologist, pathologist, etc.) who is under an agreement with an In-Network facility or when an In-Network Provider forwards laboratory samples to an Out-of-Network laboratory. However, all other limitations, requirements, and provisions under the Plan will apply. This exception does not apply in the event of consultations and situations in which the Covered Person and/or the provider selected, or had the opportunity to select, and In-Network Provider and exercised the right to receive services from an Out-of-Network Provider. Referrals by an In-Network Provider to an Out-of-Network Provider, other than an Out-of-Network laboratory, will be considered as Out-of-Network services.

Partial Hospital Confinement
Two days of partial confinement in a Hospital will be considered as one day of confinement. Partial confinement means treatment for at least 3 hours, but no more than 12 hours, in any 24-hour period.

Hospital Weekend Admissions

No benefits will be paid for the initial Friday, Saturday, and Sunday room and board charges incurred in connection with a Hospital confinement which begins on Friday, Saturday or Sunday. Exceptions are made for emergency admissions or scheduled surgery within 24 hours immediately following admission to the Hospital.

	IN-NETWORK	OUT-OF-NETWORK
Pre-Admission Testing	100%	100%

(Testing must be performed on an outpatient basis within seven days before a Hospital confinement, and related to the illness or injury that causes the confinement, and must be in place of tests performed while Hospital confined.)

SECOND/THIRD SURGICALOPINIONS	**IN-NETWORK**	**OUT-OF-NETWORK**
Second and Third Surgical Opinions (Deductible waived)	100%	100%

PENALTY FOR FAILURE TO PRECERTIFY A HOSPITALIZATION OR OUTPATIENT PROCEDURE

An additional $300 deductible will apply if the insured fails to pre-certify a Hospitalization or Outpatient surgery as described in the section entitled “Mandatory Pre-Hospitalization/Surgical Review Procedures”.

ORGAN TRANSPLANT COVERAGE

	IN-NETWORK	OUT-OF-NETWORK
Covered Transplant Procedures	80% after deductible	60% after deductible
Donor Coverage Maximum Benefit	$10,000 (applies in- and out-of-network)	

(The Plan covers a Plan Participant’s charges as a donor whether or not the recipient is a Covered Person under this Plan)

Organ and tissue transplants are covered except those classified as “Experimental and/or Investigational”.

PREVENTIVE CARE BENEFITS

Preventive Care Benefits promote wellness, disease prevention and early detection by encouraging Covered Person’s to have regular preventive examinations.

Services are considered Preventive Care when a Covered Person:

1. Does not have any symptoms or any abnormal studies indicating an abnormality at the time the service is performed;
2. Has had a screening performed within the age and gender guidelines recommended by the U.S. Preventive Services Task Force (USPSTF) with the results being considered normal;
3. Has a diagnostic service with normal results, after which a physician recommends future preventive care screening using the appropriate age and gender guidelines recommended by the USPSTF;
4. Has a preventive service performed which results in a diagnostic service being performed at the same time because it is considered an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy).

Preventive Care Benefits are not subject to copayments, the calendar year deductible or coinsurance and will be paid as noted below. Preventive diagnostic services are defined as laboratory and imaging services performed for preventive and screening purposes, based on the U.S. Preventive Services Task Force (USPSTF) guidelines (these guidelines are available by contacting your claims administrator or visiting www.healthcare.gov/center/regulations/prevention/taskforce.html).

	In-Network	Out-of Network
Primary Care Physician	100%	60% after ded.
Specialist	100%	60% after ded.

Included Preventive Care Benefits
(this is not an exhaustive listing – see the USPSTF A & B Recommendations at the above link for details)

Routine Physical Exams – including immunizations

Adults 19 year of age and older	One per 12 consecutive month period
Children age 3 through age 18	One per 12 consecutive month period
Children under age 3	
First 12 months old:	7 exams (includes routine newborn care)
13 – 24 months old:	3 exams
25 – 36 months old:	3 exams
Routine Gynecological Exam	One exam per calendar year for women

Routine Cancer Screening

Routine mammography	One routine mammogram once every two years for women between the ages of 40 – 50; and once each year for women age 50 and over.
Routine Pap Smear	One test per Calendar Year for women.
Prostate Antigen Test	One test per Calendar Year for males age 35 and over.
Routine Digital Rectal Exam	One test per Calendar year for males age 35 and over.
Fecal Occult Blood Test	One test per Calendar Year for Covered Persons age 50 and older
Sigmoidoscopy	One test per consecutive 5 year period for Covered Persons age 50 and older.
Double Contrast Barium Enema	One test per consecutive 5 year period for Covered Persons age 50 and older.
Colonoscopy	One test per consecutive 10 year period for Covered Persons age 50 and older; or under 50 if considered at high risk for colon cancer

If a health condition is diagnosed during a Preventive Care exam or screening, the preventive exam or screening will continue to qualify for coverage as a Preventive Care Benefit.

Services are considered Diagnostic Care (which do require copayments, deductibles and/or coinsurance), and not Preventive Care, when:

1. Abnormal results on previous preventive or diagnostic screening requires further diagnostic testing or services; or
2. Abnormal test results found on a previous preventive or diagnostic service requires the same test to be repeated sooner than normal age and gender guidelines, as recommended by the USPSTF, would require; or
3. Services are ordered due to current symptom(s) that require further diagnosis.

CONTRACEPTIVE PRESCRIPTION MEDICATIONS AND DEVICES

When the following services/items are received through In-Network providers, they are covered at 100% with no cost-sharing required (copay's, deductibles, and out-of pocket amounts do not apply):

- An outpatient contraceptive service which includes a consultation, examination, procedure, or medical service provided on an outpatient basis and is related to the use of a contraceptive drug or device intended to prevent pregnancy.
- Contraceptive implant systems and devices approved by the US Food and Drug Administration
- Contraceptive drugs and contraceptive drug delivery implants approved by the FDA.

MENTAL AND NERVOUS DISORDERS

	IN-NETWORK	**OUT-OF-NETWORK**
In-patient Mental and Nervous		
Eligible Charges	80% after deductible	60% after deductible
Out-Patient Mental and Nervous		
Eligible Charges	80% after deductible	60% after deductible

SUBSTANCE ABUSE

	IN-NETWORK	**OUT-OF-NETWORK**
In-patient Substance Abuse		
Eligible Charges	80% after deductible	60% after deductible
Out-patient Substance Abuse		
Eligible Charges	80% after deductible	60% after deductible

OTHER PLAN BENEFITS

	IN-NETWORK	**OUT-OF-NETWORK**
Pregnancy	80% after deductible	60% after deductible
Hospice Care Maximum of 210 days	100% deductible waived	100% deductible waived
Home Health Care	80% after deductible	60% after deductible
Private Duty Nursing Care	80% after deductible	60% after deductible
Skilled Nursing Care Facility	80% after deductible	60% after deductible
Chiropractic treatment/Spinal Manipulation Maximum of $1,500 per Calendar Year	80% after deductible	60% after deductible
All Other Benefits Listed as "Eligible Charges" In the Section entitled "Major Medical Benefits	80% after deductible	60% after deductible

MAJOR MEDICAL BENEFITS

DEDUCTIBLE - The Deductible is an amount of Eligible Charges that a Covered Person must incur before Major Medical Benefits will be payable. The Deductible will be met when Eligible Charges equal the Individual Deductible shown in the Schedule of Benefits.

The Covered Person must meet a new Deductible each Calendar Year. A Calendar Year begins on January 1 and ends on December 31 of that same year. Eligible Charges incurred in October, November or December of the preceding year which were applied to the Deductible of the previous calendar year will also be applied to the Deductible for the current Calendar Year.

The Deductible will be applied separately to each Covered Person's Eligible Charges except when the Family Deductible (shown in the Schedule of Benefits) has been met by the Family Unit with Eligible Charges used towards any Individual Deductibles. If the Family Deductible is met, all members of the Family Unit will be in a Benefit Period; and no further Deductible will be required during that Calendar Year, except for Inpatient Hospital Deductible.

In the event that two or more Covered Persons in a single Family Unit are injured in the same accident, each person need not meet a separate deductible for the treatment of injuries incurred in this accident. Only one deductible for the Calendar Year in which the accident occurred will be required for the Family Unit.

CO-PAY – A Co-Pay is an amount of Eligible Charges that a Covered Person must pay each time they receive a particular service under the Plan. Co-Pay's do not accrue toward deductibles.

BENEFIT PERIOD - A Covered Person's Benefit Period begins when the Covered Person has incurred, during the Calendar Year, Eligible Charges equal to the Deductible. A Covered Person's Benefit Period ends on the earliest of the following dates:

(1) the last day of the Calendar Year;
(2) the day such Covered Person's coverage provided by the Plan ends; or
(3) the day the Maximum Benefit while covered under this Plan is paid.

BENEFIT - The Company will pay Major Medical Benefits if, during a Benefit Period, a Covered Person incurs charges which:

(1) are not excluded by the terms of the Plan; and
(2) are not paid under any other terms of the Plan.

The amount of Benefit to be paid will be equal to:

(1) the Benefit Percentage (shown on the Schedule of Benefits) multiplied by:
(2) the total Eligible Charges which are:
  (a) in excess of the Deductible; and
  (b) incurred during the Benefit Period.

MAXIMUM BENEFITS - The Benefits paid for a Covered Person's Illnesses and Injuries will not exceed the Maximums per Covered Person shown on the Schedule of Benefits.

A Covered Person may recover from an Illness or Injury for which Major Medical Benefits were paid. If so, any Maximum Benefit which remains for that person may be increased to the Maximum Benefit shown on the Schedule of Benefits. This will happen if such Covered Person submits, without expense to the Company, satisfactory proof of good health. The Maximum Benefit will be so increased only for Eligible Charges incurred after the date the Company finds such proof to be satisfactory.

ELIGIBLE CHARGES - Only charges incurred by a Covered Person while covered under this Plan may be considered Eligible Charges. A charge is considered to be incurred on the date a service is performed or a purchase is made. Eligible Charges are the actual charges (but not more than the reasonable charges) 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 or Free-Standing Chemical Dependency Treatment Center;

(2) Intensive or Cardiac Care room and board if medically necessary;

(3) Medical services and supplies furnished by a Hospital;

(4) Anesthetics and their use;

(5) Fees of Physicians for medical treatment including, but not limited to, fees for surgical procedures.
   (a) Charges for multiple surgical procedures will be a covered expense subject to the following provisions:

      (i) If bilateral or multiple procedures are performed by one (1) surgeon, benefits will determined based on the Usual and Customary Charge that is allowed for the primary procedures; 50% of the Usual and Customary Charge will be allowed for each additional procedure performed through the same incision; and 60% of the Usual and Customary Charge will be allowed for each additional procedure performed through a separate incision. Any procedure that would 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 a procedure;

      (ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Customary Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Customary percentage allowed for that procedure; and

      (iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Customary allowance.

(6) Services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for private duty nursing;

(7) Services of a licensed physical, or occupational therapist. The therapy must be ordered by a Physician, result from an Injury or Illness, and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy;

(8) X-rays (other than dental), laboratory tests, and other diagnostic services which are performed as a result of definite symptoms of an Injury or Illness; or reveal the need for medical treatment;

(9) X-ray and radiation therapy; and chemotherapy. The materials and services of technicians are included;

(10) The transport of a Covered Person:

(a) within the continental United States and Canada
(b) by means of a professional ambulance service; and
(c) to, but not returning from, a hospital or sanitarium.

(11) Medical supplies as follows:
(a) Drugs and Medicines:
(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 or other fluids;
(c) Artificial limbs and eyes to replace natural limbs and eyes. In addition, repair and adjustment of prosthetic devices, when medically necessary;
(d) Contact lenses or lenses for standard glasses only if required promptly after, and because of cataract surgery;
(e) Cast, splints, trusses, braces, crutches, and surgical dressings;
(f) Rental of (or purchase of, if more cost effective) hospital-type equipment, including, but not limited to wheel chair, hospital bed, iron lung, and oxygen equipment;
(g) Mastectomy bras, limited to two (2) per Calendar Year;
(h) Wigs for hair loss resulting from the treatment of cancer, limited to one (1) every five (5) consecutive years.

(12) Charges for services performed in an Outpatient Surgical Center.

(13) Room and board charges for each day of confinement in a Skilled Nursing Facility if the confinement:
(a) follows a Hospital confinement for which at least three (3) straight days of hospital room and board charges were included as Eligible Charges under the Plan;
(b) begins within fourteen (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 (7) days.

No payment will be made for Skilled Nursing Facility confinement:
(a) for charges which are excluded from coverage by the terms of the Plan; or
(b) to the extent that the charges are paid under any other terms of the Plan.

Room and board charges means charges made by a Skilled Nursing Facility for the cost of room, meals, and services (such as general nursing services) provided to all inpatients on a routine basis.

(14) Services of a licensed speech therapist which is ordered by a Physician for the restoration of speech when loss is due to:
(a) cerebral vascular accident (stroke);
(b) cerebral tumor;
(c) larngectomy;
(d) congenital disorder; or
(e) Illness or Injury that is other than a learning or Mental and Nervous disorder.

(15) Second and Third Surgical Opinion;

(16) Routine Newborn Care for a newborn child who is a Covered Person at the time of birth.
Routine Newborn Care includes:
(a) Hospital charges for room and board, services, and supplies, up to a maximum of four (4) days, but only while the mother is confined for delivery; and
(b) charges related to circumcision.

Charges for Newborn Care are applied to the care of the newborn child.

This Plan complies with the Newborns' and Mothers' Health Protection Act of 1996 as follows:

Coverage for a Hospital stay following a normal vaginal delivery will not be limited to less than 48 hours for both the mother (if a Covered Person) and her newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. Coverage for a Hospital stay in connection with childbirth following a Cesarean section will not be limited to less than 96 hours for both the mother and her newborn child unless a shorter stay is agreed to by both the mother and her attending Physician.

(17) Hospice care for a Covered Person who is a "terminally ill patient" and for members of the Covered Person's family who are Covered Persons under this Plan. A "terminally ill patient" is someone who has a life expectancy of six (6) months or less as certified in writing by the Physician who is in charge of the patient's care and treatment. Eligible Hospice care expenses for a Covered Person will be limited to the following:

(a) Hospice care in a free-standing Hospice facility, hospital-based Hospice, extended care Hospice facility, or nursing home Hospice;
(b) Care received from an interdisciplinary team of Hospice professionals for Hospice and home care; and
(c) Pre-bereavement counseling;
(d) Post-bereavement counseling during the twelve (12) months following the death of the terminally ill patient, up to a limit of six (6) sessions.

(18) Home Health Care provided by a Home Health Care Provider for medical care, 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 a Skilled Nursing Facility;
(d) the Covered Person is examined by the attending Physician at least once every sixty (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, alcoholism, or drug addiction;
(i) care for the deaf or blind; or
(j) care for senility or mental deficiency or retardation, or mental illness.

(19) Cardiac rehabilitation as deemed Medically Necessary provided services are rendered:

(a) under the supervision of a Physician;

(b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
(c) initiated within 12 weeks after other treatment for the medical condition ends; and
(d) in a Medical Care Facility as defined by this Plan.

(20) Spinal manipulation/chiropractic services by a licensed M.D., D.O. or D.C. When treatment becomes maintenance care, benefits shall cease. Maintenance care consists of expenses incurred for other than analysis and adjustment of spinal subluxations by manipulation;

(21) Sterilization procedures;

(22) Eligible charges for Preventive Care include care by a Physician that is not for an Injury or Sickness, subject to the limitations and maximums noted in the Schedule of Benefits;

(23) Eligible charges for Mental and Nervous Disorders, subject to the limitations and maximums noted in the Schedule of Benefits, which are provided by psychiatrists (M.D.), psychologists (Ph.D.), or counselors (PhD.). Other providers must be under the direction of and must bill the Plan through these professionals. This plan complies with the Mental Health Parity Act of 1996.

(24) Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are covered, subject to the following limitations:

(1) The transplant must be performed to replace an organ or tissue of the Covered Person.
(2) The maximum benefit for the transplant procedures performed during a Covered Person's lifetime is shown in the Schedule of Benefits.
(3) Charges for obtaining donor organs are covered charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those charges for:

(a) evaluating the organ;
(b) removing the organ from the donor; and
(c) transportation of the organ from within the United States and Canada to the place where the transplant is to take place.

Benefit payments for donor charges are included under the Organ Transplant Benefit Maximum section shown in the Schedule of Benefits.

(4) If the organ donor is a Covered Person and the recipient is not, then, the Plan will cover donor charges for:

(a) evaluating the organ; and
(b) removing the organ from the donor

No transportation charges will be considered. The plan will always pay secondary to any other coverage.

(25) Eligible Charges for mastectomies deemed medically necessary and, as directed by the Women's Health and Cancer Rights Act of 1998, eligible charges based on consultation between the attending physician and the Covered Person, for:

(a) reconstruction of the breast on which the mastectomy has been performed;
(b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(c) prosthesis and physical complications in all stages of mastectomy, including lymphedemas.

(26) Eligible charges for Diabetic Self-Management Education to include education provided after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetic equipment and diabetic supplies, not to exceed $500. Additional education authorized on the diagnosis of a healthcare provider of a significant change in the covered individual's symptoms of condition and deemed medically necessary by the healthcare provider.

MAJOR MEDICAL EXCLUSIONS AND LIMITATIONS

(1) NON-OCCUPATIONAL COVERAGE. No benefits will be provided for losses which result from an Illness or Injury:

(a) which arises out of or in the course of employment with any employer who is eligible to obtain coverage under Workers' Compensation, or occupational disease law;
(b) for which the Covered Person is eligible for benefits under any Workers' Compensation law or occupational disease law; or
(c) for which the Covered Person is paid a Workers' Compensation benefit or occupational disease law benefit.

(2) WAR. No benefits will be paid for losses which are due to revolt, war, or any act of war, whether declared or not.

(3) RIOT-FELONY. No benefits will be paid for losses which are caused by or contributed to by taking part in a riot or civil disturbance, or while committing or attempting to commit a felony.

(4) DRUGS-POISON. No benefits will be paid for losses which are due to:
1. The voluntary taking of drugs - except those taken as prescribed by a Physician;
2. The voluntary taking of poison;
3. The voluntary inhaling of gas; or
4. The voluntary use of alcohol.

(5) PHYSICIAN'S DIRECT CARE. Benefits will be paid only for Eligible Charges incurred by a Covered Person under the direct care of a Physician.

(6) LEGAL DUTY. Coverage is provided only for treatment for which the Covered Person has a legal duty or obligation to pay. This Plan will not create such a duty or obligation to pay.

(7) NECESSARY, USUAL AND CUSTOMARY. Benefits are provided only for charges which are:
(a) medically necessary to the treatment of Illness or Injury;
(b) incurred on the advice of a Physician; and
(c) not more than those charges which are usual and customary for the services performed and the materials furnished.

Benefits will not be paid for any expenses for services or supplies which are:

(a) not provided in accordance with generally accepted professional medical standards; or
(b) incurred in connection with services and procedures including surgery or drugs which are considered experimental or research by nature according to the American Medical Association or the Food and Drug Administration.

(8) TREATMENT OF TEETH AND GUMS. No benefits will be paid for treatment of teeth, gums, alveolar process or supplies used in such treatment or for dental appliances except as specifically listed as covered under the Dental Benefit portion of this Plan or:
(a) Physician Services, excluding facility charges, if performed on an Outpatient basis, for the removal of impacted teeth; and
(b) Major Medical Benefits for expenses incurred for treatment of Injury to natural teeth, including the

replacement of such teeth or setting of a jaw fractured or dislocated in an accident. Expenses must be incurred:

(i) as a result of an accident which occurs while the Covered Persons is covered under the Plan; and
(ii) within twelve (12) months after such accident.

(9) HEARING AIDS AND EYE GLASSES. No benefits will be paid for exams to determine the need, or for the fitting or purchase of:

(a) hearing aids, unless required due to an accidental injury to the ear; or
(b) eye glasses or contact lenses except as provided in connection with cataract surgery;

unless such coverage is specifically listed in the Schedule of Benefits.

(10)COSMETIC SURGERY. No benefits will be paid for:

(a) that portion of breast surgery which involves the implanting or injecting of any substance into the body for modifying breast shape, except for charges which result from an Illness or Injury which occurs while the Covered Person is covered under the Plan; or
(b) cosmetic surgery, except for charges which:

(i) result from an accident which occurs while the Covered Person is covered under the Plan; or
(ii) are the result of congenital birth defects; or
(iii) meet the guidelines of the Women's Health and Cancer Act of 1998.

(11)EXPERIMENTAL/INVESTIGATIONAL PROCEDURES. Benefits will not be paid for those services which are deemed Experimental or Investigational.

(12)GOVERNMENT AGENCIES. Benefits will not be paid for charges incurred or Hospital confinement, services, treatment or supplies furnished by the United States or a foreign government agency.

(13)LIMIT OF MEDICAL TREATMENT. Benefits will only be paid for charges by a Physician who is present and consults with the Covered Person. Benefits will not be paid for chargesfor services of a registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed physical therapist:

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

(14)ABORTION. Benefits will not be paid for an abortion, which is not medically necessary to preserve the life of a mother.

(15)SELF INFLICTED. No benefits will be paid for losses which result from an Illness or Injury which is intentionally self induced or self inflicted while sane or insane.

(16)OTHER. Benefits will not be paid for charges not listed under "Eligible Charges".

(17)TMJ. No benefits will be paid for the treatment of the temporomandibular joint (TMJ).

(18)MERIDIAN THERAPY (ACUPUNCTURE). No benefits will be paid for Meridian Therapy (Acupuncture).

(19)REVERSAL OF STERILIZATION. No benefits will be paid for expenses related to reversal of sterilization, sex change, or sex therapy.

(20)INDUCEMENT OF PREGNANCY. No benefits will be paid for expenses related to artificial insemination, invitro fertilization, and other direct attempts to induce pregnancy, including drug therapy.

(21)OBESITY. No benefits will be paid for expenses related to the treatment of obesity, weight control, or diet. Charges for Gastric Bypass, stomach stapling, and similar procedures are never covered, whether or not they are deemed Medically Necessary.

(22)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.

(23)RADIAL KERATOTOMY. No benefits will be paid for services which are related to Radial Keratotomy surgery, or other procedures used to correct refractory disorders including Lasik, and other similar procedures..

(24)HOSPITAL WEEKEND ADMISSIONS. No benefits will be paid for the initial Friday, Saturday, and Sunday room and board charges incurred in connection with a Hospital confinement which begins on Friday, Saturday, or Sunday. Exceptions are made for emergency admissions or scheduled surgery within 24 hours immediately following admission to the Hospital.

(25)COURT MANDATED. No benefits will be paid for services that are provided due to a court order.

(26)LEARNING DISABILITIES. No benefits will be paid for charges incurred for special education or training for learning disorders.

(27)PREGNANCY OF DEPENDENT CHILD. No benefits will be paid for charges incurred as a result of or in connection with the pregnancy of a dependent child (including complications of pregnancy);

(28)PRESCRIPTION DRUGS. No benefits will be paid under the Prescription Drug Expense for:

(a) Medicines or drugs which a Covered Person is entitled to receive without charge.
(b) Medicines or drugs for which reimbursement is provided under any Workers' Compensation Law or by any municipal, state or federal program.
(c) Medicines or drugs which are lawfully obtainable without a Prescription, except insulin, including vitamins (except pre-natal vitamins dispensed with a prescription), cosmetics and dietary supplements.
(d) Therapeutic devices or appliances, including hypodermic needles and syringes (except when purchased with insulin), support garments and other non-medicinal substances, regardless of intended use.
(e) Any charge for the administration or injection of any drug including injectable insulin.
(f) Drugs labeled "Caution--limited by a federal law to investigational use" or experimental drugs even though a charge is made to the Covered Person.
(g) Refills of any Prescription in excess of the number specified by the Physician, or any refill dispensed after one year from the physician's original order.
(h) Medicines or drugs prescribed for the treatment of infertility, or weight reduction.
(I) Growth Hormones.
(j) Retin A, Accutane, Renova or similar drugs when prescribed for a Covered Person over the age of 19.
(k) Anti-hyperkenitics, such as Ritalin or Dexedrine, when prescribed for a Covered Person over the age of 19.
(l) DESI drugs.

(m) Non-Legend drugs, except for Immunodeficient drugs.
(n) Immunization agents, biological sera, blood or blood plasma and blood derivatives.
(o) Medication which is to be taken by or administered to an eligible person by a physician or in the physician's office.
(p) Medication which is to be taken by or administered to a Covered Person, in whole or in part, while the eligible person is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates a facility for dispensing prescription drugs.

(29)COMPLICATIONS OF NON-COVERED PROCEDURES. No benefits will be paid for care, services or treatment required as a result of complications from a treatment not covered under the Plan.

(30)EDUCATIONAL OR VOCATIONAL TESTING. No benefits will be paid for services for educational or vocational testing or training.

(31)DETOXIFICATION. No benefits will be paid for treatment solely for detoxification or primarily for maintenance care. Detoxification is aimed at overcoming the aftereffects of a specific drinking or drug episode. Maintenance care consists of the providing of an alcohol- free or drug-free environment.

(32)EXERCISE PROGRAMS. No benefits will be paid for exercise programs for treatment of any condition except for Physician-supervised cardiac rehabilitation, occupational, or physical therapy as covered by this Plan.

(33)TRAVEL OR ACCOMMODATIONS. No benefits will be paid for charges for travel either inside or outside the United States or its territories, or accommodations, for services or supplies, whether or not recommended by a Physician.

(34)HAIR LOSS. No benefits will be paid for care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy, radiation, or other medical treatment which results in the loss of a Covered Person's hair.

(35)HYPNOSIS. No benefits will be paid for treatment by hypnosis, except as part of the Physician's treatment of a mental illness or when hypnosis is used in lieu of an anesthetic.

(36)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, non-prescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

(37)REPLACEMENT BRACES. No benefits will be paid for replacement of 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.

(38)SLEEP DISORDERS. No benefits will be paid for treatment of sleep disorders unless deemed Medically Necessary.

(39)ORTHOPEDICS, ORTHOTICS, AND FOOT CARE. No benefits will be paid for treatment of weak, strained, flat, unstable, or unbalanced feet, maeatarsalgia or bunions, except open cutting or operations; or for corns, calluses or toenails, except the removal of nail roots and necessary services for the treatment of metabolic or peripheral vascular disease; or for charges for orthopedic shoes or other devices or appliances for the support of the feet, except for initial casting and insertion of orthomechanical devices (orthotics) following major surgery to bones of the foot.

SPECIAL LIMITATIONS AND PROVISIONS

PRIOR COVERAGE PROVISION

This Prior Coverage Provision applies only to a person who was covered on the date this Plan began and who was covered under the previous plan which this Plan replaced.

If any person is eligible for continuation of coverage under the previous plan, benefits under this Plan will be limited to only those Eligible Expenses not eligible for payment under continuation of coverage under the previous plan.

(1) DEDUCTIBLE. This Plan will allow credit toward the Deductible for any portion of a calendar year deductible that a Covered Person satisfied under the previous plan.

(2) OUT-OF-POCKET. This Plan will allow credit toward the Out-of-Pocket maximum for any portion of a calendar year out-of-pocket maximum that a Covered Person satisfied under the previous plan.

MANDATORY PRE-HOSPITALIZATION/SURGICAL REVIEW PROCEDURES (UTILIZATION REVIEW)

Treatment for a Covered Person's Illnesses or Injuries may include Inpatient Hospitalization Services or Outpatient Surgical Procedures. The Company has implemented a Pre-Hospitalization and Outpatient Surgical Review program to help assure that every Covered Person continues to receive the high quality level of care medically necessary for treatment. To access this program, call 1-800-241-7319. A Covered Person must use the Pre-Hospitalization (Pre-Certification) Review Program to obtain full benefits under this Plan.

A $300 non-compliance penalty will apply each time a Covered Person fails to receive authorization as explained in this section.

PRECERTIFICATION

(1) Non-Emergency (elective) Admission. As soon as the Covered Person is told he/she needs to be admitted to a Hospital or needs to have a scheduled surgical procedure, the Covered Person must call 1-800-241-7319 at least 72 hours prior to the admission or surgery.

(2) Emergency Admission. In case of an emergency hospitalization, the call must be made within 24 hours, or the next business day following the admission.

Inpatient Precertification

Precertification is not required for inpatient Maternity stays as long as the member's care does not exceed Federally mandated timeframes (48 hours for vaginal delivery and 96 hours for cesarean section delivery).

Precertification is required for all other inpatient stays including:

- Acute Care
- Long Term Acute Care
- High Risk Maternity
- Skilled Nursing Facility
- Rehabilitation
- Mental Health and Substance Abuse
- Inpatient MH and SA Hospital
- Inpatient MH and SA Partial Hospitalization
- Inpatient MH and SA Hospitalization

Outpatient Precertification

Precertification is required for the following outpatient procedures:

- Durable Medical Equipment
- Ear Devices
- Home Nursing Care
- Home Infusion Therapy
- High Risk Maternal Procedures
- Maxillo-facial orthopedics
- Oncology Related Procedures
- Oral Pharynx Procedures
- Sleep Studies
- Spinal Procedures
- Therapeutic Radiology
- Transplants – initial consultation and evaluation
- Mandibular Surgical Procedures
- Renal Dialysis and procedures for ESRD

Additional Outpatient Procedures Requiring Precertification

Potentially Cosmetic Procedures (e.g. Facial reconstruction, vein therapy, etc.)

Potentially Experimental/Investigational/Unproven Procedures (e.g. Keratoplasty, total disc arthroplasty, molecular pathology and gene analysis, etc.)

Unlisted Procedures (Procedures given miscellaneous identifiers when they cannot be categorized into established codes. Many codes end in "99" (e.g. Vascular surgery).

The person calling (1-800-241-7319) will need to provide 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.

The 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 patient's Physician will discuss the length of time required in the Hospital, as well as any alternative types of care appropriate for recovery.

In order to receive full benefits for any elective (non-emergency) surgery, the Covered Person must contact 1-800-241-7319 at least 72 hours prior to surgery.

The Medical Care Counselor can arrange a Home Health Care program under the direction of the Covered Person's Physician. The Home Health Care alternative may often be the most cost effective and medically appropriate treatment for the Illness or Injury.

ELECTIVE ADMISSION

Have your doctor's office call 1-800-241-7319 and provide the information requested.

URGENT ADMISSION

Have your doctor's office call 1-800-241-7319 and provide the information requested.

EMERGENCY ADMISSION

Have your doctor's office call 1-800-241-7319 within 24 hours (or next business day).

FOR ALL ADMISSIONS AND SURGERIES

Provide the following information:

- Patient name, social security number, date of birth and relationship to Covered Person.
- Name, Employee ID number and address of Covered Person.
- Group number.
- Date of admission/surgery.
- Admitting diagnosis, procedure, requested length of stay, supporting information and estimated surgical fees.

- Name, address and telephone number of Hospital.
- Name, address and telephone number of the attending Physician.

A Medical Care Counselor will obtain the necessary information and authorize the appropriate length of stay for your hospital confinement.

CONCURRENT REVIEW AND DISCHARGE PLANNING

A Medical Care Counselor will monitor the Covered Person's Medical Care Facility stay, or use of other medical services. The Medical Care Counselor will coordinate either the scheduled release or the extension of stay for a Covered Person in a Medical Care Facility, or extension or cessation of other medical services.

The Attending Physician may contact 1-800-241-7319 if he or she feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified.

CASE MANAGEMENT

When a catastrophic condition, such as spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime, care. After the person's condition is diagnosed, he or she may require extensive medical treatment or services. It also may be appropriate to receive care in an alternative setting, maybe even the Covered Persons home.

A Case Manager, in consultation with the Covered Person, their family, and the attending Physician, will monitor the Covered Person and explore, discuss and recommend coordinated and/or alternative types of medical care.

Case Management may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing/Extended Care Facility or home health care;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

The attending Physician, Covered Person, and the Plan Administrator must all agree to the alternate treatment plan.

Case Management is a voluntary service. No penalties or reduction of benefit will occur if a Covered Person, and his or her family choose not to participate.

SECOND SURGICAL OPINION

Second Surgical Opinion benefit is included to advise the Covered Person that, in many instances, there are alternatives to surgery. If a Physician recommends surgery, the Covered Person may consult with another Physician as to the necessity of the surgery.

The Covered Person may choose any Physician for the Second Surgical Opinion, provided the Physician is a board-certified specialist in treating the Covered Person's particular medical condition and is not financially or professionally associated with the first Physician who recommended surgery. If the first and second opinions differ, the Plan also provides payment of Eligible Charges for a third and final surgical opinion from a board-certified specialist. A board-certified specialist is not required if the Physician has been recommended to the Covered Person by a local medical society.

Covered Persons retain free choice to either have, nor not have, the proposed surgery, regardless of what a second or third Physician recommends. The ultimate decision to have surgery or not remains with the Covered Person.

"Second Surgical Opinion" means an evaluation of the need for surgery by a second Physician (or a third Physician if the opinions of the Physician recommending surgery and the second Physician are in conflict), including the Physician's exam of the patient and diagnostic testing.

HOW TO OBTAIN BENEFITS
-CLAIM FILING PROCEDURES-

Once you become eligible, this Plan has the responsibility for seeing that you receive all the benefits to which you are entitled. To receive these benefits as quickly as possible, complete the necessary forms clearly and accurately. To assist the Third Party Administrator (TPA) in processing your claim, please follow the steps listed below in the order that they appear.

The Plan must be given written proof of loss within ninety (90) days after the date of such loss. If is was not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason if proof if filed as soon as reasonably possible. In any event, proof of loss must be given no later than 12 months from the date of loss. The Company may require, as part of the proof, authorization to obtain medical and non-medical information.

WHEN YOU HAVE A CLAIM

Step 1. Secure the proper claim form from your employer. You should familiarize yourself with these forms and make sure that you do have the correct form when filing a claim.

Step 2. Fill out your portion of the claim form completely and accurately.

Step 3. Have your doctor fill out his portion of the form. Please make sure the doctor completes all the information requested.

Step 4. In the case of hospital confinements, a form provided by the Hospital must be completed in detail by the Hospital and submitted to the TPA.

Step 5. Attach all original bills or receipts related to the health service provided. Make sure the bill clearly identifies what services were performed and what the charge for each service was. All itemized bills must show the following:

a. The Employee's name;
b. The patient's name;
c. The Physician's name;
d. The type of service rendered;
e. An itemization of the charges;
f. The condition for which the expense was incurred; and
g. The date of service.

A receipt for prescription drugs must show the following:

a. The Employee's name;
b. The patient's name;
c. The prescribing Physician's name;
d. The prescription number;
e. An itemization for each separate prescription item; and
f. The date of purchase.

Step 6. If you have any questions regarding Steps 1 - 5, call your Third Party Administrator, (Alternative Benefit Plans, Inc.) or your Personnel Office.

Step 7. If claim is for a Dependent, follow the first five steps above and be sure to complete the portion of the claim form referring to your Dependent.

Step 8. Forward completed claim forms and all related bills to:

CIGNA PPO
P.O. Box 188061
Chattanooga, TN 37422-8061

IF YOU HAVE A QUESTION REGARDING A CLAIM - CALL: (800) 241-7319 or (770) 451-0376

Claims will not be deemed submitted unless they are received at the above address.

CLAIM PROCEDURES

A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. This section explains your rights and responsibilities regarding Claims you file.

BENEFIT DETERMINATIONS AND APPEALS

PRE-SERVICE CLAIM (non-Urgent Care)

A Pre-service Claim is a request for pre-authorization for Covered benefits that must be decided before a claimant will receive full-benefits for the medical services, procedures, or items in question under the Plan.

The Plan will notify you within 15 days of receipt of the completed claim as to the Plan's benefit determination. The notification period may be extended an additional 15 days when necessary due to matters beyond the control of the Plan (you will be notified of the extension before the end of the initial 15 day determination period). If the reason for the extension is the claim submission was not complete, you will be notified within 5 days that you have 45 days from the date you receive the notice to provide the missing information.

Appealing an Adverse Benefit Determination for a Pre-Service Claim

If your Pre-Service Claim is denied in whole or in part, you will receive written notice of the adverse benefit determination within the time frame stated above, after the Plan has received all of the information required to process your claim (if the missing information is received within the time frame noted above). The notice will include the specific reason(s) for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of the Plan's appeal procedures; and a statement indicating your right to bring a civil action under ERISA Sec. 502(a). In addition, if the adverse determination is based on an internal rule, guideline or protocol, that rule, guideline or protocol will be included in the notice; or, if it is not feasible, it will include a statement that a copy is available free of charge. If the adverse determination is based on the treatments "Medical Necessity", the notice will include an explanation of the scientific or clinical judgment for the determination; or if it is not feasible, it will include a statement that a copy is available free of charge. The notice will also explain that you have 180-days to appeal the adverse benefit determination; and that your appeal must be in writing. The Plan will notify you, in writing, of the decision regarding your appeal within 30 days after the appeal is received.

URGENT CARE CLAIM (expedited review)

An Urgent Care claim is a claim for pre-authorization of Covered benefits which, if delayed, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or would subject the claimant to severe pain that cannot be adequately managed without the treatment in question. A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

The Plan will notify you within 72 hours after it receives your request for benefits that it has received your claim and what your benefits are determined to be. The notification may initially be made via telephone, but will be followed up in writing within 3 days.

If the submission for an Urgent Care Claim is not complete, you will be notified within 24 hours after the Plan receives the claim. The notice will describe the specific information necessary to complete the claim. You

must respond to the notice by providing the missing information within 48 hours, or you will be notified that the claim has been denied. If the missing information is received by the Plan within 48 hours, The Plan will then issue a benefit determination no later than 48 hours after receiving the missing information.

Appealing an Adverse Benefit Determination for an Urgent Care Claim

If your Urgent Care Claim is denied in whole or in part, you will receive written notice of the adverse benefit determination within the time frame stated above, after the Plan has received all of the information required to process your claim (if the missing information is received within the time frame noted above). The notice will include the specific reason(s) for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of the Plan's appeal procedures; and a statement indicating your right to bring a civil action under ERISA Sec. 502(a). In addition, if the adverse determination is based on an internal rule, guideline or protocol, that rule, guideline or protocol will be included in the notice; or, if it is not feasible, it will include a statement that a copy is available free of charge. If the adverse determination is based on the treatments "Medical Necessity", the notice will include an explanation of the scientific or clinical judgment for the determination; or if it is not feasible, it will include a statement that a copy is available free of charge. The notice will explain that you have 180-days to appeal the adverse benefit determination; and that your appeal must be in writing (telephone, facsimile or other fast means is acceptable if the claim is still considered urgent). If the claim is no longer considered urgent, the Plan will notify you, in writing, of the decision regarding your appeal within 60 days after the appeal is received. If the claim is still considered urgent, the Plan will notify you of the decision regarding your appeal within 72 hours after the appeal is received (the notification may initially be made via telephone, but will be followed up in writing within 3 days).

CONCURRENT CARE DECISIONS

In the event of a reduction or termination of a benefit that was pre-authorized by the Plan, you will be notified sufficiently in advance of the reduction or termination of benefits to allow you to appeal the decision. You must appeal any adverse decision regarding Concurrent Care at least 24 hours before the reduction or termination is due to occur. The Plan will then issue a determination on your appeal no later than 24 hours after receiving the appeal.

The Plan will decide Urgent Care Claims involving an extension of a course of treatment as soon as possible, taking into account medical circumstances. The Plan will notify you of the benefit determination within 24 hours after receiving the claim, provided you submit the claim at least 24 hours before the approved period of time or number of treatments ends. The notice will include the specific reason(s) for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of the Plan's appeal procedures; and a statement indicating your right to bring a civil action under ERISA Sec. 502(a).

You may further appeal the adverse decision based on the Urgent Care appeal process stated above.

POST-SERVICE CLAIMS

A request for the reimbursement of Covered benefits for medical care that has already been provided.

The Plan will notify you within 30 days of receipt of the completed claim as to the Plan's benefit determination. The notification period may be extended an additional 15 days when necessary due to matters beyond the control of the Plan (you will be notified of the extension before the end of the initial 30 day determination period). If the reason for the extension is the claim submission was not complete, you will be notified in writing that you have 45 days from the date you receive the notice to provide the missing information.

Appealing an Adverse Benefit Determination for a Post-Service Claim

If your Post-Service Claim is denied in whole or in part, you will receive written notice of the adverse benefit determination within the time frame stated above, after the Plan has received all of the information required to process your claim (if the missing information is received within the time frame noted above). The notice will include the specific reason(s) for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of the Plan's appeal procedures; and a statement indicating your right to bring a civil action under ERISA Sec. 502(a). In addition, if the adverse determination is based on an internal rule, guideline or protocol, that rule, guideline or protocol will be included in the notice; or, if it is not feasible, it will include a statement that a copy is available free of charge. If the adverse determination is based on the treatments "Medical Necessity", the notice will include an explanation of the scientific or clinical judgment for the determination; or if it is not feasible, it will include a statement that a copy is available free of charge. The notice will explain that you have 180-days to appeal the adverse benefit determination; and that your appeal must be in writing. The Plan will notify you, in writing, of the decision regarding your appeal within 60 days after the appeal is received.

Additional Information About Appeals (applies to appeals of all claim types):

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;
(2) was submitted, considered or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been consistently with respect to all claimants; or
(4) constituted a statement or policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in 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 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 shall 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.

EXTERNAL REVIEW PROCEDURES

You may request an External Review after you exhaust the internal review (appeals) procedures described on the preceding pages and have received a final internal adverse benefit determination. Your request must be filed within four months after receiving the final internal adverse benefit determination (if there is not a corresponding date four months after the date of receipt of such a notice, the request must be filed by the first day of the fifth month following receipt of the notice).

Only claims involving medical judgment and rescission of coverage are eligible for external review. Examples of situations when a claim may be eligible for external review include:

1. The appropriate health care setting for providing medical care to an individual;
2. Whether treatment by a specialist is medically necessary or appropriate;
3. Whether treatment involved "emergency care" or "urgent care", affecting coverage level and coinsurance;
4. A determination that a medical condition is a preexisting condition
5. The Plan's general exclusion of an item or service, if the plan covers the item or service in certain circumstances based on a medical condition;
6. The frequency, method, treatment or setting for a recommended preventive service, to the extent not specific, in the recommendation or guidelines of the USPSTF, the Advisory Committee of Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration; and
7. Whether the Plan complies with the non-quantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act, and it's implementing regulations.

Preliminary Review
Within five business days following the date of the Plan's receipt of the external review request, the Plan will complete a preliminary review to determine whether:

A. You (claimant) are or were covered under the plan at the time the health care item or service was requested, or in the case of retrospective review, was covered under the plan at the time the health care item or service was provided;
B. The final adverse benefit determination does not relate to the your (claimant's) failure to meet the requirements for eligibility under the terms of the Plan;
C. You (claimant) have exhausted the plan's internal appeal process - unless you are not required to exhaust the internal appeals process.
D. You have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will notify you in writing whether your request is eligible for external review. If your request is not complete, you must provide the missing information within the original four month filing period (four months after you receive a final internal adverse benefits determination) or within 48 hours of receiving notification that your original request was not complete. The Plan's notice will include a description of all items required to make your request for external review complete.

Independent Review Organization
If your request is complete and is deemed eligible for external review, the Plan will assign an Independent Review Organization (IRO) that is accredited by the URAC to conduct the external review. The Plan is required to contract with at least three IRO's and rotates assignments among them to insure unbiased, random selection.

The IRO will notify you in writing of your request's eligibility and acceptance for external review. If your request is accepted, you will have 10 business days to submit any additional information the IRO will need to consider when making their decision. Information received after this 10 day period will not be considered by the IRO. Upon receipt of any information from you, the IRO must, within one business day, forward the

information to the Plan. If this information results in the Plan's reconsidering it's adverse benefit determination, the external review may be terminated. You will be notified of this reversal in writing within one business day after the Plan makes the decision.

The plan is required to provide the assigned IRO documents and any information considered in the making of the adverse benefit determination within five days of the assignment of the IRO. If the plan does not provide these documents, the IRO may terminate the external review and make a decision to reverse the final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify you and the Plan.

The IRO will review all of the information and documents submitted in a timely manner and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO will consider the following in reaching a decision (to the extent that they are available and appropriate):

A. Your (claimant's) medical records;
B. The attending health care professional's recommendation;
C. Reports from appropriate health care professionals and other documents submitted by the Plan, you (claimant) or your treating provider;
D. The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan – unless the terms of the Plan are inconsistent with applicable law;
E. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
F. Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
G. The opinion of the IRO's clinical reviewer or reviewers;

The IRO will provide written notice of the final external review decision to you and the Plan within 45 days after the IRO receives the request for external review. If the final external review decision reverses the Plan's final internal adverse benefit determination, the Plan will immediately provide coverage or payment for the claim.

Expedited External Review

If you receive an internal adverse benefit determination, you may request an expedited external review if:

A. The adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
B. The final adverse benefit determination involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Preliminary Review

Upon receipt of a request for expedited external review, the Plan will immediately determine whether the request meets the guidelines previously listed for preliminary review. The Plan will then immediately send notice to the you regarding it's determination.

Independent Review Organization

If your request qualifies for expedited external review, The Plan will immediately assign an IRO and will transmit all necessary documents and information to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO will provide you and the Plan with notice of the expedited external review decision as quickly as possible, but in no event more than 72 hours after receiving the request for the expedited external review. If the notice is not provided in writing, the IRO will provide written confirmation within 48 hours of notifying you and the Plan of the decision.

DEFINITIONS

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

ACTIVE WORK or ACTIVELY AT WORK: An Employee's full-time performance of all customary duties of such Employee's occupation for at least thirty (30) hours per week and at the Company's usual place of business, or other business locations to which the Company requires the Employee to travel.

AMBULATORY SURGICAL CENTER: A licensed facility that:

(1) Mainly is used for performing outpatient surgery;
(2) has a staff of Physicians;
(3) has continuous Physician and nursing care by registered nurses (R.N.'s); and
(4) does not provide for overnight stays.

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

BIRTHING CENTER: This is a freestanding facility that:

(1) Meets licensing standards;
(2) is set-up, equipped and run to provide prenatal care; delivery and immediate postpartum care;
(3) makes charges;
(4) is directed by at least one Physician who is a specialist in obstetrics and gynecology;
(5) has a Physician or certified nurse midwife present at all births and during the immediate postpartum period;
(6) extends staff privileges to Physicians who practice obstetrics and gynecology in an area hospital;
(7) has at least two beds or two birthing rooms for use by patients during labor and delivery;
(8) provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by an R.N. or certified nurse midwife;
(9) provides, or arranges with a facility in the area for diagnostic x-ray and laboratory services for the mother and child.
(9) has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of a perineal tear;
(10) is equipped and trained to handle medical emergencies and provide immediate support measures to sustain life if complications arise during labor and if a child is born with an abnormality which impairs function or threatens life and/or limb.
(11) accepts only patients with low risk pregnancies;
(12) has a written agreement with a Hospital in the area for emergency transfer of a patient or a child. Written procedures for such transfer must be displayed and the staff must be aware of them;
(13) provides an ongoing quality assurance program. This includes reviews by Physicians who do not direct the medical facility;
(14) keeps a medical record on each patient and child.

BRAND NAME DRUG: A medicine or drug that is identified by a registered trade-mark created by the drug manufacturer.

CALENDAR YEAR: January 1st through December 31st of the same year.

COMPANY: The Lauren Corporation and each participating subsidiary and affiliate Company, including the following:

(1) Lauren Engineers and Constructors, Inc.
(2) Lauren Services, ULC
(3) Lauren Bharat Engineering Pvt. Ltd.
(4) TLC, Air, LLC
(5) Lauren Engineers and Constructors India Pvt. Ltd.

COSMETIC SURGERY: Medically unnecessary surgery performed for the purpose of improving appearance rather than restoring bodily function.

CONVALESCENT FACILITY: This is an institution that:

(1) Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
    (a) professional nursing care by an R.N., or an L.P.N. directed by an R.N.; and
    (b) physical restoration services to help patients to meet a goal of self-care in daily living activities.
(2) Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.;
(3) is supervised full-time by a physician or R.N.;
(4) keeps a complete medical record on each patient;
(5) has a utilization review plan;
(6) is not mainly for custodial or educational care, or for care of mental disorders;
(7) makes charges.

CUSTODIAL CARE: This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to by whom they are prescribed, recommended, or performed.

COVERED EMPLOYEE: An employee for whom the coverage provided by this Plan is in effect.

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

DENTIST: A person legally licensed to practice dentistry or oral surgery and who is practicing within the scope of his license.

DEPENDENT: A person who:

(1) Meets the definition of the a Dependent or a Spouse under the provisions of the Internal Revenue Code of the United States; and

(2) is a Covered Employee's:
    (a) Spouse (unless the spouse is legally separated from the Covered Employee);
    (b) Child less than 26 years of age;
    (c) unmarried Child over 26 years of age meeting all of the following conditions:
        i. totally and permanently disabled and unable to earn a living (proof of such disability must be submitted to the Company within 30 days of the date coverage would have ended due to the child's age);
        ii. dependent on the Covered Employee for principle support; and
        iii. covered under the Plan on a day prior to the day coverage would have ended due to the child's age.

Spouse
A Spouse is defined as a member of the opposite sex who is legally married (certificate of matrimony) to the employee.

Child
A Child is a Covered Employee's:
(a) son, daughter, stepson, stepdaughter; or
(b) a child legally adopted by the employee or legally placed for adoption; or
(c) an eligible foster child who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Proof of Dependent Eligibility
New Employees and Employees seeking new coverage for their previously non-covered Dependents are required to prove dependent eligibility by supplying the following required documentation:

Dependents	**Documentation Required**
Spouse	Photocopy of marriage certificate
Children	
Natural Child	Photocopy of birth certificate showing name of employee as parent
Step Child	Photocopy of birth certificate showing name of employee's spouse as parent, and a photocopy of marriage certificate showing the names of the employee and spouse
Adopted and Foster Children	Photocopies of Affidavits of Dependency, Final Court Orders with the presiding judge's signature and seal, or Adoption Final Decree with the presiding judge's signature and seal

Documentation must be provided within 30 days of dependent's expected eligibility date for coverage, or the dependent must wait until the next Open Enrollment Period to join the plan.

DURABLE MEDICAL EQUIPMENT: Equipment which:

(1) Can withstand repeated use;
(2) is primarily and customarily used to serve a medical purpose;
(3) is generally not useful to a person in the absence of an illness or injury; and
(4) is appropriate for use in the home.

EMERGENCY CARE: This means the first treatment given in a hospital's emergency room or a minor emergency clinic right after the sudden and at that time, unexpected onset of a change in a person's physical or mental condition which:

(1) requires hospital level care because:
    (a) the care could not safely and adequately have been provided other than in a Hospita/minor emergency clinic; or
    (b) adequate care was not available elsewhere in the area at the time and place it was needed; and
(2) if the Hospital level care was not given could, as determined by the Company, reasonably be expected to result in:
    (a) loss of life or limb; or
    (b) significant impairment to bodily function; or
    (c) permanent dysfunction of a body part.

EMPLOYEE: A person:

(1) whose employment with the Company is:
    (a) on a permanent full-time basis;
    (b) the person's principle occupation; and
    (c) for regular wage or salary.
(2) who is regularly scheduled to work at such occupation at least thirty (30) hours eachweek;
(3) who is a member of an employee class which is eligible for coverage under this Plan; and
(4) who is a permanent resident of the United States.

Employee does not include a person who:

(1) performs service of a recognized profession, including but not limited to, an attorney or an accountant; and
(2) is paid on a basis other than regular wage or salary.

ENROLLMENT DATE: The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period. The Enrollment Date for a Special or Late Enrollee is always the first day of coverage.

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

EXPENSE INCURRED: An expense shall be deemed to be incurred on the day the purchase is made or the service rendered for which the charge is made.

EXPERIMENTAL/INVESTIGATIONAL PROCEDURES: A drug, device, procedure or treatment will be determined to be experimental or investigational if:

(1) there is insufficient outcome data available from controlled clinical trials published in peer review literature to substantiate its safety and effectiveness for the disease or injury involved; or
(2) if required by the FDA, approval has not been granted for marketing; or
(3) a recognized national society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
(4) if the treatment facility authorizing or prescribing the drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

FAMILY UNIT: A Covered Employee and persons covered under this Plan as such Covered Employee's Dependents.

FOSTER CHILD: An unmarried child under the limiting age shown in the definition of Dependent in the Definitions section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met:

(1) The child is being raised as the Covered Employee’s dependent;
(2) the child depends on the Covered Employee for primary support;
(3) the child lives in the home of the Covered Employee; and
(4) the Covered Employee may legally claim the child as an income tax deduction.

FREE-STANDING CHEMICAL DEPENDENCY TREATMENT CENTER: A place which meets all of the following requirements:

(1) It is accredited by the Joint Commission on Accreditation of Hospitals or is licensed by the appropriate state licensing authority as a chemical dependency treatment center;
(2) it is operated chiefly for the treatment of chemical dependency;
(3) it provides only treatment that is directly under the supervision of a Physician M.D.;

(4) it provides 24-hour nursing service by graduate nurses (R.N.);
(5) it keeps complete medical records on each person; and
(6) it makes charges.

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

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

HIPAA: Health Insurance Portability and Accountability Act of 1996.

HOME HEALTH CARE PROVIDER: A home health agency or a visiting nurses' association which meets all of the following requirements:

(1) Is licensed by the state;
(2) qualifies as a home health care agency under Medicare;
(3) meets the standards of the applicable area wide health care planning agency;
(4) provides skilled nursing services and other services on a visiting basis in the patient's home;
(5) is responsible for administering a home health care program;
(6) has full-time supervision by a Physician or R.N.;
(7) keeps complete medical records on each person;
(8) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician; and
(9) it makes charges.

HOME HEALTH CARE PLAN: A formal plan for Home Health Care which meets the following requirements:

(1) Is a formal, written plan made by the insured's attending Physician;
(2) is reviewed at least every thirty (30) days;
(3) it states a specific diagnosis;
(4) it certifies that the home health care is in place of Hospital confinement; and
(5) it specifies the type and extent of home health care required for the treatment of the insured.

HOSPICE: 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 (1) Physician, one(1) registered professional nurse (R.N.), one (1) social worker, and at least one (1) pastoral or other counselor, and volunteers;
(4) must be 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;
(7) offers a coordinated program of home care and Inpatient care for terminally ill patients and the patient's family;
(8) provides an ongoing quality assurance program which includes reviews by Physicians other than those who own or direct the agency; and
(9) makes charges.

The term "hospice" does not include an organization or part thereof which:

(1) is primarily engaged in providing;
  (a) custodial care;
  (b) care for drug addicts and alcoholics;
  (c) domestic services;
(2) is a place of rest;
(3) is a place for the aged; or
(4) is a hotel or similar institution.

HOSPICE CARE PLAN: A plan of terminal patient care that is established and conducted by a Hospice and supervised by a Physician.

HOSPITAL: A place which meets all of the following requirements:
(1) It is accredited as a general hospital by the Joint Commission on Accreditation of Hospitals;
(2) it is open at all times;
(3) it is operated chiefly for the treatment of sick or injured persons as inpatients;
(4) it has a staff of one (1) or more Physicians available at all times;
(5) it provides 24 hour nursing service by graduate registered nurses (R.N.);
(6) it includes areas designated for diagnosis and major surgical procedures. Or, if it is chiefly a place for the treatment of mentally ill or mentally retarded persons, it has an agreement, by contract or otherwise, with an accredited hospital to perform surgery which may be required; and
(7) it makes charges.

The term "Hospital" does not include:

(1) a convalescent, nursing, rest, or Skilled Nursing Facility; or
(2) a facility chiefly operated for treatment of the aged, drug addicts or alcoholics.

ILLNESS: 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: Bodily injury caused by external means and which results directly from the accident and independently of all other causes.

IN-NETWORK CARE: Care which is received at or from a Participating Provider who is contracted with the Preferred Provider Organization the plan has selected to provide benefits.

INPATIENT: Confined as a registered bed patient in a Hospital, Skilled Nursing Facility, Hospice, or Free-Standing Chemical Dependency Treatment Center.

INTENSIVE CARE UNIT: 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 also includes what is referred to as a “coronary care unit” or an “acute care unit”. It must include the following:

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

LEGEND DRUG: Any medicine or drug which has a label which reads, “Caution: Federal Law prohibits dispensing without a prescription”.

L.P.N.: This means a licensed practical nurse.

MEDICAL CARE FACILITY: A Hospital, or a facility that treats one or more specific ailments or any type of Skilled Nursing/Extended Care Facility.

MEDICARE: Medical benefits provided by Title XVIII of the Social security Act, as amended.

MEDICALLY NECESSARY: Medically necessary is defined as health care or services or supplies which, in the judgment of the attending physician, are appropriate and consistent with the physician's diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered. At no time will the following services of supplies be considered to be medically necessary:

(1) Those that do not require the technical skills of a medical, a mental health, or a dental professional; or
(2) those furnished mainly for the personal comfort of convenience of the person, any person who cares for him or her, any person who is a part of his or her family, any healthcare provider or healthcare facility; or
(3) those furnished solely because the person is an inpatient on any day on which the person’s illness or injury could safely and adequately be diagnosed or treated while not confined; or
(4) those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician’s or dentist’s office or other less costly setting.

MEDICARE: Health Insurance for the Aged and Disabled under Title XVIII of the Social Security Act, as amended.

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

MORBID OBESITY: 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 for a person of the same height, age, and mobility as the Covered Person.

NO-FAULT AUTO INSURANCE: The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

NON-PARTICIPATING PHARMACY: A Pharmacy which is not participating in the Preferred Provider Organization which the Company has selected to provide Prescription Drug benefits under this plan.

NON-SURGICAL IN-NETWORK DOCTOR’S OFFICE VISIT: A visit to the office of a PPO Network doctor. The participating doctor charges a separate fee for each “office visit”. The “office visit” codes are determined by the American Medical Association’s “Physician’s Current Procedural Terminology” (CPT) coding guide. An office visit also includes any non-surgical service for which the doctor bills IN ADDITION TO his fee for the office visit AT THE SAME TIME AND AT THE SAME SITE as an office visit (For Example: Laboratory or X-ray services sent to an independent provider are subject to deductible and co-insurance). Services performed in a doctor’s office are not, by themselves, eligible as an office visit – these types of services include, but are not limited to physical therapy, spinal manipulation, office surgery of any type, injections (including allergy), Magnetic Resonance Imaging, CT Scans, PET Scans, or other similar diagnostic testing . Office surgery does not qualify as an “office visit”.

OPEN-ENROLLMENT PERIOD: The period of time which is sixty (60) days prior to the end of the Plan Year during which an employee or dependent, who previously declined coverage, may re-apply for coverage. Coverage will not become effective until the first day of the month following the sixty (60) day open-enrollment period. The current open-enrollment period begins November 1st of each calendar year, and ends December 31st of the same calendar year.

OUT-OF-AREA CARE: Care which is not received at or from a participating provider because a participating provider network is not available in the state in which care is received.

OUT-OF-NETWORK CARE: Care which is not received at or from a participating provider.

OUTPATIENT: Receiving medical services, but not confined as a registered bed patient in a Hospital, Skilled Nursing Facility, or Hospice.

OUTPATIENT SURGICAL CENTER: Any public or private establishment which:

(1) has an organized medical staff of Physicians;
(2) has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
(2) provides continuous Physician services and registered professional nursing services while patients are in the facility;
(4) which does not provide services or other accommodations for patients to stay overnight; and
(5) makes charges.

PARTICIPATING PROVIDER/PHYSICIAN: This is a health care provider that has contracted with the Preferred Provider Organization which the Company has selected to provide benefits to Covered Persons as directed by, and in conjunction with the plan of benefits.
PARTICIPATING PHARMACY: This is a Pharmacy which is participating in the Preferred Provider Organization which the plan has selected to provide Prescription Drug benefits.

PHARMACY: A licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

PHYSICIAN: A medical practitioner who:

(1) is a legally qualified physician or surgeon (or is a professional person deemed by state law to be the same as a legally qualified physician); and
(2) is acting within the lawful scope of his or her license.

Physician does not include a person who:

(1) is the Covered Person receiving treatment; or
(2) is a relative of the Covered Person receiving treatment.

PLAN: The Lauren Corporation Employee Benefit Plan, which is a benefits plan for certain employees of Corporation and its participating subsidiary and affiliate companies, and is described in this document.

PLAN YEAR: The 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year. The current Plan Year begins on January 1st of each calendar year and ends on December 31st of the same calendar year.

PRE-ADMISSION TESTING: X-Ray and lab exams which:

(1) are performed on an Outpatient basis;

(2) are performed within seven (7) 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): This is the organization(s) which the plan has contracted to furnish services or supplies to Covered Persons for a negotiated fee, on an In-Network basis. A listing of preferred providers (including a pharmacy listing) was delivered in conjunction with a copy of the plan of benefits. Preferred Providers may differ from state to state and for different benefit areas under this plan such as medical, prescription drug, etc.

PRESCRIPTION: Means the Physician's order for each separate Prescription Drug and each authorized refill of that order.

PRESCRIPTION DRUG: Means:

(1) a Legend Drug;
(2) a state restricted drug;
(3) a compounded medication, of which at least one ingredient is a Legend Drug or a state restricted drug; or
(4) injectable insulin; or
(5) an oral contraceptive

SKILLED NURSING FACILITY: A place, or a distinct part of a place which meets all of the following criteria:

(1) It is licensed according to state and local laws;
(2) its chief purpose is to provide skilled nursing treatment to a Covered Person who is recovering from an Illness or Injury;
(3) it includes areas for medical treatment;
(4) it provides 24-hour-a-day nursing service under the full-time supervision of a Physician or a graduate registered nurse (R.N.);
(5) it maintains daily health records for each patient;
(6) it has an agreement which provides for the services of a Physician;
(7) it has a suitable method for providing drugs and medicines to patients;
(8) it has an arrangement with one or more Hospitals for the transfer of patients;
(9) it has an effective utilization review plan;
(10) its functions are developed with the advice and review of a skilled group which includes at least one (1) Physician;
(11) it is not solely a place for:
    (a) rest, rehabilitation or custodial care;
    (b) the aged;
    (c) alcoholics; or
    (d) those who are mentally retarded or who have mental disorders; and
(12) it makes charges.

SPINAL MANIPULATION: 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.

SUBSTANCE ABUSE: The condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

TEMPOROMANDIBULAR DISORDER: Disease or dysfunction of the Temporomandibular Joint, which links the lower jaw bone to the skull, and/or the chewing muscles.

TOTAL DISABILITY: An Injury or Illness which:

(1) with respect to a Covered Employee, prevents the Covered Employee from doing each of the main duties of such Covered 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.

USUAL AND CUSTOMARY: The ordinary charge made by a person, group or other entity which provides services, treatments or materials. It does not include any charge which the Company 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 of similar income or net worth in the area where the Covered Person normally resides.

The term "area" means a county or such greater area as is required to obtain a typical cross section of others who provide such services, treatments or materials to persons of similar income or net worth.

VISIT: Each instance of treatment, consultation, therapy or related session given by a health care provider. For the purpose of defining one Home Health Care Visit, each four-hour instance is considered one Home Health Care Visit, although one Visit may be less than four hours in duration.

WAITING PERIOD: The period of time that begins with an employee's most recent date of employment with the Company and ends on the day prior to the day such employee is eligible for coverage under the Plan.

LIMITED CONTINUATION OF COVERAGE (COBRA)

INTRODUCTION

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

PLAN ADMINISTRATOR

The Lauren Corporation Employee Benefit Plan Administrator is Lauren Engineers & Constructors, Inc., 901 South First Street, Abilene, TX 79602, (325) 670-9660. The Plan Administrator is responsible for administering COBRA continuation coverage. If you have questions about your COBRA continuation coverage, you should contact the Lauren Engineers & Constructors, Inc. Human Resources Department or you may contact the nearest Regional or District office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA CONTINUATION COVERAGE

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

Employee

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

1. Your hours of employment are reduced, or

2. Your employment ends for any reason other than your gross misconduct.

Spouse

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

1. Your spouse dies;

2. Your spouse's hours of employment are reduced;

3. Your spouse's employment ends for any reason other than his or her gross misconduct;

4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

5. You become divorced or legally separated from your spouse.

Dependent Children

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

1. The parent-employee dies;

2. The parent-employee's hours of employment are reduced;

3. The parent-employee's employment ends for any reason other than his or her gross misconduct;

4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

5. The parents become divorced or legally separated; or

6. The child stops being eligible for coverage under the plan as a "dependent child."

NOTIFICATION

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs.

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

LENGTH OF COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, either by Disability Extension or by a Second Qualifying Event.

DISABILITY EXTENSION OF THE 18 MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice, including an actual copy of the Social Security Administrations written notification to you, should be sent to Lauren Engineers & Constructors.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

An 18 month extension of COBRA coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include:

(1) death of a Covered Employee
(2) divorce or separation from the Covered Employee
(3) Covered Employee enrolls in Medicare
(4) a Dependent child ceases to be eligible for coverage as a Dependent under the Plan

You must notify the Plan Administrator within 60 days after the second qualifying event occurs.

BANKRUPTCY

If the Plan includes retiree coverage, a Covered Retiree (or Dependent of a Covered Retiree) may be able to continue Coverage for a longer period when the Company files for Chapter 11 Reorganization. This period will be as required by Section 4980B of the Internal Revenue Code.

ELECTION

The Plan Administrator is required to send you a COBRA Election Notice within 30 days of their receiving notice that a qualifying event has occurred (an employer that administers COBRA continuation for their own plan has 44 days to send you an Election Notice).

You must make written election for coverage by the 60th day following the date you receive the COBRA Election Notice. Each qualified beneficiary retains a separate right to elect COBRA continuation coverage.

You do not have to send payment for continuation coverage with your Election Notice. However, you must pay the required monthly cost within 45 days of the election date (This is the date the Election Notice is post-marked, if mailed). If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

MONTHLY COST

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. Usually the Monthly Cost will not exceed 102% of the total average monthly cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. However, when a disabled Covered Person continues beyond 18 months, the Monthly Cost will increase to 150% of that total average monthly cost. The Monthly Cost must be paid on a monthly basis, within 30 days of the due date and in the manner prescribed by the Company. The Covered Person may elect to pay the Cost on a quarterly, semi-annual or annual basis.

PAYMENT OF CLAIMS

No claim incurred during any month of the COBRA extension period will be payable under this COBRA provision until the Company receives the applicable Monthly Cost for the Covered Person's COBRA Continuation Coverage.

TERMINATION

A Covered Person's Coverage under the COBRA 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 is covered under any other group health plan (as an employee or otherwise);*
(3) the date the Covered Person becomes eligible for Medicare (Part A, B or both) benefits ;

(4) the date the Covered Person fails to make timely payment of the Monthly Cost under the Plan (subject to a 30-day grace period);
(5) for a disabled Covered Person who continues Coverage beyond 18 months, the 1st of the month which begins 30 days after the Covered Person is no longer considered disabled by the Social Security office; or
(6) the end of the applicable 18, 29 or 36 month period. (In no case will Coverage continue beyond 36 months from the original qualifying event, even if a second qualifying event occurs during the COBRA coverage period.)

*__EXCEPTION__: If the other group health plan includes a pre-existing conditions limit applicable to a condition the Covered Person has, Coverage will not end in accord with part (2) until that limit is satisfied.

However, as specified under HIPAA, Covered Persons who are exempt from the pre-existing conditions limitation provision of the other group plan under which they are covered due to creditable coverage, must terminate their COBRA coverage on the date their new group policy becomes effective.

CONTINUATION OF COVERAGE DURING AN APPROVED LEAVE OF ABSENCE GRANTED TO COMPLY WITH FEDERAL LAW

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by the Family and Medical Leave Act of 1993 (FMLA). If the Company grants you approved FMLA leave for a period in excess of the period required by the FMLA, any continuation of coverage during that excess period will be determined by the Company.

If the Company grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Plan Benefits for you and your eligible dependents.

At the time you request leave, you must agree to make any contributions required by the Company to continue coverage.

If any coverage the Company allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

(a) The date you are required to make any contribution and you fail to do so.
(b) The date the Company determines your approved FMLA leave is terminated.
(c) The date the coverage involved is discontinued as to your eligible class.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Plan Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Limited Continuation of Coverage, COBRA Coverage, on the same terms as though your employment terminated, other than for gross misconduct, on such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date the Company determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for the Company following the date the Company determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date the Company determines the approved FMLA leave terminated. If you do not make such request within 31 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent.

If any coverage being continued terminates because the Company determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date the Company determines the approved FMLA leave is terminated.

COORDINATION OF BENEFITS

If a person is covered under more than one plan, the plans could pay benefits for more than 100% of the covered charges under the plans. To prevent benefit payment exceeding this Plan's allowable benefits, the Coordination of Benefits (COB) provision is included. It coordinates all the benefits provided by this Plan with similar benefits payable under any other medical plan.

In this section, the term "plan" means any health care coverage or similar 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 plan;
(3) Any coverage under Labor-Management-Trustee Plans, union welfare plans, employer organization plans, or employee benefit organizations plans;
(4) Any government programs (including Medicare);
(5) Any coverage required or provided by law;
(6) "No Fault" auto insurance; and
(7) Third party liability insurance.

Each policy contract or other plan for benefits or services will be considered a separate plan. A plan may include a COB provision (or similar provision) on some, but not all, of its benefits or services. The benefits or services subject to the COB provision will be considered a separate plan from the benefits or services not subject to a Coordination of Benefits provision.

In this section, the term "allowable expense" means any Usual and Customary Charge covered in full or in part under more than one plan. When this Plan is secondary (i.e., when this Plan pays after the benefits of another plan), "allowable expense" will include any deductible or coinsurance amounts not paid by the other plan. No more than 100% of allowable expenses will be paid by all plans together. In no event will an "allowable expense" include an expense incurred when the person's coverage is not in effect under this Plan. When a plan provides benefits in the forms of services, rather than cash payments, the reasonable cash value of the services will be considered a benefit paid.

In the case of HMO (Health Maintenance Organization) plans: This Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment is full. Also, when an HMO pays its benefits first, 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.

COORDINATION PROCEDURES

If a Covered Person is covered under more than one plan, this Coordination of Benefits section will apply. This section will be used to determine the amount of benefits payable under this Plan for a Covered Person.

One plan is the primary plan, and all the other plans are secondary, in the order described below. The primary plan pays its benefits first, without taking the other plans into consideration. The secondary plans then pay benefits up to the extent of their liability after taking into consideration the benefits provided by the other plans. Benefits under other plans include benefits which a Covered Person could have received if such benefits had been claimed.

(1) If a plan has no COB provision (or similar provision), it is automatically the primary plan.

(2) If all the plans have COB provisions, a plan is primary (Plan A) if it covers the person as an employee (or member or subscriber), and secondary (Plan B) if it covers the person as a dependent.

However, if the person covered in a plan that is primary (Plan A) is a Medicare beneficiary, and if Medicare is Secondary to the plan that is considered as secondary under the above rule (Plan B), then the secondary plan will pay before the primary plan.

(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 have the same birthday, the plan covering the parent longer is the primary plan;
(c) if the other plan coordinates benefits based upon the sex of the parents, then the plan that covers such person as a dependent of a male person is the primary plan;
(d) if the parents are separated or divorced, the rules below will apply:
(i) The plan covering the child as a dependent of the parent with legal custody of the child would be the primary plan; unless
ii) a court decree sets the obligation for medical expenses of such child. The plan which covers the child as a dependent of the parent with such obligation will be the primary plan.

(4) If a plan is "No Fault" auto insurance or third party liability insurance, it is the primary plan. No reimbursement is available for auto insurance plan deductibles. This plan shall always be considered the secondary carrier regardless of an individual's election under personal injury protection coverage with the auto insurance carrier.

(5) If the primary plan is still not established by (1), (2), (3), or (4), then the plan that covers such person for the longest, continuous period of time will be the primary plan.

(6) Regardless of (2) through (5) above, a Plan which covers the person as an active employee (or a dependent of an active employee) will be primary to a Plan which covers the person as:
(a) a laid-off or retired employee;
(b) the dependent of a laid-off, retired or deceased employee; or
(c) a COBRA beneficiary who is continuing coverage in accord with federal law.

(7) Medicare will be primary or secondary or last as specifically stated in Federal Law. When Medicare is to be primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

(8) If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will be the primary plan.

RIGHT TO EXCHANGE DATA

The Company has the right to exchange benefit information with any insurance company, organization, or person to determine benefits payable using this 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 Company with data it requires to apply this provision.

PAYMENT AND OVERPAYMENT

If payments have been made under any other plan which should have been made under this Plan, the Company will have the right to reimburse to the extent necessary to satisfy the intent of this provision. If the Company pays benefits in good faith to an organization, the Company will not have to pay such benefits again. The Company has the right to recover any overpayment made because of coverage under another plan. The Company may recover this overpayment from any insurance company, organization or person to whom, or for whom, the Company paid
benefits under this Plan.

SUBROGATION
THIRD PARTY LIABILITY

SUBROGATION

Subrogation is the Company's limited right to be substituted for a Covered Person in a claim for damages for willfully or negligently caused Injuries. If payment is made for services on behalf of a Covered Person under this Plan, the Company, to the extent of such payment, shall be subrogated to all rights of recovery while the Covered Person, or the Covered Person's representative, may have against any other party or liability insurer (including, but not limited to: first party coverage such as uninsured motorist coverage, underinsured motorist coverage, and automobile policy med pay provisions). The Covered Person shall do whatever is reasonably needed to secure the Company's rights, and shall do nothing to damage such rights. The Covered Person agrees that the Plan shall have first priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses.

The Plan requires a Subrogation Agreement be executed and returned to the Plan Administrator prior to making any payments on account of auto injury or other injury or illness involving third-party liability.

As a condition of participation in this Plan, the Covered Person agrees to reimburse the Plan for any payments made by the Plan, prior to receiving any reimbursement for any expense not actually incurred.

THIRD PARTY LIABILITY

If a Covered Person has medical charges:

(1) as a result of the negligence or intentional acts of a third party; and
(2) the Covered Person makes a claim for benefits under the Plan for such charges;

the Covered Person (or legal representative of a minor or incompetent) must agree in writing to repay the Company from any amount of money received by the Covered Person from the third party (or its insurer).

The repayment will be to the extent of the benefits paid by the Plan, but will not exceed the amount of the payment received by the Covered Person from the third party (or its insurer). The reasonable expense, such as lawyer's fees and court costs, incurred in obtaining payment from the third party may be deducted from the repayment to the Plan only if agreed upon, by the Plan, in writing.

The repayment agreement will be binding upon the Covered Person (or legal representative of a minor or incompetent) whether or not:

(1) the payment received from the third party (or its insurer) is the result of:
    (a) a legal judgment;
    (b) an arbitration award;
    (c) a compromise settlement; or
    (d) any other arrangement.

(2) the third party (or it insurer) has admitted liability; or
(3) the medical charges are itemized in the third party payments.

The Plan’s right to recovery under this subrogation provision shall apply regardless of how the settlement proceeds are classified by either party, their attorneys, and, if applicable, the court.

GENERAL PLAN PROVISIONS

SUMMARY PLAN DESCRIPTION

The Company will issue to each Covered Employee a Summary Plan Description (SPD). The SPD will state:

(1) the benefits provided;
(2) to whom benefits will be paid; and
(3) limitations or requirements to the Plan that may applied to the Covered Person.

The SPD is not part of the Plan Document. If there is a conflict between the Plan and the SPD, the Plan will control.

STATEMENTS

In the absence of fraud, all statements made by a Covered Person are representations and not warranties. No such statement will be used to contest the coverage provided by the Plan unless:

(1) it is a written statement; and
(2) a copy of such statement is furnished to the Covered Person or the Covered Person's beneficiary, if any.

MISSTATEMENT OF AGE

If a Covered Person's age has been misstated, the amount of benefits will be that which would have been payable based upon the person's correct age.

FUTURE OF THE PLAN

The Company intends to continue this Plan indefinitely, but reserves the right to terminate or amend the Plan in any way. If the Plan is discontinued, all eligible claims outstanding at that time will be paid in full or paid on a pro-rated basis. No consent of any Covered Person or any other person referred to in the Plan will be required to terminate, modify, amend or change the plan.

CLAIM FUND

The Lauren Corporation Employee Benefit Claim Fund is maintained at the Private Bank located in Chicago, IL.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

This Plan is intended to comply with the Welfare Benefit Provisions of ERISA.

The name of the Plan is: The Lauren Corporation Employee Benefit Plan

The original Plan effective date with is: February 1, 1997
The Plan is hereby amended and restated effective: January 1, 2015

The name, address and zip code of the Sponsor of the Plan, (Plan Administrator and Named Fiduciary) is:
The Lauren Corporation
901 South First Street
Abilene, TX 79602

Company Identification Number (EIN): 58-1821154
Plan Number: 501

The Plan Administrator is responsible for the administration of the Plan. Functions performed by the Plan Administrator include: the receipt and deposit of contributions, maintenance of records of the Plan participants, authorization and payment of Plan administrative expenses, selection of consultants, selection of Third Party Administrator and assisting the Third Party Administrator with the determination of the eligibility of individual claimants for receipt of benefits.

The designated agent for service of legal process is:
The Lauren Corporation
901 South First Street
Abilene, TX 79602

Claims Administrator is:
Alternative Benefit Plans, Inc.
2920 Brandywine Road, South, Suite 106
Atlanta, GA 30341
(The Plan is administered by the Plan Administrator with Alternative Benefit Plans, Inc. (a Third Party Administrator) acting as claims paying agent.)

Plan Contributions: Both the Company and Employees contributes to the cost of the Plan.

The Plan fiscal year ends on: December 31st.

The name and address of Plan trustee (fiduciary):
The Lauren Corporation
901 South First Street
Abilene, TX 79602

LOSS OF BENEFITS (Amending and Terminating the Plan)

The Plan Administrator may terminate the Plan, or modify, amend or change the provisions, terms, and conditions of the Plan. No consent of any Covered Person or any other person referred to in the Plan will be required to terminate, modify, amend, or change the Plan.

STATEMENT OF ERISA RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections under ERISA. The Act provides that all Plan participants shall be entitled to:

(1) the Summary Plan Description, within ninety (90) days after you become a participant or within one hundred twenty (120) days after the Plan becomes subject to the reporting and disclosure provision of the Act;

(2) a summary of any change in the Plan Description or a summary of a material modification in the terms of the Plan, within two hundred ten (210) days after the end of the Plan year in which the change is adopted. A summary describing material reductions in covered services is required to be provided to you not later than 60 days after the adoption of the change, unless summaries of the changes, meeting ERISA guidelines, are provided at regular intervals of not more than ninety (90) days.

(3) an updated Summary Plan Description every five (5) years incorporating any amendments; and if no amendments have been adopted, another Summary Plan Description every ten (10) years;

(4) a summary of the annual report, within two hundred ten (210) days after the end of the Plan year;

(5) examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan Descriptions; and

(6) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.

The Plan Administrator must furnish to you within thirty (30) days of your written request (except for reasons beyond the control of the Plan Administrator) a copy of the following:

(1) the latest updated Summary Plan Description;
(2) the Plan Description;
(3) the latest annual report;
(4) the documents under which the Plan was established or is operated;
(5) terminal reports, if any.

The Plan Administrator may require you to pay a reasonable charge for the copies.

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

RIGHT TO SUE

Depending on the circumstances, civil action under ERISA can be brought by the Secretary of Labor, fiduciaries, Plan Administrators, Plan participants and others.

Your right to bring civil action includes the following:

(1) To compel a Plan Administrator to supply Plan documents requested in writing by you within thirty (30) days of the written request;
(2) To enforce rights under the Plan and to recover benefits due;
(3) For appropriate relief from breach of fiduciary duty;
(4) To enjoin any act or practice which violates any provision of Title I of ERISA, the terms of the Plan, or to obtain other equitable relief;
(5) To obtain review of a final action of the Secretary of Labor, to restrain the Secretary from taking action contrary to ERISA, or to compel the Secretary to take action.

U.S. district courts have exclusive jurisdiction over civil and criminal actions brought under Title 1 of ERISA except that cases pertaining to benefit recovery brought by participants may also be brought in state courts. U.S. district courts have jurisdiction in grant relief without respect to the amount in controversy or the citizenship of the parties. 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 frivolous.

LEGAL ACTION

Legal action to recover any lost benefits under this Plan may not be brought:

(1) until the Plan's appeal procedure, including utilization of a professional/peer review committee, has been exhausted per the terms of the ERISA (see section on CLAIMS REVIEW AND APPEAL PROCEDURE); OR
(2) later than three (3) years after the expense/disability was incurred.

FURTHER INFORMATION

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

A current directory of PWBA regional and district offices is set forth below:

Atlanta Regional Office, 61 Forsyth St., S.W.
Suite 7B54, Atlanta, GA 30303
Phone: (404) 562-2156

Boston Regional Office, One Bowdoin Square
7th Floor, Boston, MA 02114
Phone: (617) 424-4950

Chicago Regional Office, 200 West Adams Street
Suite 1600, Chicago, IL 60606
Phone: (312) 353-0900

Cincinnati Regional Office, 1855 Dixie Highway
Suite 210, Ft. Wright, KY 41011-2664
Phone: (606) 578-4680

Dallas Regional Office, 525 Griffen Street
Room 707, Dallas, TX 75202-5025
Phone: (214) 767-6831

Detroit District Office, 211 West Fort Street
Suite 1310, Detroit, MI 48226-3211
Phone: (313) 226-7450

Kansas City Regional Office, City Center Square
1100 Main, Suite 1200, Kansas City, MO 64105-2112
Phone: (816) 426-5131

Los Angeles Regional Office, 790 E. Colorado Blvd.
Suite 514, Pasadena, CA 91101
Phone: (818) 583-7862

Miami District Office, 111 NW 183rd Street
Suite 504, Miami, FL 33169
Phone: (305) 651-6464

PRIVACY NOTICE

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

The Lauren Corporation Employee Benefit Plan is required by law to maintain the privacy of "protected health information."

"Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures The Lauren Corporation Employee Benefit Plan will make of your protected health information.

The Lauren Corporation Employee Benefit Plan reserves the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office.

PERMITTED USES AND DISCLOSURES

The Lauren Corporation Employee Benefit Plan can use or disclose your protected health information for purposes of treatment, payment and health care operations.

Treatment means the provision, coordination or management of your health care, including referrals for health care from one health care provider to another. For example, a provider under The Lauren Corporation Employee Benefit Plan may need to know health care information in plan files that might assist in treatment.

Payment means activities to obtain and provide reimbursement for the health care provided to you, including determinations of eligibility or coverage; claims adjudication; billing and collection activities; reviewing health care services for medical necessity, coverage, justification of charges and similar activities; utilization review activities; and certain disclosures to consumer reporting agencies. For example, the information on or accompanying health care bills sent to the plan may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

As another example, prior to providing health care services, The Lauren Corporation Employee Benefit Plan may need information from a provider about your medical condition to determine whether the proposed course of treatment will be covered. When the plan receives a bill from the provider, The Lauren Corporation Employee Benefit Plan can obtain information regarding your care if necessary to provide payment.

Health care operations means the support functions related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities, underwriting and other activities related to the creation, replacement or renewal of an insurance or re-insurance contract; . For example, we may use your medical information to evaluate the performance of providers used in our plan. We may also combine medical information about many patients to decide how to better provide needed benefits under the plan.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The Lauren Corporation Employee Benefit Plan may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

The Lauren Corporation Employee Benefit Plan may disclose your protected health information to your family or friends of any other individual identified by you when they are involved in your care or the payment for your care.

The Lauren Corporation Employee Benefit Plan will only disclose the protected health information directly relevant to their involvement in your care or payment. The Lauren Corporation Employee Benefit Plan may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition, or death. If you are available, The Lauren Corporation Employee Benefit Plan will give you an opportunity to object to these disclosures, an the plan will not make these disclosures if you object. If you are not available, The Lauren Corporation Employee Benefit Plan will determine whether a disclosure to your family or friends is in your best interest, and the plan will disclose only the protected health information that is directly relevant to their involvement in your care. When permitted by law, The Lauren Corporation Employee Benefit Plan may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

Except for the situations set forth below, The Lauren Corporation Employee Benefit Plan will not use or disclose your protected health information for any other purpose unless you provide written authorization.

You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that The Lauren Corporation Employee Benefit Plan already has taken action in reliance on your authorization.

EXCEPTIONAL SITUATIONS

We may use or disclose your protected health information in the following situations without your authorization:

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

Health Oversight Activities. We may disclose medial information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

Inmates. If you become an inmate of a correctional institution or fall under the custody of a law enforcement official, the plan may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care; to protect you health and safety of the health and safety of others; or for the safety and security of the correctional institution.

Law Enforcement. We may release medical information in these situations: 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; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report

a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you 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.

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

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law.

Organ to Tissue Donation. If you are an organ donor, we may release 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.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection for the President, other authorized persons or foreign heads of state or conduct special investigations.

Public Health Risks. We may disclose medical information about you 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 product recalls, repairs or replacements; to notify a person who may have been exposed to 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.

Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Workers' Compensation. We may release medical information about you for programs that provide benefits for work-related injuries or illness.

YOUR RIGHTS

- You have the right to request restrictions on The Lauren Corporation Employee Benefit Plan's uses and disclosures of protected health information for treatment, payment and health care operations. However, The Lauren Corporation Employee Benefit Plan is not required to agree to your request.

- You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.

- Subject to payment of a reasonable copying charge (if you cannot afford to pay for copies, you will not be denied access), you have the right to inspect and copy the protected health information contained in the plan's records, except for psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. In come circumstances, you may have a right to have this decision reviewed.

- You have the right to request a correction to your protected health information, but The Lauren Corporation Employee Benefit Plan may deny your request for correction. Any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

- You have the right to receive an accounting of disclosures of protected health information made by the plan to individuals or entities other than to you, except for disclosures to carry out treatment, payment and health care operations as provided above; to persons involved in your care or for other notification purposes as provided by law; for national security or intelligence purposes as provided by law; to correctional institutions or law enforcement officials as provided by the law; or that occurred prior to April 14, 2004.

- You have the right to request and receive a paper copy of this notice from us.

FILING A COMPLAINT

If you believe that your privacy rights have been violated, you should immediately contact our privacy officer at (325) 670-9660. The Lauren Corporation Employee Benefit Plan will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact the privacy officer at (325) 670-9660.

The Lauren Corporation, a Texas corporation, (the “Company”) hereby re-states their self-funded Health Care Plan entitled The Lauren Corporation Employee Benefit Plan, (the “Plan”), effective January 1, 2015.

The purpose of 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 agrees to make payments as provided in this Plan.

This document, in it’s entirety, constitutes the Plan.

The Company has caused this instrument to be executed by its duly authorized officers this first (1st) day of January, 2015.

_____ _____

(Name) (Title)