SUMMARY PLAN DESCRIPTION (SPD)

of the **Tyonek Native Corp BasicCare Program**

(the "Benefit Program")

This booklet provides important information about the Benefit Program offered by your Employer.

PLEASE NOTE: A person can only be covered if eligible for the coverage; if enrolled; and if the required premium has been paid. If you have any questions about your enrollment status, please contact your Employer.

This booklet, together with the copy of the form used to enroll, makes up the Summary Plan Description.

Your health insurance coverage, offered by Reliance Standard Life Insurance Company (RSL), does not meet the minimum standards required by the Affordable Care Act. Instead, it has annual limits which are the amounts specified in the Medical Section of this Summary Plan Description. For plan years beginning September 23, 2011, the Affordable Care Act prohibits limits on benefits which are less than $1.25 million annually; that annual limit increases to $2 million for plan years beginning September 23, 2012.

In order to apply the lower limits described above, RSL requested a waiver of the requirement that coverage for key benefits be at least the required amount. That waiver was granted by the U.S. Department of Health and Human Services because RSL demonstrated to the Department that providing the minimum required by the Act would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for two years.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact your ERISA Plan Administrator.

In addition, you can contact RSL Specialty Products Administration at 866-375-0775.

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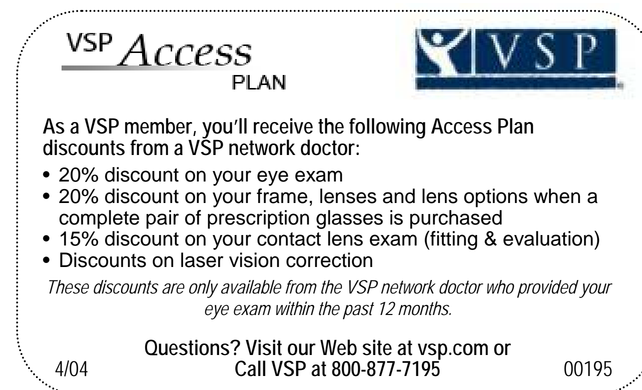
ID CARDS

Please Remember:

- ID Cards are only valid if 1) you have enrolled AND 2) your first premium has been paid.
- Your Medical ID Card should be in the same package that included this booklet. A separate Prescription Drug ID Card will arrive shortly after your first premium has been paid for Medical Coverage. The VSP Access Plan Membership Card is included below.
- Carry your ID Cards with you when you visit a health care provider. Information on the cards will help the provider to file a claim for you.
- ID Cards are not proof of coverage under any plan.
- ID Cards become void if your coverage is terminated.

CUT OUT THE VSP ACCESS PLAN MEMBERSHIP CARD AND KEEP IN YOUR WALLET.



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BENEFIT PROGRAM INFORMATION

Carrier:	Reliance Standard Life Insurance Company
Carrier's Address:	2001 Market Street, Suite 1500, Philadelphia, PA 19103

IMPORTANT FACTS ABOUT THE BENEFIT PROGRAM

Eligible Employees:	All employees working at least 30 hours per week.
Eligibility:	Immediate
Coverage Begins:	The first day of the month following your enrollment provided you are eligible and the required premium is paid.
Enrollment Date:	The date your coverage begins or, if you had to satisfy an employment waiting period for benefits (see "Eligibility" above), the first day of that waiting period provided you enrolled when you first became eligible.
Coverage Year:	September 1, 2012 – September 30, 2013

ERISA INFORMATION

ERISA Plan Name:	Tyonek Native Corp BasicCare Program
Type of ERISA Plan:	Health and Welfare Benefits
ERISA Plan Number:	As on file with the ERISA Plan Administrator
ERISA Plan Fiscal Year End:	As on file with the ERISA Plan Administrator
ERISA Plan Sponsor:	Tyonek Native Corp
ERISA Plan Administrator:	Rhonda Bauer 229 Palmer Rd. Madison, AL 35758 Phone: (256) 722-3258 Fax: (256) 722-3285
Agent for Service:	ERISA Plan Administrator
Employer Identification #:	20-1603684

Questions?
Just call RSL Specialty Products Administration at 1-866-375-0775. Representatives are ready to answer your coverage questions Monday through Friday, from 8:30 am to 5:30 pm, ET.

Preguntas? Este folleto contiene un resumen en ingles de su Programa de Beneficios de Grupo. Si usted tiene dificultad en entender cualquier parte, llame al numero gratuito 1-866-375-0775. Representantes de consulta estan disponibles lunes a viernes, de 8:30 am a 5:30 pm (hora del Este), para darle asistencia en espanol.

GENERAL QUESTIONS

Can I change my enrollment choices?
Not usually. Typically you must wait for the next open enrollment period. However, there are certain times when enrollment changes can be made.

If you didn't enroll in Medical Coverage because you and/or your dependents were already covered under another plan, and that coverage is lost, you can request a special enrollment within 31 days of the loss of that other coverage.

Reasons for losing other medical coverage:
- Divorce, legal separation, or death;
- Termination of a dependent's employment;
- Reduction of a dependent's hours;
- Termination of COBRA rights; or
- Loss of employer's contribution to spouse's medical coverage.

If you have a change in your family situation, such as a divorce, legal separation, death, marriage, or birth/adoption of a child, you can request a special enrollment within 31 days of that change.

YOU MUST COMPLETE A LIFE EVENT CHANGE FORM to make any enrollment change. That form is available from your Employer.

When will coverage end?
Coverage ends if:
- premiums aren't paid in full;
- you enter an Armed Service on full-time active duty;
- you are no longer eligible for the coverage; or
- the group policy terminates.

If coverage ends, you may be entitled to continue your coverage under COBRA. There is information about COBRA later in this booklet.

How much does the Benefit Program cost?
The premium due for the Benefit Program varies depending upon which family members you cover. You should check your copy of the form you used to enroll to determine the amount due for your coverage.
Note: Premium amounts are subject to change over time.

Who is an eligible dependent?
If the Benefit Program allows for dependents to be covered, eligible dependents are:
- your lawful spouse; and
- your eligible children through age 25.

Eligible children include your children by birth, stepchildren, foster children, legally adopted children, children living with you while you are completing adoption procedures, and children for whom coverage has been court-ordered.
Note: If you have a covered child who turns 26 and is handicapped and unable to earn a living, they may still be eligible for coverage. You must notify your Employer within 31 days to ensure continued eligibility for that child. Proof of continued eligibility may be required from time to time.

When does coverage begin and end for my dependents?
Your dependents' coverage begins when your coverage begins if you enrolled them when you enrolled. It ends when yours does, or when the dependent is no longer eligible. Your child born while coverage is in force is covered for the first 31 days. A newborn child's coverage includes necessary care and treatment of congenital defects, birth abnormality, prematurity, and routine newborn care. The child will remain covered for injury and sickness after the first 31 days only if you apply for coverage and pay any required premium within the 31-day period after the child's birth. A minor child who comes under your care and control while coverage is in force is covered for injury and sickness provided you file a petition to adopt. The child will be covered from the date of placement in your home if you apply for coverage and pay any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. The carrier reserves the right to approve or disapprove any late application to cover a dependent.

If a court order requires that I provide coverage for my dependents, how will this begin?
You and your Employer will both receive the court order requiring coverage to begin for your dependents. Your Employer will then be responsible for making the appropriate arrangements and notifying the carrier.

What if both my spouse and I work for the same Employer?
You can either both choose single coverage or one of you may choose family coverage. You may not be covered twice. If you and your spouse have one or more eligible children, only one of you may cover all dependents (spouse and children).

PRIVACY PRACTICES 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.

RELIANCE STANDARD LIFE INSURANCE COMPANY
FIRST RELIANCE STANDARD LIFE INSURANCE COMPANY
RELIANCE STANDARD LIFE INSURANCE COMPANY OF TEXAS

PRIVACY NOTICE

The Reliance Standard Life Insurance group of companies recognizes that protecting the privacy and security of the personal information we obtain about our customers is an important responsibility. This Privacy Notice generally describes our policy about how we treat that information. This notice refers to Reliance Standard Life Insurance Company, First Reliance Standard Life Insurance Company and Reliance Standard Life Insurance Company of Texas using the terms "we," "us," and "our."

Information we may obtain. Depending on the type of product or service that we are providing, we may obtain Customer Information, Financial Information and/or Health Information about you.

Customer Information includes identifying information such as your name, address, telephone number, Social Security number and demographic data about you. It also includes information about your transactions with us such as the type and value of the Reliance Standard products you own and the amount of premiums and fees that you pay to us.

Financial Information includes information about your income, assets, liabilities, and the type and value of other insurance that covers you.

Health Information includes information about your health and medical history and your insurance underwriting risk factors.

Security of the information. We maintain physical, electronic and procedural safeguards that comply with Federal and State laws to protect all of the information we have obtained about you.

From whom we obtain information. We may obtain Customer Information, Financial Information and/or Health Information from any of the following sources:
- Your application and related forms;
- Your insurance agent or broker;
- Your communications with us;
- Your employer;
- Your medical providers;
- Consumer reporting agencies;
- Your claim for benefits; and
- Anyone you have authorized to provide information to us.

What we do with the information we obtain. The Customer Information, Financial Information and Health Information (collectively referred to here as "Information") which we obtain is used in order to provide our products and services to you, and may be used to evaluate your request for products or services, evaluate your claim for benefits and process your transactions with us. We may also use the Information to offer you other products and services which we or our affiliated companies (that is, members of the Delphi Financial group of companies) provide. The Information may be disclosed to non-affiliated entities with whom we have contracted to perform certain business services for us. This may include entities which provide claims administration, underwriting, investigation, reinsurance, policyholder or other services to us or on our behalf. These companies are carefully selected, and are required by the terms of their contract with us to maintain the confidentiality of the Information. We may also disclose Information about you if you have authorized us to do so, or as otherwise permitted or required by law.

We do **not** disclose any nonpublic personal information about you to any non-affiliated company for marketing purposes or for any other purpose except as described in the previous paragraph.

Independent Sales Agents. Your policy may have been placed with us through an independent agent or broker ("Sales Agent"). Your Sales Agent may gather and retain Information about you. The use and protection of Information by your Sales Agent is your Sales Agent's responsibility, not our responsibility. If you have questions about whether or how your Sales Agent uses or discloses such information, please contact your Sales Agent.

doctor who provided your eye exam within the past 12 months. For questions regarding the VSP Access Plan, call VSP at 1-800-877-7195 or visit their website at www.vsp.com.

COBRA – EXTENDED COVERAGE

What is COBRA?
As noted previously, if your coverage ends you may be entitled to have continued coverage in some circumstances. A federal law known as COBRA gives you this continuation right. It stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

While you may elect COBRA continuation coverage on behalf of your dependents, each person who was covered at the time coverage ends has his or her own right to elect COBRA and/or any other state continuation or conversion rights. This means that your dependents may elect such coverage even if you decide not to. So, if you have enrolled your eligible spouse or children, please share this information with them. If you would like additional copies of this booklet to share with your spouse or children, please contact your Employer. For more information about your COBRA rights, contact your Employer.

When am I eligible for COBRA?
You and your covered dependents are eligible for COBRA continuation if you lose coverage because you quit or lose your job for any reason, other than gross misconduct, or your hours are reduced. Generally, you and your dependents are entitled to continue health coverage for 18 months. However, if you or your dependents are disabled, then the period may be extended to a total term of 29 months (see "What if I am disabled when my employment ends?").

What about my dependents?
Your dependents are also eligible for COBRA continuation if they lose coverage at any time due to:

- your death;
- your divorce or legal separation;
- your becoming entitled to Medicare while on COBRA; or
- your dependent no longer meeting the eligibility definition under the Benefit Program (for example, a dependent child reaching the age limit).

In any of these qualifying events your dependents are entitled to continue health coverage for 36 months from the date of the event.

What must I do to elect COBRA?
Your Employer must provide notice when you lose or quit your job, your hours are reduced, or you become entitled to Medicare. Your Employer will notify you of your right to elect COBRA. Within 60 days of that notification, you must respond, in writing, of your election. Do not send a payment with your election.

When will I pay for COBRA coverage?
Once your election is received, you will be notified by mail of the amount of your first premium and where to send your payment. You will have 45 days from your election to make your initial premium payment. This first premium payment will retroactively cover the period from your coverage termination date to the date of your election. After that, the regular monthly payments (shown on your initial notice) are due by the first of each month. No bills or reminder notices will be sent to you.

Do my dependents and I have to keep my Employer informed?
Yes. You and your dependents must notify your Employer of your current address and, if different, the address(es) of your dependents (spouse and children). You and/or your dependents must provide notice of: (1) your divorce or legal separation; (2) your dependent's loss of coverage for any of the reasons previously listed (see "What about my dependents?"); and (3) a determination by the Social Security Administration that you or your covered dependents are disabled. You and your dependents must mail or hand-deliver written notice of these events within 60 days to your Employer.

When does COBRA end?
COBRA coverage will end on the earliest of:

- the expiration of the maximum allowable term of 18, 29 or 36 months;
- the date the required premium is not paid when due;
- the date the group health coverage is terminated for active employees;
- the date the person on COBRA coverage first becomes covered under any other group health plan, without limitation as to any pre-existing condition that affects coverage; or
- the date the person on COBRA coverage becomes entitled to Medicare benefits.

What if I am on extended sick leave when my employment ends?
Under the federal Family and Medical Leave Act of 1993 (FMLA), you may be entitled to extended sick leave from your employment. If during that period you do not pay your premium, you can still elect COBRA if your employment ends during your FMLA leave. In such a case, you would not have to make up the missed premium for any time when you were on FMLA leave, but you would not be covered for any gaps in coverage.

What if I am disabled when my employment ends?
In order to extend continuation coverage for you and your dependents to 29 months, you or a covered family member must be disabled before or within the first 60 days of COBRA coverage. If this is the case, a copy of the

Social Security Administration's "determination of disability" must be sent to your Employer within 60 days of the determination, and within the original 18 months of your COBRA coverage. The premium to be paid for this additional 11 months of coverage may be substantially greater than the premium for the initial 18-month period and you will be notified of the additional cost of the extended coverage. If, during the 11-month extension, you or your covered dependents are no longer disabled, you must notify your Employer within 30 days. The extended COBRA coverage will end when you or your dependent are no longer disabled.

Is there another way to extend COBRA coverage?
Yes. If, while under the initial 18-month COBRA continuation coverage, your covered dependents experience another event that separately entitled them to COBRA continuation, they may get up to 18 additional months of continuation coverage. Notice of the second qualifying event must be given to your Employer. This extension is available only if the event would have caused the dependent to lose coverage under the Benefit Program had the first loss of coverage not occurred.

What premium has to be paid for COBRA coverage?
Generally, you will pay the rate for active employees under the Benefit Program, plus a 2% administrative fee. If the rate changes for active employees, your rate will change accordingly. As noted above, the premium for the 11-month extension because of disability could be substantially higher than normal.

Can I convert to another policy when my COBRA coverage ends?
Yes, provided that your COBRA continuation coverage is ending because you have reached the end of your 18-, 29-, or 36-month period. For the 180 days before that expiration date, you have the option of converting to another medical policy. For a discussion of conversion please see the topic, "CONVERSION OF YOUR MEDICAL COVERAGE", below.

What rights does a person on COBRA have during an open enrollment period?
A person on COBRA has the same rights at open enrollment as any other covered person under the Benefit Program.

Is there a way, other than COBRA, to extend coverage?
In some limited circumstances, and as governed by state law, you may be entitled to extended coverage if you lose your coverage and do not elect COBRA. At such time, you should contact your Employer to determine what rights, if any, you might have.

CONVERSION OF YOUR MEDICAL COVERAGE

What does conversion mean?
"Conversion", as used here, means changing your existing Employer-sponsored group medical insurance coverage to a different policy.

When do I have a conversion privilege?
If you are currently enrolled as an active employee or a COBRA participant as of your coverage termination date, you may be eligible for a conversion privilege that would allow you to convert your Medical Coverage if you:

- have been covered under the Benefit Program for at least three months;
- are not eligible for Medicare;
- were current in your premium payments; and
- are not eligible for, or covered under, another group policy providing similar benefits.

You may also be eligible to convert Medical Coverage on your dependents if they were covered under the Benefit Program and they meet the eligibility criteria of the conversion policy.

How do I convert my Medical Coverage?
You must call RSL Specialty Products Administration at 1-866-375-0775 within 31 days of the end of your coverage.

Will a conversion policy cost the same?
No. The conversion policy will be more expensive than the premium you were paying for the Medical Coverage under the Benefit Program.

YOUR RIGHTS UNDER ERISA

As a participant in the Benefit Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

What are my ERISA rights?
ERISA provides that all Benefit Program participants are entitled to:

- examine, without charge, at the Employer's office, all Benefit Program documents, including insurance contracts and copies of all documents filed by the ERISA Plan Administrator with the U.S. Department of Labor or the Internal Revenue Service, such as detailed annual reports and Benefit Program descriptions;
- obtain copies of all Benefit Program documents and other Benefit Program information upon written request to the ERISA Plan Administrator, who may make a reasonable charge for copies of the materials; and

surgery needed for an accident must be performed within 90 days of the accident;

- Expenses used to satisfy any co-pay, or in excess of any benefit limit or maximum, or in excess of negotiated or usual and customary charges;
- Drugs not requiring a prescription;
- Inpatient doctors' visits and inpatient private-duty nursing charges; and
- Services provided by a member of the covered person's immediate family or services provided by the ERISA Plan Sponsor.

FILING A CLAIM

How do I file a claim?
Your medical provider will most likely want to file a claim for you using his or her own form. If you need to file a claim yourself, you may request a claim form from your Employer, or you may call RSL Specialty Products Customer Service at 1-866-375-0775. Claims should be mailed to: RSL Specialty Products Administration, Claims Department, 505 S. Lenola Road, Suite 231, Moorestown, NJ 08057. Claims must be submitted within one year of the date of the loss. The carrier reserves the right to require a medical examination at its expense. For Claims Customer Service call 1-866-375-0775, Monday through Friday, 8:30 a.m. to 5:30 p.m., ET.

When will I know if my claim is denied?
If all or a part of your claim is denied, you will be notified in writing within 30 days from the date your claim was received. Under some circumstances, the carrier can notify you that it is extending this 30-day time frame by an additional 15 days. The denial notice will include: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a description of any information needed to make the claim complete; (d) a statement of your right to review (on request and at no charge) relevant internal guidelines, documents, and other information; and (e) an explanation of how to appeal for reconsideration of the decision, including your right to bring a lawsuit. If you are required to submit additional information to support your claim, you will have 45 days to do so.

How do I appeal a denied claim?
If you disagree with the decision, you may request a review within 180 days of the initial denial. If you do not submit your appeal on time, you generally will lose the right to appeal the denial. Your appeal must be in writing, clearly stating the reason you believe the denial is incorrect, and include any additional documentation that you feel would support a further review of your claim. You (on request and at no charge) may have reasonable access to and receive copies of all relevant documents concerning your claim. The reviewer of your appeal will be a different person or persons from the reviewer of your initial claim and will not be a subordinate of the initial reviewer. Your claim will be reviewed and a decision will be issued within 60 days from the date your appeal was received. If the decision on appeal continues to deny your claim, you will be furnished with a notice of adverse benefit determination on review, setting forth: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a statement of your right to review (on request and at no charge) relevant internal guidelines, documents, and other information; and (d) a statement of your right to bring a lawsuit.

What if I miss a deadline for filing a claim or appealing?
If you do not submit your claim on time, do not appeal on time, or do not otherwise follow the claims procedures, you may lose your right to file suit in court because you may have failed to exhaust your internal administrative appeals rights, which may be a prerequisite to bringing suit.

Is there any coordination of benefits?
This Medical Coverage does not coordinate benefits with any other coverage that you might have. That means we will not reduce your benefit because you have other coverage that pays you for the same expenses. If you have coverage from another source, that other coverage could reduce their benefits based on what this Medical Coverage pays you. An example would be Medicare or Medicaid. The rules of these programs require that your benefits under those plans be reduced by the amount of benefits you would receive under this Medical Coverage.

IMPORTANT NOTE: Your Medical Coverage allows access to important medical provider and pharmacy provider networks that utilize negotiated charges which may save you money. You may contact MultiPlan (at 1-800-877-0005) or Express Scripts (at 1-866-282-1491) to find network providers in your area.

VSP ACCESS PLAN MEMBERSHIP

What does membership in the VSP Access Plan give me?
Membership in the VSP Access Plan is a separate benefit that you receive when you are enrolled in the Medical Coverage. This benefit, which is provided through Vision Service Plan, offers discounts on eye exams and prescription glasses from VSP network doctors. When you visit a network doctor, you can receive a 20% discount on your eye exam, a 15% discount on your contact lens exam, a 20% discount on your frame, lenses and lenses options when a complete pair of prescription glasses is purchased. You also can receive discounts on laser vision correction. The discounts for prescription glasses and contact lenses are only available from the VSP network

also covered expenses. All covered expenses must be incurred while the Medical Coverage is in force and not be excluded.

What is "durable medical equipment"?
It is equipment that can withstand repeated use, is primarily for medical purposes, and is appropriate for use in the home; but, does not include medical supplies of an expendable nature.

What does "injury" mean?
Injury is a covered person's bodily injury caused by an accident that results, directly and independently of all other causes, in a covered expense being incurred. All injuries sustained in one accident, including all related conditions and recurring symptoms of the injuries, will be considered one injury.

What are "inpatient" expenses?
Inpatient expenses are incurred at licensed hospital facilities when you are admitted as an inpatient and charged for at least one day's room & board.

What are "mammography screening tests"?
The following are mammography screening tests: one baseline mammogram for a covered person age 35 through 39 years, inclusive; a mammogram every 2 years for a covered person age 40 through 49, inclusive (or more frequently if recommended by a doctor); and a mammogram every year for a covered person age 50 and over.

What are "other hospital charges"?
Other hospital charges are certain ancillary hospital inpatient charges other than room & board. They include pharmacy, medical and surgical supplies and devices, laboratory, x-rays, operating and recovery room expenses, etc.

What are "outpatient" expenses?
Outpatient expenses are incurred at doctors' offices, free-standing clinics, and hospitals when you are not admitted as an inpatient nor are you billed for room & board charges.

What does "sickness" mean?
Sickness is a covered person's sickness or disease that results, directly and independently of all other causes, in a covered expense being incurred.

What does "usual and customary" mean?
Usual and customary is a guideline that the carrier uses to determine how much of a medical expense the Medical Coverage will consider. A "usual" charge is the charge made for a given service by a medical care provider to the majority of its patients. A "customary" charge is one that is charged by the majority of providers within a community for the same services.

What is "well baby care"?
Well baby care is the following screening and early detection services for a covered child up to 24 months of age, when supervised and performed by a doctor: initial history and follow-up histories of the developmental appraisals; physical examinations; discussions and counseling; nutritional assessments; gross screening of sight and hearing; dental care; testing for sickle cell anemia and PKU, and hematocrit testing; and, routine and necessary immunizations.

What is "wellness care"?
It is medical examinations and procedures that are preventative in nature and not for the treatment of an injury or sickness.

EXCLUSIONS AND LIMITATIONS
No benefits will be paid for loss caused by or resulting from:
- Mental or nervous disorders;
- Alcoholism or substance abuse treatment;
- Intentionally self-inflicted injuries, suicide, or any attempt thereat while sane or insane;
- Acts of declared or undeclared war;
- A covered person's commission or attempted commission of a felony;
- Work-related injury or sickness, whether or not benefits are payable under Workers' Compensation or similar law;
- Eye examinations for glasses, any kind of eye glasses, or prescriptions therefore;
- Hearing examinations, or hearing aids;
- Treatment in a hospital or facility owned or run by the United States Government, unless a charge is made for such services in the absence of insurance, or in a hospital that does not unconditionally require payment;
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury resulting from an accident that happens while covered under the Medical Coverage, and rendered within 6 months of the accident;
- Cosmetic surgery, except losses related to or resulting from cosmetic surgery needed as a result of a mastectomy reconstruction or an accident that happens while covered under the Medical Coverage. The

- continue health care coverage for yourself or dependents if there is a loss of coverage under the Benefit Program as a result of a qualifying event (see the topic "COBRA – EXTENDED COVERAGE"). You or your dependents may have to pay for such coverage.

Review this booklet and the documents governing the Benefit Program for the rules governing your COBRA continuation coverage rights.

How long does it take to receive copies?
The ERISA Plan Administrator is required to provide you copies of requested materials within 30 days. If you do not receive the material within this time frame, you may file suit in federal court. In such a case, the court may require the ERISA Plan Administrator to provide the requested materials and pay you up to $110 a day until you receive them, unless the delay was beyond the control of the ERISA Plan Administrator.

What if I believe my rights have been denied?
ERISA imposes duties upon the people or companies who are responsible for the operation of the Benefit Program. These people or companies are referred to as Fiduciaries. Fiduciaries must act solely in the interest of you and your dependents, as Benefit Program participants. As the ERISA Plan Sponsor your Employer is a Fiduciary and, as such, must not discharge you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Benefit Program or exercising your rights under ERISA.

What if I believe that I have been discriminated against?
You have the right to file suit in a federal court if you think your Employer or anyone else is discriminating against you or otherwise stopping you from exercising your rights under ERISA. If you win your lawsuit, the court may require the losing party to pay your legal costs and fees, in addition to whatever other penalties it may impose. However, if you lose, the court may order you to pay the costs and fees, (for example if it finds your claim was frivolous).

Is filing suit my only option?
No. If you have any questions or problems with the Benefit Program, you should first contact the ERISA Plan Administrator, who is also the agent for service of legal process. If the ERISA Plan Administrator does not satisfactorily help you, contact the nearest area office of the Pension and Welfare Benefits Administration, United States Department of Labor. This federal agency is responsible for enforcing the law under ERISA and will be able to give you guidance as to what your rights are and how you can enforce them.

Where can I get more information on my rights under ERISA?
If you have any questions about this statement or about your rights under ERISA or COBRA, 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, NW, Washington, DC 20210. You can also visit the Employee Benefits Security Administration's website at www.dol.gov/ebsa.

CONFORMITY WITH THE LAW
If any provision of the Benefit Program is contrary to any law to which it is subject, such provision is hereby amended to conform thereto. Nothing in the Benefit Program is intended to replace or affect any requirements for coverage by Workers' Compensation insurance.

BENEFIT PROGRAM TERMINATION, AMENDMENT, AND ADMINISTRATION
The Employer intends to continue the Benefit Program but reserves the right at any time, at its discretion, to terminate the Benefit Program, to modify the Benefit Program, to provide different cost-sharing between the Employer and participants, or to amend the Benefit Program in any respect. In the event the Benefit Program is terminated, any assets held in trust for the Benefit Program will be used to provide welfare benefits for employees of the ERISA Plan Sponsor or a successor, or they will be used in other ways not prohibited by the Internal Revenue Service regulations.

SUMMARY PLAN DESCRIPTION
This booklet, together with the copy you made of the form you used to enroll, is a Summary Plan Description. It provides a summary of the major provisions and benefits of the Benefit Program. It is also intended to tell you about the limitations and exclusions of the Benefit Program. Because this booklet is only a summary, it has not been written with all of the technical words and legal phrases used in the official Benefit Program documents. For full details about the insurance coverage, you may obtain a copy of the policy(ies) from the Employer. The official Benefit Program documents remain the final authority and, in the event of a conflict with this booklet, shall govern in all cases.

ASRM
ASRM is a Third Party Administrator that provides records keeping and claims paying services for the carrier identified under "BENEFIT PROGRAM INFORMATION". The carrier is the underwriter of the insurance contract(s). As a Third Party Administrator, ASRM has no discretionary powers under the Benefit Program and, in particular, has no discretionary power in the paying or denying of claims. ASRM is referred to as "RSL Specialty Products

Administration" throughout this booklet.

PROGRAM FUNDING

Benefits will be provided on a fully-insured basis through the insurance contract(s) issued by the carrier directly to the ERISA Plan Sponsor. Participants are responsible for all required premiums, less any Employer contribution. The carrier provides certain policyholder and claims processing through ASRM (see above). The carrier serves as the claims review fiduciary with respect to the insurance contract(s) and the Benefit Program. The claims review fiduciary has the discretionary authority to interpret the Benefit Program and the insurance contract(s) and to determine eligibility for benefits. Decisions by the claims review fiduciary are complete, final and binding on all parties.

MEDICAL COVERAGE

INPATIENT BENEFITS

What are the hospital inpatient benefits?

The Medical Coverage pays 70% of the charges a covered person incurs for covered inpatient expenses, up to a per person maximum benefit of $15,000 each coverage year for sickness and $10,000 each coverage year for injury. Inpatient benefits for sickness are also subject to the limits shown in the question below.

What are the limits on covered inpatient benefits for sickness?

They are:

Hospital Room & Board:	$1,000	per day
Surgeons' Fees:	$2,000	per coverage year
Anesthesiologists' Fees:	$400	per coverage year
Other Hospital Charges:	$1,000	per coverage year

Are there any restrictions on the number of hospital days that can be covered for childbirth admissions?

Yes, coverage is restricted to 48 hours of inpatient care after an uncomplicated vaginal delivery and 96 hours of inpatient care after an uncomplicated caesarean section. If the mother and newborn child have a shorter hospital stay than indicated above or if prescribed by the attending doctor, coverage will also include one home visit by a qualified provider within 24 hours after hospital discharge or as soon as reasonably possible. The benefits payable under the Medical Coverage for childbirth are also subject to the same maximums and limits that would apply to any other covered expenses incurred for a sickness.

Is reconstructive surgery following a mastectomy covered?

Yes. A covered person who has a mastectomy is covered by the Medical Coverage for reconstruction of the affected breast, surgery and reconstruction of the other breast for appearance, and for prostheses and any physical complications at all stages of mastectomy (including lymphedemas) as determined by the attending doctor and patient. These services are subject to the same maximums and limits that would apply to any other covered expenses incurred for a sickness.

OUTPATIENT BENEFITS

What are the outpatient benefits?

The Medical Coverage pays 70% of the charges a covered person incurs for most covered outpatient expenses, up to a per person maximum benefit of $1,500 each coverage year.

Is there a separate benefit for outpatient visits to a doctor's office?

Yes. For each visit to a doctor's office, you are responsible for paying the first $20 of the doctor's charge. After this $20 co-pay, the Medical Coverage pays the balance of the charge for the visit, subject to the coverage year outpatient maximum benefit. The co-pay does not include other charges that you may incur during the office visit, such as for tests, labs, x-rays, etc., which are covered as outpatient expenses.

Is there also a separate benefit for visits to an emergency room?

Yes. The Medical Coverage pays 100% of the charges a covered person incurs for covered outpatient expenses during a visit to an emergency room, up to a per person maximum benefit of $50 per visit for sickness and $500 per visit for injury. Emergency room benefits are not subject to the coverage year outpatient maximum benefit, but are subject to the limits shown in the question below.

What are the limits on emergency room benefits?

They are per person limits of 3 visits each coverage year for sickness and 2 visits each coverage year for injury.

WELLNESS CARE BENEFITS

What are the wellness care benefits?

The Medical Coverage pays 100% of the charges incurred for wellness care, subject to a per person maximum benefit of $100 each coverage year.

PRESCRIPTION DRUG BENEFITS

Is there a benefit for outpatient prescription drug expenses?

Yes. For each generic drug prescription you have filled, you are responsible for paying the first $10 of the charge. After this $10 co-pay, the Medical Coverage pays the balance of the charge for the generic drug, subject to a per person maximum benefit of $1,000 each coverage year. For each brand-name drug prescription you have filled, you are responsible for paying the first $40 of the charge. After this $40 co-pay, the Medical Coverage pays the balance of the charge for the brand-name drug, subject to a per person maximum benefit of $300 each coverage year.

Can I use any pharmacy?

Yes, but you can use the Prescription Drug ID Card you will receive with the Medical Coverage to help save money and stretch your benefit dollars at a pharmacy that participates in the Express Scripts, Inc. network.

How does the Prescription Drug ID Card work?

Most pharmacies participate in the Express Scripts, Inc. network, but you should check with the pharmacy before you make your purchase or call Express Scripts, Inc. at 1-866-282-1491 for providers in your area. Participating pharmacies provide discounts of up to 15% on all prescriptions and when you present your card, you pay the applicable co-pay. The Medical Coverage pays the balance of the charge, subject to the applicable coverage year maximum. You will not have to file a claim on purchases made at participating pharmacies. The pharmacist will tell you exactly what to pay.

What happens if I have to purchase a prescription before I receive my Prescription Drug ID Card?

Your outpatient prescription drug benefits begin the same day as your other Medical Coverage benefits. However, you cannot take advantage of the network features of the prescription benefits until you receive your Prescription Drug ID Card. And, it may take a few weeks for you to receive your card. If you need to purchase a prescription before you get your card, you will have to: 1) check with the pharmacy before you make your purchase to see if it participates in the Express Scripts, Inc. network; and 2) pay the full, undiscounted price for your prescription. Once you receive your Prescription Drug ID Card, you can: 1) call Express Scripts, Inc. at 1-866-282-1491 for a claim form; and 2) file a claim for benefits under the Benefit Program with Express Scripts, Inc. Do not file your prescription drug claims with RSL Specialty Products Administration.

What if I use a non-participating pharmacy?

You must pay the full price up front. Then you must call Express Scripts, Inc. at 1-866-282-1491 and request a claim form. File the claim with Express Scripts, Inc. You will be reimbursed 100% of the actual charges (minus the applicable co-pay) up to the applicable coverage year maximum (for in- or out-of-network purchases). Do not file your prescription drug claims with RSL Specialty Products Administration.

Are there other ways that I can lower the cost of my prescriptions?

If you take a generic medication on a regular basis, a mail order service is available that may provide an even larger discount. You may visit Express Scripts, Inc. at their website www.express-scripts.com or call Express Scripts, Inc. at 1-866-282-1491 for more information.

What if I have a prescription from my dentist?

You may only purchase medical prescriptions, except when the prescription is issued in connection with covered dental treatment for an accident covered under your Medical Coverage.

COMMONLY USED TERMS

What does "co-pay" mean?

A co-pay is the specified amount that you are responsible for paying each time you incur charges for covered doctors' office visits and prescription drugs, before the Medical Coverage begins to pay benefits.

What is the "coverage year"?

It is the period of time during which benefit maximums accumulate. Each new coverage year, the maximums are reset. You will find the coverage year under "BENEFIT PROGRAM INFORMATION". The coverage year should not be confused with the ERISA Plan Fiscal Year End.

What are "covered expenses"?

Covered inpatient expenses are: hospital room and board charges, surgeons' charges, anesthesiologists' charges, and other hospital charges. Covered outpatient expenses are: doctor's office visit charges; charges for diagnostic labs, X-rays, and cardiovascular tests; charges for emergency room visits; charges for surgery; rental charges for durable medical equipment, up to the purchase price; charges for prescription drugs; charges for prosthetic appliances and orthotics; charges for ambulance trips to and from a hospital; charges for speech, occupational, and physical therapies; charges for chiropractic adjustments; and charges for part-time or intermittent skilled nursing services rendered by a registered nurse or licensed practical/vocational nurse in the covered person's home. The Medical Coverage covers the preceding expenses when they are medically necessary for the diagnosis or treatment of sickness and injury. Charges for mammography screening tests, well baby care, and wellness care are