

CINCINNATI FINANCIAL CORPORATION GROUP BENEFIT PLAN

MEDICAL BENEFITS

SUMMARY PLAN DESCRIPTION

JANUARY 1, 2009

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SECTION 1 INTRODUCTION

Cincinnati Financial Corporation sponsors the Cincinnati Financial Corporation Group Benefit Plan, which is a group benefit plan with various ERISA welfare benefits. This booklet, which is referred to as the "Summary Plan Description" (or "SPD") only summarizes the component of the Cincinnati Financial Corporation Group Benefit Plan that provides group medical benefits to Participants.

When the term "Plan" is used in this SPD *it is only intended to refer to* the "medical benefits" component of the Cincinnati Financial Corporation Group Benefit Plan.

The Plan is governed by the plan document and this SPD. If this SPD conflicts with the plan document, the Plan Administrator has the sole discretion to interpret the terms and purpose of the Plan to resolve the conflict.

We recommend that you read the entire SPD so that you fully understand how benefits are provided under the Plan. When reading the SPD, you will notice that capitalized words and phrases are generally defined in Section 9 of this SPD.

Please be aware that your Doctors do not have a copy of this SPD, which means that they may not understand how the Plan operates.

SECTION 2 GENERAL PLAN INFORMATION

Since the Plan is subject to ERISA, the Plan Administrator is required to provide Participants with certain information about the Plan. This section contains that information and includes Participants' ERISA rights and the Plan's procedures for requesting certificates of creditable coverage under HIPAA. Some of the information in this section may also be described in greater detail in other parts of this SPD.

1. Plan Name And Number

(a) Plan Name. The legal name of the plan is the Cincinnati Financial Corporation Group Benefit Plan. This SPD only describes the component of the Cincinnati Financial Corporation Group Benefit Plan that provides medical benefits. When the term "Plan" is used in this SPD it is *only intended to refer to* the "medical benefits" component of the Cincinnati Financial Corporation Group Benefit Plan. The Plan was originally established on January 1, 2000 and was most recently amended effective January 1, 2009.

(b) Plan Number. The plan number is 510.

2. Type Of Plan

The Plan is an ERISA group welfare benefit plan which provides medical benefits to Eligible Associates and their eligible family members.

3. Plan Year

The Plan Year is the 12-month period beginning January 1 and ending December 31. The Plan is administered on the basis of that 12-month period.

4. Plan Sponsor

The Plan Sponsor is Cincinnati Financial Corporation whose address, telephone number and employer identification number ("E.I.N.") are:

Address:	6200 South Gilmore Road Fairfield, Ohio 45014
Telephone Number:	(513) 870-2000
E.I.N.:	31-0746871

5. The Employers

The Employers. Cincinnati Financial Corporation is also considered the "Employer," along with: (a) The Cincinnati Insurance Company (31-0542366); (b) The Cincinnati Casualty Company (31-0826946); (c) The Cincinnati Indemnity Company (31-1241230); (d) The Cincinnati Life Insurance Company (31-1213788); (e) CFC Investment Company (31-0790388); (f) CinFin Capital Management Company (31-1596849); (g) Cincinnati Specialty Underwriters Insurance Company (65-1316588); and (h) CSU Producer Resources (11-3823180). Each company has adopted the Plan for its Eligible Associates and their eligible family members.

The Employers are generally referred to throughout this SPD as "CFC" unless otherwise indicated by the context. With respect to an Eligible Associate, the term "CFC" generally means the Employer by whom he or she is, or was, employed most recently unless otherwise indicated by the context.

6. Plan Administration

General. As Plan Sponsor, Cincinnati Financial Corporation may, and has, delegated its administrative duties to The Cincinnati Insurance Company (the "Plan Administrator") and to the "Appeals Committee," as described below.

Plan Administrator. As Plan Administrator, The Cincinnati Insurance Company is responsible for administering the Plan, which includes maintaining the Plan's records, processing claims, administering COBRA coverage, administering HIPAA compliance, and acting as the Plan's agent for service of legal process. The Cincinnati Insurance Company has

the power, in its sole discretion, to manage and interpret the Plan and to determine who is entitled to benefits and the amount of those benefits. The Cincinnati Insurance Company is also the Plan's "named fiduciary" under ERISA.

Appeals Committee. A committee (the "Appeals Committee") acts on behalf of the Plan to decide appeals of claims that were initially denied by the Plan Administrator.

7. **Questions.**

Benefits And Claims Questions. If Participants have questions about claims or benefits, they should contact the Plan Administrator at:

c/o Life and Health Claims Department
P.O. Box 145496
Cincinnati, Ohio 45250
(513) 870-2000

Precertification Questions. If Participants have questions about the Plan's precertification procedures, they can either contact the Plan Administrator at the address or telephone number specified above, or they may call Health Span at (513) 551-1420 or (800) 972-7726.

8. **Plan Funding**

The Plan Is Self-Funded. Medical benefits under the Plan are paid directly by CFC from its general assets. That legally makes the Plan a "self-funded plan" with respect to the medical benefits described in this SPD. There is no separate fund, trust or insurance from which Plan benefits are paid. The cost of the Plan's benefits and administrative expenses will be funded by the contributions required to be made by Covered Associates, individuals receiving COBRA coverage and CFC. CFC determines the required contributions and may generally change those amounts at any time without prior notice.

Please keep in mind that benefits under other components of the Cincinnati Financial Corporation Group Benefit Plan may be provided through insurance

Associate Pre-Tax Payment Of Contributions. Eligible Associates may elect to pay their required contributions for Plan coverage on a pre-tax basis under the Cincinnati Financial Corporation Tax Advantage Plan, commonly referred to as the "TAP Plan." Pre-tax elections under the TAP Plan must generally be made through the CFCNet during the annual Open Enrollment Period (which currently is in November of each year). This tax-saving advantage allows you to have contributions deducted from your paycheck before taxes are calculated. This means that you pay less in taxes and take home more of your salary. You may learn more about making pre-tax elections by reading the TAP Plan's summary plan description or by contacting CFC's Personnel Department.

Stop-Loss Insurance. CFC decided not to purchase stop-loss insurance. CFC may elect to purchase stop loss insurance at any time.

9. Statement Of ERISA Rights

ERISA Rights. Under ERISA, Participants are entitled to the rights and protections described below in this Item 9.

Plan Information. Participants may examine (without charge) at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Upon written request to the Plan Administrator, Participants may obtain copies of documents governing the operation of the Plan, including copies of the latest annual report (Form 5500 Series) and an updated SPD. The Plan Administrator may charge you a reasonable amount for the copies.

Participants may also receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

COBRA Coverage. In certain situations, Participants may continue their Plan coverage if there is a loss of coverage as a result of a COBRA Qualifying Event. Participants will be required to pay for the cost of COBRA coverage and an administrative charge.

Participants who have questions about their COBRA rights should review Item 8 of Section 3 of this SPD, contact CFC's Personnel Department, or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). The EBSA's Addresses and telephone numbers are available through EBSA's website at www.dol.gov/ebsa.

Prudent Actions By Plan Fiduciaries. In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries," have a duty to do so prudently and in the interest of Participants. No one, including CFC, may fire a Participant or otherwise discriminate against a Participant in any way to prevent the Participant from obtaining a benefit or exercising his or her ERISA rights.

Enforcement Of Rights. If a Participant's claim for benefits is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps a Participant can take to enforce the above rights. For example, if a Participant requests a copy of Plan Document or the latest annual report from

the Plan and does not receive them within 30 days, the Participant may file suit in a federal court, provided the Participant has first exhausted the Plan's administrative remedies described in Section 7. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant up to \$110 a day until the Participant receives the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control. If a Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in a state or federal court, provided the Participant has first exhausted the Plan's administrative remedies described in Section 7. In addition, if a Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the Participant may file suit in federal court, provided the Participant has first exhausted the Plan's administrative remedies described in Section 7. If Plan fiduciaries misuse the Plan's assets, or if a Participant is discriminated against for asserting his or her rights, the Participant may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant sued to pay those costs and fees. If the Participant loses, the court may order the Participant to pay those costs and fees (for example, if it finds the Participant's claim is frivolous).

Assistance With Questions. If a Participant has any questions about the Plan, the Participant should contact CFC's Personnel Department. If a Participant has any questions about this statement or about ERISA rights, or if the Participant needs assistance in obtaining documents from the Plan Administrator, the Participant should contact the nearest EBSA office listed in the Participant's telephone directory (under U.S. Department of Labor) or on the EBSA's website at www.dol.gov/ebsa, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. Participants may also obtain certain publications about their ERISA rights and responsibilities by calling the EBSA's publications hotline.

10. Plan Modification, Amendment And Termination

Notwithstanding any contrary provision in this SPD or any other document, and notwithstanding any contrary written or oral representations made by any individual, the Plan Administrator may, in its sole and absolute discretion, at any time, amend or terminate the Plan (and benefits provided under the Plan). This includes, but is not limited to, the right to change, increase, or decrease Associate Contributions or Employer Contributions at any time. No consent is required on the part of any Participant, or anyone else, for the Plan Administrator to amend or terminate the Plan. The Plan may not be amended orally or by any course or purported course of conduct, but only by a written amendment intended by the Plan Administrator to be an amendment. All amendments to, or termination of, the Plan are effective as of a date established by the Plan Administrator.

11. No Contract Of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and CFC giving you the legal right to be continued as a CFC associate.

12. Newborns' And Mothers' Health Protection Act

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan may generally not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's Provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than 48 hours following a vaginal delivery (or 96 hours following a cesarean section). Also, the Plan may not require a Provider to obtain authorization to prescribe a length of stay not in excess of 48 hours following a vaginal delivery (or 96 hours following a cesarean section).

13. Women's Health And Cancer Rights Act

The Plan is required by the Women's Health and Cancer Rights Act of 1998 to provide benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). These benefits will be provided subject to the same deductibles and coinsurance applicable to other Plan medical and surgical benefits. If You would like more information on these benefits, please call CFC's Personnel Department.

14. Requesting A HIPAA Certificate Of Creditable Coverage

HIPAA requires the Plan to provide a certificate of creditable coverage ("Certificate") to an individual upon request, as long as it is requested while the individual is a Participant or within 24 months after the individual's Plan coverage ends. The request also can be made by someone else on an individual's behalf.

Requests for Certificates should be directed to CFC's Personnel Department. Telephone requests are accepted only if the Certificate will be mailed to the address that the Plan has on file for the individual. Other requests must be made in writing and must include: (a) the name of the individual for whom the Certificate is requested; (b) the last day that the individual was covered under the Plan; (c) the name of the Eligible Associate who Enrolled the individual in the Plan; (d) a telephone number to reach the individual for whom the Certificate is requested; (e) the name of the person making the request and evidence of the person's authority to request and receive a Certificate on behalf of the individual; (f) the address to which the Certificate should be mailed; and (g) the signature of the individual requesting the certificate.

After receiving a proper request, the Plan Administrator will provide the Certificate in a reasonable and prompt manner.

SECTION 3 ENROLLMENT AND COVERAGE

1. Initial Enrollment

An Eligible Associate and his or her Dependents first become eligible to Enroll in the Plan when the Eligible Associate is hired (or rehired) by CFC. Plan coverage becomes effective on the Eligible Associate's hire (or rehire) date as long as the Eligible Associate Enrolls himself or herself and his or her Dependents in the Plan within 30 days of being hired or rehired. If an Eligible Associate and his or her Dependents do not Enroll in the Plan within 30 days of the Eligible Associate being hired or rehired, they cannot Enroll in the Plan until the earlier of the following events: (a) the next annual Open Enrollment Period; (b) a Change In Status; (c) a special enrollment period; or (d) the Plan Administrator approves a Qualified Medical Child Support Order (a "QMCSO").

2. Enrollment During An Annual Open Enrollment Period.

During each annual Open Enrollment Period, an Eligible Associate, or Participant, may Enroll himself or herself and his or her Dependents in the Plan. Plan coverage becomes effective on the January 1st which immediately follows the Open Enrollment Period.

3. Changes In Status

An Eligible Associate, or Participant, may either add or drop Plan coverage for himself or herself and his or her Dependents when a Change In Status occurs as long as the coverage change is consistent with the Change In Status and is permitted by the Plan Administrator. Plan coverage changes usually become effective on the date the Change In Status event occurs as long as the Eligible Associate, or Participant, Enrolls or drops Plan coverage within 30 days of the Change In Status.

4. Special Enrollment Periods

An Eligible Associate, or Participant, may Enroll himself or herself and his or her Dependents in the Plan during the following 4 special enrollment periods.

Loss Of Other Coverage. Enrollment in the Plan is permitted if: (a) an Eligible Associate or Dependent had alternate health coverage when they previously had the opportunity to Enroll in the Plan; and (b) the alternate health coverage ended because of loss of eligibility (for reasons other than failure to pay contributions, or for cause), another company stopped making company contributions, or in the case of COBRA coverage, the coverage ended. Plan coverage becomes effective on the date the alternate health coverage ended as long as an Eligible Associate, or Participant, Enrolls himself or herself and his or her Dependents in the Plan within 30 days of the date the alternate health coverage ended.

New Dependent. Enrollment in the Plan is permitted if an Eligible Associate, or Participant, acquires a Dependent through marriage, birth, adoption or Placement For Adoption. Plan coverage becomes effective on the date a new Dependent is acquired as long as the Eligible Associate, or Participant, Enrolls himself or herself and his or her newly acquired Dependents in the Plan within 30 days of the date of the marriage, birth, adoption or Placement For Adoption.

Termination Of Medicaid Or Children's Health Insurance Program ("CHIP") Coverage. Enrollment in the Plan is permitted if an Eligible Associate or Dependent had health coverage under a Medicaid or state child health plan and that coverage ended because of loss of eligibility. Plan coverage becomes effective on the date the Medicaid or state child health plan coverage ended as long as the Eligible Associate, or Participant, Enrolls himself or herself and his or her Dependents in the Plan within 60 days of the date the Medicaid or state child health plan coverage ended.

Eligibility For Premium Assistance Under Medicaid Or CHIP. Enrollment in the Plan is permitted if an Eligible Associate or Dependent becomes eligible for a premium assistance subsidy under a Medicaid or state child health plan. Plan coverage becomes effective on the date the Eligible Associate or Dependent is determined to be eligible for the premium assistance subsidy under the Medicaid or state child health plan as long as the Eligible Associate, or Participant, Enrolls himself or herself and his or her Dependents in the Plan within 60 days of the date the Eligible Associate or Dependent is determined to be eligible for the premium assistance subsidy under the Medicaid or state child health plan.

5. Qualified Medical Child Support Orders

The Child of a Participant who is the subject of a QMCSO will be covered under the Plan after the Plan Administrator approves the QMCSO. A Participant must immediately Enroll the Child in the Plan and pay for the cost of covering the Child under the Plan. If an Eligible Associate is not Enrolled in the Plan but is required by a QMCSO to Enroll the Child, the Eligible Associate must immediately Enroll himself or herself and the Child in the Plan, and pay the cost of covering himself or herself and the Child.

6. Termination Of Plan Coverage

Unless otherwise provided in Items 7 or 8 below, Plan coverage for a Covered Associate and/or his or her Covered Dependents terminates on the day the Covered Associate's coverage terminates. For example, coverage will terminate for the Covered Associate and his or her Covered Dependents on the day: (a) the Covered Associate's employment with CFC terminates; (b) the Covered Associate voluntarily terminates coverage for himself or herself and/or his or her Covered Dependents; (c) the Plan is amended to make the Covered Associate and/or his or her Covered Dependents ineligible; (d) the CFC company which employs the Covered Associate decides to no longer participate in the Plan; (e) the Covered Associate does not pay the Associate Contributions in a timely manner; (f) the Covered Associate, or his or her

Covered Dependents, attempts to defraud the Plan; (g) an individual is no longer is a Dependent; (h) a Covered Associate gets divorced or legally separated, which makes his or her Spouse ineligible to continue being covered under the Plan; or (i) the Plan terminates.

7. Continuation OF Plan Coverage

FMLA Leaves Of Absence. The Plan allows for the continuation of Plan coverage for a Covered Associate and his or her Covered Dependents during a leave of absence which is subject to the Family and Medical Leave Act of 1993 ("FMLA"). In order to eligible for coverage during the leave, CFC must approve the leave, the Covered Associate must have worked at least 1,250 hours for CFC during the past 12 months and he or she must make the same Associate Contributions as he or she was making prior to the leave.

Plan Coverage during an FMLA leave may be continued until the earlier of: (a) the end of the leave; (b) the Covered Associate gives notice to CFC that he or she does not intend to return to work at the end of the leave; or (c) the occurrence of any of the events described in Item 6 above. When coverage terminates, the Covered Associate and his or her Covered Dependents may be eligible for COBRA coverage as described in Item 8 below.

Military Leaves Of Absence. The Plan allows for the continuation of coverage for a Covered Associate and his or her Covered Dependents during a military leave of absence which is covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If a Covered Associate elects to continue coverage and his or her military leave is less than 31 days, he or she is only required to pay the applicable Associate Contributions. If the length of the military leave is longer than 31 days, the Covered Associate will have to pay the Total Contribution Amount for coverage provided to similarly situated Covered Associates who are not serving in the military plus a 2% administrative fee.

If a Covered Associate chooses not to continue Plan coverage, he or she and his or her Covered Dependents are eligible to have their Plan coverage reinstated on the date the Eligible Associate returns to work with CFC with reemployment rights guaranteed under USERRA.

Plan Coverage during a USERRA leave may be continued until the earlier of: (a) 24 months after the military leave begins; (b) the day after the Covered Associate fails to timely apply for, or return, to employment with CFC in accordance with USERRA; or (c) the occurrence of any of the events described in Item 6 above. The Plan will not pay benefits related to any Illness or Injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of military service. If USERRA coverage expires prior to the full 24 months, the Covered Associate and his or her Covered Dependents may be eligible for the COBRA coverage described in Item 8 below. There may also be other limited situations where COBRA coverage is available. Contact CFC's Personnel Department for details.

Disability Leaves Of Absence. If a Covered Associate who has been Actively At Work with CFC for at least one year becomes disabled, he or she may elect to continue Plan coverage for himself or herself and his or her Covered Dependents during the disability leave. For purposes of disability leaves, "disabled" has the same meaning as in the Cincinnati Financial Corporation Long-Term Disability Plan (the "LTD Plan").

In order to receive extended Plan disability coverage, a Covered Associate must pay the Associate Contributions for the period which begins on the date the Covered Associate is no longer Actively At Work with CFC until the date he or she becomes eligible to begin receiving benefits under the LTD Plan. After that, the Covered Associate must pay the applicable Total Contribution Amount.

Plan Coverage during a disability leave may be continued until the earlier of: (a) the date on which the Covered Associate is no longer disabled; (b) the date which is 5 years after the date the Covered Associate became eligible to begin receiving benefits under the LTD Plan; and (c) the occurrence of any of the events described in Item 6 above. When coverage terminates, the Covered Associate and his or her Covered Dependents may be eligible for COBRA coverage as described in Item 8 below.

Other Approved Leaves Of Absence. If a Covered Associate goes on an approved leave of absence for reasons other than those described above, he or she may elect to continue Plan coverage during the leave for himself or herself and his or her Dependents during the leave if he or she agrees to pay the applicable Associate Contributions specified by the Plan Administrator.

Plan Coverage during an approved leave may be continued until the earlier of: (a) the date agreed upon in writing by CFC at the time the leave was approved; (b) the date which is six months following the first day of the leave; or (c) the occurrence of any of the events described in Item 6 above. When coverage terminates, the Covered Associate and his or her covered dependents may be eligible for COBRA coverage as described in Item 8 below.

8. COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires the Plan to offer Qualified Beneficiaries the opportunity to continue their Plan coverage after their coverage normally would have ceased. COBRA coverage is available for Qualified Beneficiaries only if a COBRA Qualifying Event occurs which results in a loss of Plan coverage. COBRA coverage is generally identical to the coverage a Qualified Beneficiary had on the day before a COBRA Qualifying Event and the coverage provided to similarly situated Participants.

Notices Required To Be Provided By Qualified Beneficiaries. After a Qualifying Event occurs, Qualified Beneficiaries *must comply* with the notice requirements described below in order to receive COBRA coverage under the Plan. If a Qualified Beneficiary does not comply with those requirements in a timely manner, *all rights to elect COBRA coverage under the Plan will be lost.*

- Divorce Or Legal Separation Or A Child's Loss Of Dependent Status. In the event of a Covered Associate's divorce or legal separation, or a Child's loss of Dependent status under the Plan, a Qualified Beneficiary must notify the Plan Administrator within 60 days of the later of: (a) the date of the Qualifying Event; or (b) the date on which the Qualified Beneficiary would lose Plan coverage as a result of the Qualifying Event.

- Second Qualifying Events. In the event a Qualified Beneficiary is already receiving COBRA coverage under the Plan, and the Covered Associate dies, becomes divorced or legally separated, or a Child loses Dependent status under the Plan, the Qualified Beneficiary must notify the Plan Administrator within 60 days after the later of: (a) the date of the second Qualifying Event; or (b) the date on which the Qualified Beneficiary would lose Plan coverage as a result of the second Qualifying Event.

- Disability. A Qualified Beneficiary must notify the Plan Administrator within 60 days of the date the Social Security Administration determines a Qualified Beneficiary is disabled, *and before* the end of the 18-month period following the date of the Covered Associate's termination of employment, or reduction in hours, with CFC. A Qualified Beneficiary must also notify the Plan Administrator when the disabled Qualified Beneficiary, whose disability resulted in the extended COBRA coverage period, is no longer disabled (as determined by the Social Security Administration). A notice must be provided to the Plan Administrator within 30 days after the date of the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled.

- Coverage Under Medicare Or Another Group Plan. A Qualified Beneficiary must notify the Plan Administrator if, after electing COBRA coverage, a Qualified Beneficiary becomes Entitled To Medicare or becomes covered under another group health plan (but only after that plan's preexisting condition exclusions are satisfied). The notice must be provided within 30 days of the date the other coverage becomes effective or, upon becoming Entitled To Medicare.

- Documentation Accompanying A Notice. When notifying the Plan Administrator of the events described above, a Qualified Beneficiary must provide the proof and documentation requested by the Plan Administrator.

- Manner Of Providing Notice. Notices of the events described above must be provided to the Plan Administrator in writing and in the form required by the Plan Administrator. The Plan will not accept oral notices. The notices must be postmarked no later than the applicable due dates described above and mailed to the attention of CFC's Personnel Department at P.O. Box 145496, Cincinnati, Ohio 45250.

COBRA Elections. A Qualified Beneficiary must properly elect COBRA coverage by completing the forms specified by the Plan Administrator and sending them to the attention of CFC's Personnel Department at P.O. Box 145496, Cincinnati, Ohio 45250. The completed election forms must be submitted no later than 60 days after the later of: (a) the date the Plan

sent the COBRA election notice to the Qualified Beneficiary; or (b) the date Plan coverage is lost due to a COBRA Qualifying Event. The Plan *does not accept oral elections*.

Special COBRA rights apply to certain Qualified Beneficiaries who qualify for a “trade readjustment allowance” or “alternative trade adjustment assistance” under the federal Trade Act of 2002. Those Qualified Beneficiaries are entitled to a second opportunity to elect COBRA coverage for themselves and certain Family members (if they did not already do so), but only within a limited period of 60 days (or less), and only during the 6 months immediately after their Plan coverage ends. If you think you qualify for assistance under the Trade Act of 2002, contact CFC’s Personnel Department for additional information. Also, You can contact the Health Care Tax Credit Customer Contact Center toll-free at (866) 628-4282 (TTD/TTY callers call toll-free at (866) 626-4282) or go to www.doleta.gov/tradeact/ for more information. Qualified Beneficiaries must contact CFC’s Personnel Department promptly after qualifying for assistance under the Trade Act of 2002 or they will *lose their special COBRA rights*. COBRA coverage elected during the special second election period is not retroactive to the date that coverage was lost, but begins on the first day of the special second election period.

If a Qualified Beneficiary does not submit a properly completed COBRA election form to the Plan Administrator in a timely manner, *all rights to elect COBRA coverage under the Plan will be lost*.

Cost Of COBRA Coverage. Qualified Beneficiaries are required to pay the applicable Total Contribution Amount for their COBRA coverage plus a 2% administrative fee. If there is an extension of COBRA coverage due to disability, the administrative fee is increased to 50% unless the only persons who elect the disability extension are non-disabled Qualified Beneficiaries. The Plan may change the amount of required COBRA contributions in accordance with the Code and regulations as interpreted by the Plan Administrator. If a Qualified Beneficiary does not make COBRA payments as described below, *all COBRA coverage rights under the Plan will be lost*.

- **Payment Amount.** A Qualified Beneficiary will not be considered to have made a COBRA payment if his or her check is returned for insufficient funds or otherwise. The Plan will not accept a partial COBRA payment unless the amount of the shortfall is not more than the lesser of \$50, or 10% of the amount required to be paid (an “Insignificant Amount”). In that situation, a Qualified Beneficiary has 30 days from the time he or she is provided with notice of the payment shortfall to pay the remaining amount due. If the amount of a payment shortfall is more than an Insignificant Amount, the Qualified Beneficiary must pay the remaining amount by the normal payment due dates described below. Qualified Beneficiaries are responsible for ensuring that their COBRA payments are correct. Qualified Beneficiaries may contact CFC’s Personnel Department to confirm the correct amount of their COBRA payments. No claims will be processed until a Qualified Beneficiary properly elects, and pays for, COBRA coverage.

- **First Payment.** A Qualified Beneficiary must make the first COBRA payment no later than 45 days after the date of his or her COBRA election. The first payment must cover the

cost of COBRA coverage from the time the Qualified Beneficiary's coverage under the Plan would have otherwise terminated up through the end of the month before the month in which the Qualified Beneficiary makes his or her first payment.

- **Other Payments.** After a Qualified Beneficiary makes his or her first COBRA payment, subsequent monthly COBRA payments are due on the first day of each coverage month. However, Qualified Beneficiaries will be given a 30-day grace period to make each monthly payment. The Plan will provide COBRA coverage as long as the payment for a coverage month is made before the end of the 30-day grace period. If a Qualified Beneficiary makes a monthly payment after its due date, but during the payment's 30-day grace period, his or her COBRA coverage will be suspended as of the payment's due date and then retroactively reinstated back to the payment's due date when the payment is made. Any claim that a Qualified Beneficiary submits while his or her COBRA coverage is suspended may be denied and have to be resubmitted after COBRA coverage is reinstated.

- **Payment Address.** Checks for COBRA payments should be made payable to "The Cincinnati Insurance Company" and mailed to the attention of CFC's Personnel Department at P.O. Box 145496, Cincinnati, Ohio 45250.

Disabled Qualified Beneficiaries. The following provisions apply to a Qualified Beneficiary who is determined, by the Social Security Administration, to be disabled, and who is eligible for COBRA coverage as a result of a Covered Associate's termination of employment or reduction in hours of employment with CFC.

A disabled Qualified Beneficiary may elect to extend his or her COBRA coverage (and the coverage of all related non-disabled Qualified Beneficiaries) from 18 months to 29 months. The Qualified Beneficiary's disability must be determined (by the Social Security Administration) to be in existence within the first 60 days of his or her COBRA coverage. This extension of COBRA coverage to 29 months applies to all Qualified Beneficiaries who: (a) lost Plan coverage due to a Covered Associate's termination of employment or reduction in hours of employment with CFC; and (b) elected COBRA coverage under the Plan. Please keep in mind that 50% administrative fee discussed will apply as discussed above.

Extended COBRA continuation disability coverage for all related Qualified Beneficiaries will terminate as of the later of: (a) the first day of the month that is more than 30 days after the Social Security Administration's determination that the formerly disabled Qualified Beneficiary is no longer disabled; or (b) the end of the COBRA coverage period that applies without regard to the disability extension.

Children Born (Or Adopted) During A COBRA Coverage Period. A Child born to, adopted by, or Placed For Adoption with, a Covered Associate during a period of COBRA coverage, is considered to be a Qualified Beneficiary. The Child's COBRA coverage begins when the Child is properly Enrolled in the Plan, and lasts for as long as COBRA coverage lasts for the Covered Associate's other Qualified Beneficiaries.

COBRA Coverage Periods. The allowable COBRA coverage periods are as follows:

COBRA Qualifying Event	COBRA Coverage Periods
A Covered Associate's termination of employment (other than for gross misconduct), or reduction in hours of employment, with CFC.	Up to 18 months for the Covered Associate and his or her Dependents from the date of the COBRA Qualifying Event.
A Covered Associate's death, Medicare entitlement, divorce or legal separation.	Up to 36 months for the Covered Associate's Dependents from the date of the COBRA Qualifying Event.
Child's loss of Dependent status under the Plan.	Up to 36 months, for the Dependent Child, from the date of the COBRA Qualifying Event.
A Qualified Beneficiary becomes disabled following a Covered Associate's termination of employment (other than for gross misconduct), or reduction in hours of employment, with CFC.	Up to 29 months from the date of the COBRA Qualifying Event for the disabled Qualified Beneficiary and related Qualified Beneficiaries.

Second COBRA Qualifying Events. In the event of second COBRA Qualifying Events, in some cases COBRA coverage may be extended up to 36 months measured from the date of the first COBRA Qualifying Event.

Special Medicare Rule. If a Covered Associate experiences a termination of employment (other than for gross misconduct), or reduction in hours of employment, with CFC less than 18 months after the date he or she became Entitled To Medicare, the maximum COBRA coverage period will be 36 months beginning on the date the Covered Associate became Entitled To Medicare. This 36-month COBRA coverage period applies only to the Covered Associate's Dependents.

COBRA coverage will end before the end of the periods described in the chart above upon the occurrence of any of the following events: (a) CFC, and related companies, cease to provide group health plan to employees; (b) COBRA contributions are not made in a timely manner; (c) a Qualified Beneficiary reaches the maximum required COBRA coverage period for his or her Qualifying Event; (d) a Qualified Beneficiary becomes covered under another group health plan, or Entitled To Medicare, after electing COBRA coverage under the Plan. However, COBRA coverage terminates only if the Qualified Beneficiary's creditable coverage satisfies the new plan's preexisting conditions limitation. The Plan may retroactively cancel COBRA coverage and require reimbursement of all benefits paid after the date of commencement of coverage under Medicare or the other group health plan; or (e) a disabled Qualified Beneficiary recovers from his or her disability during the 11-month disability extension of COBRA coverage as discussed above.

COBRA Premium Assistance And Special COBRA Election Period. The American Recovery and Reinvestment Act of 2009 ("ARRA") expands eligibility for COBRA coverage and provides a premium reduction to certain qualified individuals.

- **Premium Reduction.** The premium reduction for COBRA coverage is available to "assistance eligible individuals." An "assistance eligible individual" generally is a Qualified Beneficiary who: (a) is eligible for COBRA coverage at any time between September 1, 2008 and December 31, 2009; (b) elects COBRA coverage; and (c) is eligible for COBRA as a result of the Covered Associate's involuntary termination of employment between September 1, 2008 and

December 31, 2009. Those who are eligible for other group health coverage (such as through a spouse's plan or a new employer's plan) or for Medicare are not eligible for the premium reduction.

ARRA treats assistance eligible individuals who pay 35% of their COBRA premium as having paid the full amount. The premium reduction applies to periods of coverage beginning on or after March 1, 2009. The premium reduction for an individual ends upon eligibility for other group health plan coverage or Medicare, after 9 months of the reduction, or when the maximum period of COBRA coverage ends, whichever occurs first. Individuals paying reduced COBRA premiums must notify the Plan Administrator if they become eligible for coverage under another group health plan or Medicare.

- Special COBRA Election Opportunity. A Qualified Beneficiary who is eligible for COBRA as a result of a Covered Associate's involuntary termination of employment between September 1, 2008 and February 16, 2009 and who did not elect COBRA coverage when it was first offered (or who did elect COBRA coverage, but who is no longer enrolled) will have a new COBRA election opportunity. This election period begins on February 17, 2009 and ends 60 days after the Plan Administrator provides notice about the availability of the premium reduction. This special election period does not extend the period of COBRA coverage beyond the original maximum COBRA coverage period. COBRA coverage elected in this special election period begins March 1, 2009.

- Notice. The Plan Administrator must provide notice about the premium reduction to Qualified Beneficiaries whose COBRA Qualifying Event occurs during the period from September 1, 2008 through December 31, 2009. The Plan Administrator may provide this notice separately or along with notices that are provided following a COBRA Qualifying Event. This notice will go to all Qualified Beneficiaries, whether they have COBRA coverage or not, who had a COBRA Qualifying Event from September 1, 2008 through December 31, 2009. Qualified Beneficiaries who are eligible for the special COBRA election period described above also must receive a notice informing them of this opportunity. For those Qualified Beneficiaries who are eligible for the special COBRA election period, this notice must be provided by April 18, 2009.

- Expedited Review Of Denials Of Premium Reduction. Individuals who are denied treatment as assistance eligible individuals (and thus are denied eligibility for the premium reduction) may request an expedited review of the denial by the Department of Labor. The Department of Labor must make a determination within 15 business days of receipt of a completed request for review.

- Income Limits. If an individual's modified adjusted gross income for the tax year in which the premium assistance is received exceeds \$145,000 (or \$290,000 for joint filers), then the amount of the premium reduction during the tax year must be repaid. For taxpayers with adjusted gross income between \$125,000 and \$145,000 (or \$250,000 and \$290,000 for joint

filers), the amount of the premium reduction that must be repaid is reduced proportionately. Individuals may permanently waive the right to receive a premium reduction.

SECTION 4 BENEFIT LIMITATIONS

The Plan will pay its portion of Covered Expenses subject to all of the Plan's terms, conditions, exclusions and limitations, including those described below.

1. Deductibles

Satisfying Annual Deductibles. Other than for preventive care as described in Item 3 below, no benefits will be paid by the Plan until the applicable annual deductible is satisfied. Before satisfying the applicable annual deductible, Participants must pay for 100% of their Covered Expenses (other than those related to preventive care).

(a) **Individual Coverage.** Participants with individual Plan coverage must incur at least \$1,500 in Covered Expenses (including Prescription Copayments) during the Plan Year to satisfy their annual deductible.

(b) **Family Coverage.** Participants with other than individual Plan coverage must incur at least \$3,000 in Covered Expenses (including Prescription Copayments) during the Plan Year to satisfy their annual deductible.

2. Coinsurance For Medical Benefits

Coinsurance is the percentage of Covered Expenses that Participants must pay after the applicable deductible described in Item 1 above has been satisfied. Before the deductible is satisfied, Participants must pay 100% of their Covered Expenses. After the applicable deductible is satisfied, the Plan generally pays 100% of Covered Expenses if In-System Providers are used and 60% of Covered Expenses if Out-Of-System Providers are used (up to the Out-Of System out-of-pocket maximum). There are exceptions to these rules which are discussed throughout this SPD, such as the for preventive care Services described in Item 3 below and for Prescription Drugs (as described in Item 2 of Section 5).

3. Preventive Care Benefits

Preventive care Services are those intended to prevent (not treat) an illness, injury or condition.

The following preventive care services *are not* subject to the Plan's deductible requirements described in Item 1 above. The Plan pays 100% of Covered Expenses related to the following preventive care Services if provided by In-System Providers, and 60% of the Covered Expenses if provided by Out-Of-System Providers. No precertification is required for these services.

Service	Restrictions
Blood Pressure & Pulse Measurement	1 procedure a Plan Year per Participant is covered. Must be performed by a Nurse or Doctor.
Cholesterol Screening	1 procedure a Plan Year per Participant is covered.
Colonoscopy & Sigmoidoscopy	1 procedure every 3 Plan Years per Participant over age 50 is covered.
Gynecological Exams	1 procedure a Plan Year per Participant is covered.
Hemoccult Stool Specimen	1 procedure a Plan Year per Participant over age 50 is covered.
Immunizations & Inoculations	
Mammograms	1 procedure a Plan Year per Participant over age 40 is covered.
Physical Exams	1 procedure a Plan Year per Participant is covered.
Routine Prenatal Care	
Prostate Screenings	1 procedure a Plan Year per Participant over age 40 is covered.
Rectal Examination	1 procedure a Plan Year per Participant over age 40 is covered.
Urinalysis For Sugar & Albumin	1 procedure a Plan Year per Participant is covered.
Well Child Care	Well Child Care is covered from birth <i>to age 18</i> .

4. Prescription Copayments And Coinsurance

Before the deductible described in Item 1 above is satisfied, Participants must pay 100% of their Prescription Drug Covered Expenses. After the applicable deductible is satisfied, the Plan and Participants pay the amounts described in Item 2 of Section 5. Prescription Copayments and coinsurance amounts must be paid at the time Prescription Drugs are purchased.

5. Out-Of-Pocket Maximums

Out-Of-Pocket Maximum Amounts. The Plan has an out-of-pocket maximum feature that helps limit the amount of money Participants must pay for Covered Expenses during a Plan Year. Once a Participant, or his or her family, has paid the amounts specified in the chart below, the Plan generally pays 100% of the subsequent Covered Expenses (including Covered Expenses for Prescription Drugs) for the remainder of the Plan Year. This feature helps ensure that the amount a Participant pays is manageable.

Out-Of-Pocket Maximums		
Coverage	In-System	Out-Of-System

Individual Coverage	\$2,500 per Plan Year	\$5,000 per Plan Year
Family Coverage	\$5,000 per Plan Year	\$10,000 per Plan Year

Reaching Annual-Of-Pocket Maximums. If a Participant has family coverage, he or she, and his or her Covered Dependents, must pay for Covered Expenses during the Plan Year equal \$5,000 (for In-System) and \$10,000 (for Out-Of-System) to reach their annual out-of-pocket maximum. Covered Expenses incurred for Services provided by Out-Of-System Providers *are not considered* when determining if a Participant satisfied the annual out-of-pocket maximum limits for In-System Providers. Also, the following charges are not considered when determining if a Participant satisfied his or her annual out-of-pocket maximum: (a) charges in excess of Usual And Customary charges; (b) charges for items excluded from Plan coverage; and (c) charges not paid by the Plan because a Participant did not use the Plan's precertification procedures when required.

6. Lifetime Benefit Limits

The Plan has an overall lifetime benefit limit of \$2,000,000 per Participant for all Covered Expenses. At the end of each Plan Year, a Participant's overall lifetime benefit limit is increased by \$1,000. However, a Participant's overall lifetime benefit limit may never exceed \$2,000,000.

A Participant has reached the lifetime benefit limits described above once Covered Expenses during his or her lifetime equal those amounts. The lifetime benefit limits are not restored to the maximum amounts after an interruption in a Participant's Plan coverage due to termination of employment with CFC or for any other reason. After a Participant resumes Plan coverage after an interruption in coverage, his or her maximum benefit limitations are those specified in the chart above reduced by Plan benefits previously paid on his or her behalf prior to the interruption in coverage. Also, the lifetime benefit limitations are reduced by any benefits paid on behalf of a Participant under any Predecessor Plan sponsored by CFC.

7. Precertification Procedures

The Plan's precertification procedures allows Participants to verify, in advance of receiving a Service, that the recommended Service is a Covered Expense and within reasonable costs. Participants are solely responsible for complying with the Plan's precertification procedures described below.

Non-Emergencies. When non-emergency Services requiring precertification are recommended by a Provider, either the Participant or his or he Provider must contact Health Span (at 513-551-1420 or 800-972-7726) prior to the time the Services are provided. Health Span will review the request and notify the Participant or Provider of its decision. If Health Span denies precertification, the Participant or Provider may appeal the decision in accordance with the Plan's benefit claims and appeals procedures described in Section 7.

Emergencies. In Emergency Situations, advance precertification is generally not required if Health Span cannot be reasonably contacted prior to the Participant receiving

Services. However, the Participant or his or her Provider must contact Health Span (at 513-551-1420 or 800-972-7726) as soon as reasonably possible after receiving the Services. If Health Span denies precertification, the Participant or Provider may appeal the decision in accordance with the Plan’s benefit claims and appeals procedures described in Section 7.

Penalties. Benefits for Services which require precertification may be reduced or not paid at all (as determined by the Plan Administrator) if a Participant does not comply with the precertification rules described above.

SECTION 5 BENEFITS

1. Schedule Of Medical Benefits

Unless specifically indicated, the following benefits *are subject to* the Plan’s annual deductibles as described in Section 4.

Certain capitalized words and phrases used in the chart below are defined in Section 9. To fully understand the chart, you should also review the applicable definitions.

Service	In-System	Out-Of-System	Requirements	Precertification Required
Abortions	100%	60%	Abortion must be for a therapeutic purpose (e.g., diagnosis of a genetic defect in the fetus), or the Participant’s life is endangered.	Yes
Acupuncture	100%	60%	Acupuncture must be performed for therapeutic purposes by a Doctor or a licensed acupuncture practitioner.	No
Allergies	100%	60%	Only allergy testing (e.g., hay fever testing) and serum preparation and administration are covered	No
Ambulance	100%	60%	Must be for transportation to and from a Hospital, between Hospitals, between a Hospital and a Skilled Nursing Facility, or transportation by other methods if Medically Necessary.	No
Blood & Plasma Transfusions	100%	60%	Benefits are reduced by refunds or allowances paid by a Hospital or other supplier on behalf of a Participant.	No
Blood Pressure & Pulse Measurement [other than preventive]	100%	60%	Must be necessary for the diagnosis and treatment of an Injury or Sickness.	No

Service	In-System	Out-Of-System	Requirements	Precertification Required
Breast Augmentation	100%	60%	Only covered if Participant undergoes a full or partial mastectomy, and then Plan covers: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction on the breast on which the mastectomy was not performed for purposes of producing a symmetrical appearance; (3) prostheses, including brassieres designed specifically for post-mastectomy use; and (4) treatment of physical complications at all stages of mastectomy, including lymphedemas.	Yes
Breast Reduction	100%	60%	Must be Medically Necessary.	Yes
Chiropractic Services	100%	60%	Up to 15 visits a Plan Year per Participant are covered.	No
Cholesterol Screening [other than preventive]	100%	60%	Must be necessary for the diagnosis and treatment of an Injury or Sickness.	No
Colonoscopy [other than preventive]	100%	60%	Must be necessary for the diagnosis and treatment of an Injury or Sickness.	No
Cosmetic Surgery	100%	60%	Only Necessary Cosmetic Surgery is covered.	Yes
Dental Benefits	100%	60%	Only Medical Dental Services are covered.	No
Diagnostic Tests	100%	60%		No
Durable Medical Equipment	100%	60%	Only the lesser of the cost to rent or purchase Durable Medical Equipment is covered.	Yes, if greater than \$1,000
Endoscopic retrograde cholangiopancreatography ("ERCP")	100%	60%	Must be necessary for the diagnosis and treatment of an Injury or Sickness.	No
Esophagogastroduodenoscopy ("EGD")	100%	60%	Must be necessary for the diagnosis and treatment of an Injury or Sickness.	No
Federal Government – Inpatient	100%	60%	Participant must be legally required to pay for the Inpatient Hospital Services	No

Service	In-System	Out-Of-System	Requirements	Precertification Required
Federal Government-Outpatient	100%	60%	Participant must be: (1) an armed forces retiree or the retiree's Dependent; (2) treated at a federal facility for a non-service related Injury or Sickness; and (3) charged for the Services.	No
Foreign County Services	100%	60%	Participant must: (1) be on business or vacation; (2) need to use the Services; and (3) be charged for the Services.	No
Genetic Counseling	100%	60%	(1) Genetic Counseling must be ordered by a Doctor and Medically Necessary under guidelines promulgated by the American Medical Association and the American College of Medical Genetics to determine cancer susceptibility or for diagnostic purposes for persons with symptoms of a genetic disorder; (2) Participant must display clinical features or be at direct risk of inheriting the Sickness for which the counseling is sought; (3) the counseling results directly impacts Participant's treatment; and (4) after a history, physical examination, pedigree analysis, and completion of appropriate Diagnostic Tests, a definitive diagnosis remains uncertain.	Yes
Genetic Testing	100%	60%	(1) Genetic Testing must be ordered by a Doctor and be Medically Necessary under the guidelines promulgated by the American Medical Association and The American College of Medical Genetics to determine cancer susceptibility or for diagnostic purposes for persons with symptoms of a genetic disorder; (2) Participant must display clinical features or be at direct risk of inheriting the Sickness the testing is designed to detect; (3) test results directly impact Participant's treatment; and (4) after a history, physical examination, pedigree analysis, and completion of appropriate Diagnostic Tests, a definitive diagnosis remains uncertain.	Yes

Service	In-System	Out-Of-System	Requirements	Precertification Required
Gynecological Exams [other than preventive]	100%	60%	Must be necessary for the diagnosis and treatment of an Injury or Sickness.	No
Heart Pacemaker	100%	60%		No
Hemoccult Stool Specimen [other than preventive]	100%	60%	Must be necessary for the diagnosis and treatment of an Injury or Sickness.	No
Home Health Care & Home Infusion	100%	60%	Must be ordered by a Doctor	Yes
Hospice Care Services	100%	100%	Participant must have sustained an Injury, or have been diagnosed with a Sickness that will terminate his or her life in 6 months or less.	No
Hospital-Inpatient	100%	60%	Only Inpatient Hospital Services and Inpatient Medical Treatment are covered.	Yes
Hospital-Outpatient	100%	60%	Only Outpatient Medical Treatment is covered.	No
Insulin Benefits	100%	60%	Only insulin Services and supplies to treat and monitor diabetes are covered	No
Mammograms [other than preventive]	100%	60%	Must be necessary for the diagnosis and treatment of an Injury or Sickness.	No
Maternity Services	100%	60%	Maternity Services are covered in accordance with the subject to the Newborns' and Mothers' Health Protection Act.	No
Mental Health-Inpatient	100%	60%	Only Services for Inpatient Treatment of Mental Or Nervous Illness or Doctor visits during which convulsive therapy is administered are covered. Benefits are paid on the same basis as Sickness benefits.	Yes
Mental Health-Outpatient	100%	60%	Only Mental Or Nervous Illness treatment is covered.	No
Miscellaneous Benefits	100%	60%	Services not described in this SPD may be covered as determined by the Plan Administrator.	If required by the Plan Administrator
Occupational Therapy	100%	60%	Therapy must be performed by a licensed therapist and prescribed by a Doctor. Up to 30 occupational therapy visits a Plan Year per Participant are covered.	No

Service	In-System	Out-Of-System	Requirements	Precertification Required
Oxygen & Equipment	100%	60%		No
Pap Smear And Pelvic Exam [other than preventive]	100%	60%	Must be necessary for the diagnosis and treatment of an Injury or Sickness.	No
Physical Exams [other than preventive]	100%	60%	Must be necessary for the diagnosis and treatment of an Injury or Sickness.	No
Physical Therapy	100%	60%	Must be prescribed by a Doctor. Up to 30 Physical Therapy visits a Plan Year per Participant are covered.	No
Prostate Screenings [other than preventive]	100%	60%	Must be necessary for the diagnosis and treatment of an Injury or Sickness.	No
Rectal Examination [other than preventive]	100%	60%	Must be necessary for the diagnosis and treatment of an Injury or Sickness.	No
Septoplasty	100%	60%	Elective surgery and procedures not connected to an Injury or Sickness are not covered.	Yes
Shoes	100%	60%	Only appliances attached to shoes and prescribed by a Doctor are covered.	No
Sigmoidoscopy [other than preventive]			Must be necessary for the diagnosis and treatment of an Injury or Sickness.	
Skilled Nursing Facility Benefits	100%	60%	Plan covers Skilled Nursing Facility Services for 1 or more Periods of Skilled Nursing Facility Confinement if: (1) prior to a Period Of Skilled Nursing Facility Confinement, Participant was an Inpatient for at least 3 consecutive days for the same Sickness or Injury; (2) attending Doctor completes a treatment plan including a diagnosis, proposed course of treatment and projected date of discharge from the facility; (3) Medically Necessary; and (4) Participant is under the continuous care of a Doctor. Periods of Skilled Nursing Facility Confinement in excess of 60 days are not covered.	Yes
Sleep Apnea	100%	60%		No
Speech Therapy	100%	60%	Up to 30 Speech Therapy visits a Plan Year per Participant are covered.	No

Service	In-System	Out-Of-System	Requirements	Precertification Required
Sterilization Procedures	100%	60%		No
Substance Abuse Disorders- Inpatient	100%	60%	Only Services for Inpatient Substance Abuse Disorders are covered. Benefits are paid on the same basis as Sickness benefits.	Yes
Surgical Benefits- Inpatient	100%	60%	Primary surgeon's Services are covered, and assistant surgeons' Services are covered if: (1) assistant surgeon's Covered Expenses do not exceed 20% of those of the primary surgeon; (2) assistant surgeon is a M.D., D.O. or D.P.M.; (3) presence of assistant surgeon is Medically Necessary; and (4) presence of assistant surgeon has a Medicare coverage code.	Yes
Surgical Benefits- Outpatient & Ambulatory	100%	60%	Primary surgeon's Services are covered, and assistant surgeons' Services are covered if: (1) assistant surgeon's Covered Expenses do not exceed 20% of those of the primary surgeon; (2) assistant surgeon is a M.D., D.O. or D.P.M.; (3) presence of assistant surgeon is Medically Necessary; and (4) presence of assistant surgeon has a Medicare coverage code.	No
Temporomandibular Joint Syndrome ("TMJ")	100%	60%	Must be specifically diagnosed with TMJ by a D.D.S., D.M.D., M.D. or D.O., and the TMJ Treatment must be prescribed by that Provider.	Yes
Transplant Services	100%	60%		Yes
Urinalysis For Sugar & Albumin [other than preventive]	100%	60%	Must be necessary for the diagnosis and treatment of an Injury or Sickness.	No
Vision Care	100%	60%	Vision Care Services are covered.	No
Vision Therapy	100%	60%	Up to 30 Vision Therapy Service visits a Plan Year per Participant are covered.	No
Well Child Care [other than preventive]	100%	60%	Well Child Care is covered from birth to age 18.	No

2. Prescription Drug Benefits

The Plan pays the amounts described in the chart below *only* if the Participant:

(a) purchases the Prescription Drugs at an In-System Pharmacy or through the Plan's mail order service;

(b) first satisfies the applicable deductible described in Item 4 of Section 4; and

(c) pays his or her Prescription Copayment and coinsurance amount described in the chart below until the In-System out-of pocket maximum described in Item 5 of Section 4 is satisfied.

The Plan *does not pay for* the cost of Prescription Drugs purchased at Out-Of-System Pharmacies. Some Prescription Drugs (as determined by the Plan Administrator) require a Participant to obtain prior authorization from the Plan. If prior authorization is not obtained, the Plan will not pay for the Prescription Drugs.

	Generic Drugs	Formulary Brand-Name Drugs	Non-Formulary Brand-Name Drugs
In-System Pharmacy	Plan pays 100% Participant pays 0%	Participant pays a \$25 co-pay	Plan pays 65% Participant pays 35% [\$40 minimum]
Mail Order	Plan pays 100% Participant pays 0%	Participant pays 2½ times co-pay for a 3-month supply	Participant pays 2 ½ times co-pay for 3-month supply

Proton pump inhibitors and non-sedating antihistamines are subject to a co-pay and co-insurance unless the Participant has a prescription for an over-the-counter equivalent. If a Participant has a prescription for an over-the-counter proton pump inhibitor or non-sedating antihistamine, the Plan will pay 100% after the Participant satisfies his or her deductible.

3. Exclusions From Coverage

The Plan does not cover any of the following items.

- Services, supplies and equipment not Medically Necessary for the treatment of a Participant's Injury, Sickness, screening or any other procedure covered by the Plan.
- Benefits not specifically provided for in this SPD unless otherwise determined by the Plan Administrator.
- Breast augmentation or implant surgery unless required by the Women's Health and Cancer Rights Act of 1998.
- Breast pumps.
- Charges in excess of the Usual And Customary charge.
- Custodial care, such as bathing and cooking unless specifically provided for in the SPD.
- Diet pills or drugs used to treat obesity or promote weight loss.

- Drugs purchased outside the United States.
- Examination for, prescribing, fitting or purchasing hearing aids.
- Experimental artificial heart and implant surgery.
- Health education unless prescribed by a Doctor to assist a Participant with an Injury or Sickness.
- Hospital room and board expenses incurred for a non-emergency weekend Hospital admission (i.e., Friday or Saturday).
- Hypnotism.
- Infertility surgical procedures, artificial insemination, in-vitro fertilization (including GIFT, ZIFT and all other assisted reproductive technology) or donor egg or sperm donation or retrieval.
- Injuries which are not Non-Occupational Injuries.
- Midwives other than Certified Nurse-Midwives.
- Penile implants.
- Physical fitness programs and expenses.
- Premarital exams.
- Private Hospital rooms (unless no semi-private rooms are available), televisions, telephones, gourmet meals and other Hospital expenses not reasonable and Medically Necessary for the treatment of a Participant's Injury or Sickness.
- Procedures related to weight reduction, including surgical procedures for various types of diet problems such as gastric by-pass surgery, gastric stapling or the reversal of such procedures.
- Non-Prescription Drugs.
- Services provided by a government or government plan at no cost to a Participant.
- Services performed by Christian Science practitioners.
- Services performed by blood relatives or "legal-relatives," including a spouse, parent, children, brothers, sisters, grandparents, uncles or aunts of a Participant.
- Services which a Participant is not, in the absence of insurance, required to pay for.
- Sex change surgery or treatments or transformation changes or procedures.
- Sexual or marriage counseling.
- Sicknesses which are not Non-Occupational Sicknesses.
- Swimming pools, hot tubs or tanning beds.

- Treatment in a Skilled Nursing Facility or extended care facility unless specifically provided for in the SPD.
- Treatment of an Injury or Sickness due to war or an act of war.
- Treatment of alopecia (baldness).
- Water beds.
- Workers' Compensation expenses incurred from an occupational related Injury or Sickness, including occupational therapy or education in special schools, that is subject to Workers' Compensation, in whatever form.

4. Payment To Parties Other Than Participants

Plan Benefits may be made directly to Providers. Also, if the Plan Administrator determines that a Participant to whom Plan benefits are payable is unable to care for his or her personal affairs, is a minor or has died, then payment may be paid to the Participant's spouse, child, relative or to an institution that has custody of the Participant. The Plan Administrator may delay benefit payments until a legal representative is appointed. Plan benefit payments are considered a complete discharge of the Plan's liabilities.

5. Erroneous Payments

- Providers, Participants and any other person or entity accepting, or benefiting from, the payment of Plan benefits agrees to be bound by the terms of the Plan. This includes, but is not limited to, submitting benefit claims in accordance with state health care practice acts, Medicare guidelines, other applicable laws or standards, and other standards approved by the Plan Administrator

- The Plan Administrator has the right to recover (from the recipient and/or from the Participant on whose behalf the payment was made) payments that should not have been paid under the terms of the Plan, or payments payable (or made) in connection with benefit claims that were not submitted as described above. Erroneous payments also include, but are not limited to, payments made: (a) pursuant to a misstatement made to obtain Plan coverage; (b) pursuant to a misstatement in a proof of loss; (c) pursuant to a fraudulent act; (d) with respect to an ineligible person; (e) in anticipation of obtaining a recovery in subrogation if a Participant fails to comply with the Plan's provisions regarding subrogation; or (f) pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Illness to the extent that such benefits are recovered.

- A Participant, Provider, health plan, insurer, or any other person or entity who receives an erroneous payment, or on whose behalf the payment was made, is responsible for repaying the erroneous amount to the Plan no later than 30 days of the earlier of discovery or demand unless otherwise provided by the Plan Administrator, or may incur prejudgment interest.

- The Plan Administrator also has the sole authority to decide whether the repayment must be made in a lump sum or deducted from a Participant's other present or future benefit claims. As a condition of participating in the Plan, each Participant authorizes any deductions from other benefit claims.

- If legal action is necessary to recover an erroneous payment, the recipient of the erroneous payment must reimburse the Plan for legal expenses that it incurred.

6. No Assignment

No benefits payable under the Plan may be subject to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber Plan benefits is automatically void. No individual has the right to assign his or her right to sue to recover benefits under the Plan, to enforce rights under the Plan, or to any other causes of action which he or she may have against the Plan or its fiduciaries.

7. Right To Receive And Release Information

As a condition of participating in the Plan, Participants agrees to provide the Plan Administrator with all information necessary to administer the Plan, and authorize the Plan Administrator to obtain and release any information necessary to administer the Plan in accordance with the administrative simplification provisions of HIPAA.

SECTION 6 COORDINATION OF BENEFITS

1. Coordination With Other Plans

If a Participant is also covered under one or more Other Plans and the sum of the benefits payable under all the plans involved exceeds the Participant's Allowable Expenses, then the benefits payable under all the plans involved will not exceed the Allowable Expenses as determined under the Plan. Benefits payable under the Other Plans are included in the this determination, whether or not a claim has been made to the Other Plans.

When coordinating benefits, one of the plans is designated as the primary plan, all "Other Plans" are designated as secondary plans, as described below. The primary plan will pay benefits without regard to the secondary plans. The secondary plans will coordinate their payments so that the total benefits from all plans do not exceed Allowable Expenses. No plan will pay more than it would have paid in the absence of these coordination of benefits provisions.

Participants must provide the Plan with the information the Plan requests with respect to the Other Plans and benefits provided (or possibly payable) by the Other Plans. If the Plan paid benefits in excess of the amount provided under these provisions, the Plan has the right to recover the overpayments from any person, insurance company or other organization.

The order of benefits are determined in accordance with the following rules.

- The primary plan for a claimant is the plan which covers the person making the claim as an employee.
- For Children's expenses, the primary plan is the plan of the parent whose birthday (month and day of birth, not the year of birth), occurs earlier in the calendar year.
- For Children's expenses when parents are separated or divorced: (a) if there is a court decree that establishes who is financially responsible for health care expenses for the Children, the Plan covering that parent is the primary plan; and (b) if there is no court decree, the plan covering the parent with custody is the primary plan. If the parent with custody has not remarried, the plan covering the parent without custody the secondary plan. If the parent with custody has remarried, the secondary plan is the plan covering the step-parent, and the plan covering the parent without custody pays benefits third.
- The plan covering an individual as an employee (or as the employee's dependent) who is neither laid-off, retired or terminated (or that individual's dependent) is the primary plan. The Other Plans covering that individual as a laid-off, retired or terminated employee (or that individual's dependent) are secondary.
- The plan covering an individual as an employee (or as a dependent of the employee) is the primary plan if the individual is also being provided with COBRA continuation coverage under the Other Plans involved, and the Other Plans are secondary.
- If any of the Other Plans don't have coordination of benefits or have a provision different from the Plan, one of the Other Plans without a coordination of benefits provisions, or with contrary provisions, is the primary plan.
- In the event of conflicting coordination provisions between the Plan and any Other Plan, the plan covering the Participant the longest is primary.

2. Coordination With Certain Government-Sponsored Plans

Except in certain situations with Medicare, the Plan will generally be primary to any federal or state/federal plan. To the extent that the Plan's rules conflict with those of a government-sponsored plan, the rules of the government-sponsored plan will prevail.

3. Coordination With Medicare

The Plan intends to comply with the Medicare secondary payor rules as long as the Plan is required to do so. The Plan is the primary payor of Allowable Expenses for Participants Entitled To Medicare, and Medicare is the secondary payer of Allowable Expenses in accordance with the following provisions.

The Plan will be the primary payer for a Participant who is covered under the Plan by reason of his or her Current Employment Status with CFC and who is also Entitled To Medicare, for as long as Current Employment Status continues.

The Plan will be the primary payer for a disabled Participant who is Entitled To Medicare but still participates in the Plan by reason of Current Employment Status, for as long as Current Employment Status continues.

The Plan will be the primary payer for a Participant who is Entitled To Medicare solely on the basis of having end-stage renal disease (“ESRD”). However, Medicare will be the primary payer of for an individual with ESRD after expiration of the period that begins on the date the individual first becomes Entitled To Medicare Part A benefits (under Social Security Act §226A) and ends 18 months later.

4. Coordination With Other Governmental Plans and Coverage

The Plan will coordinate benefits with other governmental plans and health coverage as required by applicable laws, as interpreted by the Plan Administrator.

5. Circumstances In Which The Plan Is Always Secondary

The Plan is always secondary with respect to benefits paid or payable by any automobile or liability policy, uninsured or underinsured motorist policy, no-fault insurance policy, self funded liability plan or medical payments coverage under any such policies.

SECTION 7 BENEFIT CLAIMS AND APPEALS PROCEDURES

1. General

The Plan Administrator is responsible for adjudicating benefit claims and for providing full and fair review of the claims. Benefits under the Plan will be paid only if the Plan Administrator decides, in its sole and absolute discretion, that a Participant is entitled to them. Unless otherwise provided by the Plan Administrator, a benefit claim must be in writing in a form acceptable to the Plan Administrator. The Plan’s claims, notice and appeals procedures are only required to be followed to the extent required by ERISA.

If a claim is submitted by a Provider who does not have recourse against a Participant for amounts not paid by the Plan, only the procedures described in Section 6 below will apply.

If a claim is submitted by a Participant (or his or her authorized representative), or by a Provider who has recourse against a Participant for amounts not paid by the Plan, the procedures described below apply except for Item 6. Those procedures do not apply to disputes with Providers, insurers or managed care organizations regarding payments that may be due to them, provided the resolution of the dispute has no effect on Plan benefits to Participants, as determined in the sole and absolute discretion of the Plan Administrator.

2. Pre-Service Urgent Care Claims

Pre-Service Urgent Care Claims are claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize a Participant's life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of the Participant's medical condition, could cause severe pain. Pre-Service Urgent Care Claims are administered in accordance with the following provisions.

The Plan Administrator has the duty of determining whether a particular claim is one for urgent medical care on the basis of information furnished by or on behalf of a Claimant, applying the judgment of a prudent layman with average knowledge of health and medicine, but deferring to the judgment of a physician with knowledge of the Claimant's condition. The Plan Administrator will notify the Claimant of the Plan's determination as soon as possible, but not later than 72 hours after receipt of the claim by the Plan.

If a Claimant fails to provide information sufficient to determine whether benefits are payable under the Plan, the Plan Administrator will notify the Claimant, as soon as possible, but not more than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant will be given a reasonable amount of time, but not less than 48 hours, to provide the necessary information. Once the Plan Administrator receives the additional information, the claim will be decided within 48 hours of the earlier of: (a) the Plan Administrator's receipt of the requested additional information; or (b) the end of the period within which the Claimant had to provide the additional information.

The Plan Administrator may orally provide a notice of claim denial to a Claimant. If oral notice is given, a written (or electronic) notice will be provided to the Claimant within 3 days. Notice of a favorable benefit determination will contain information which is sufficient to apprise the Claimant of the Plan's favorable decision.

If a Claimant fails to follow the Plan's claims procedures, the Plan Administrator will notify the Claimant of the Plan's proper procedures within 24 hours. The notification may be oral unless the Claimant requests otherwise.

3. Pre-Service Non-Urgent Care Claims

Pre-Service Non-Urgent Claims are claims for Plan benefits that require notification and approval prior to receiving medical care. Pre-Service Non-Urgent Care Claims are administered in accordance with the following provisions.

The Plan Administrator will notify a Claimant of the Plan's determination within a reasonable period of time, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator: (a) determines that the extension is necessary due to matters beyond the control of the Plan; and (b) notifies the Claimant before the end of the initial 15-day period of the

circumstances requiring the extension, and of the date by which the Plan expects to make a decision.

If an extension (described in the paragraph above) is necessary because a Claimant failed to submit the information necessary to decide the claim, the extension notice will specifically describe the necessary information, and the Claimant will be given at least 45 days from receipt of the notice within which to provide the necessary information. If the necessary information is received by the Plan within the 45-day period, the Plan Administrator will notify the Claimant of the determination within 15 days after the information is received. If the Claimant does not provide the necessary information within the 45-day period, the claim will be denied.

If a Claimant fails to follow the Plan's claims procedures, the Plan Administrator will notify the Claimant of the Plan's proper procedures within 5 days. The notification may be oral unless the Claimant requests otherwise.

4. Post-Service Care Claims

Post-Service Care Claims are claims for benefits that are filed after medical care has been received. Post-Service Care Claims are administered in accordance with the following provisions.

The Plan Administrator will notify a Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator: (a) determines that the extension is necessary due to matters beyond the control of the Plan; and (b) notifies the Claimant before the end of the initial 30-day period of the circumstances requiring the extension, and of the date by which the Plan expects to make a decision.

If an extension (described in the paragraph above) is necessary because a Claimant failed to submit the information necessary to decide the claim, the extension notice will specifically describe the necessary information, and the Claimant will be given at least 45 days from receipt of the notice within which to provide the necessary information. If the necessary information is received by the Plan within the 45-day period and the claim is denied, the Plan Administrator will notify the Claimant of the denial within 15 days after the information is received. If the Claimant does not provide the necessary information within the 45-day period, the claim will either be denied or the Plan's decision will be tolled from the date the extension notice is sent until the date the Claimant responds to a request for information.

5. Concurrent Care Claims

Concurrent Care Claims are claims that request to extend treatment in situations where an on-going course of treatment was previously approved by the Plan for a specific period of

time or number of treatments. Concurrent Care Claims are administered in accordance with the following provisions.

If a Claimant's request to extend treatment is a Pre-Service Urgent Care Claim, the Plan Administrator will make a determination on the request as soon as possible, and will notify the Claimant of the Plan's decision within 24 hours after the Plan received the claim, provided the request was made at least 24 hours prior to the end of the approved treatment. If the request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Pre-Service Urgent Care Claim and decided in accordance with the procedures for deciding Pre-Service Urgent Care Claims.

If a Claimant's request to extend treatment does not involve urgent care, the request will be considered a new claim and decided according to Post-Service Care Claim or Pre-Service Non-Urgent Care Claim procedures, as applicable.

If the Plan Administrator is notifying a Claimant of a reduction or termination of an ongoing course of treatment (other than by Plan amendment or termination), the Plan Administrator will notify the Claimant in advance of the reduction or termination so that the Claimant can may appeal the decision before the treatment is reduced or terminated.

6. Provider Claims

Written proof of charges upon which a claim is based must be provided to the Plan Administrator within 90 days after the end of the Plan Year in which the charges were incurred. If the Plan Administrator determines that it was not reasonably possible to provide written proof within 90 days after the end of the Plan Year, the Plan Administrator will not reduce the claim for that reason if the proof is provided as soon as reasonably possible. Notwithstanding the forgoing, proof of charges must be provided to the Plan no later than one year from the date on which the charges were incurred unless otherwise provided by the Plan Administrator.

7. Notification Of An Adverse Benefit Determination

The Plan Administrator will provide a Claimant with a notice, either in writing or electronically, containing the following information: (a) the specific reasons for the denial; (b) references to the specific Plan provisions on which a denial is based; (c) a description of any additional information necessary for the Claimant to perfect the claim, and an explanation why such information is necessary; (d) a description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review; (e) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; (f) any internal rule, guideline, protocol, or similar criterion that was relied on in making the determination (or a statement that it was relied upon and that a copy will be provided free of charge, upon request); (g) in the case of denials based on Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the

scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (h) in the case of denials involving urgent care, a description of the expedited review process applicable to such claims.

8. Appeal Of Adverse Benefit Determinations

Claims Appeal Procedures. Claimants are entitled to appeal an adverse claims decision in writing to the Plan's designated appeals administrator (the "Appeals Committee") and get a full and fair review in accordance with the following provisions.

- The appeal must be made within 180 days following the Claimant's receipt of notice of an adverse claims decision.
- The Claimant may submit with his or her appeal written comments, documents, records and other claim related information.
- The review will take into account all comments, documents, records, and other information submitted by a Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.
- The review will not afford deference to the adverse benefit determination being reviewed and will be conducted by the Appeals Committee, which consists of individuals who did not make the adverse claims decision being appealed and who are not subordinate to the individual who made the decision.
- In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the Appeals Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.
- The Appeals Committee will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.
- Upon request and free of charge, the Claimant will be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

- In the case of a Pre-Service Urgent Care Claim, a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant. Also, all necessary information, including the Plan's benefit determination on review, will be transmitted between the Appeals Committee and the Claimant by telephone, facsimile, or other available similarly expeditious method.

Review Of Denied Claims. The Appeals Committee will review and make a determination on an appeal and communicate its decision to the Claimant in accordance with the following provisions.

- Pre-Service Urgent Care Claims. Decisions on review of Pre-Service Urgent Care Claims appeals will be made and communicated to the Claimant as soon as possible, but in no event later than 72 hours after the Appeals Committee received the request for the review.

- Pre-Service Non-Urgent Care Claims. Decisions on review of Pre-Service Non-Urgent Care Claims appeals will be made and communicated to the Claimant within a reasonable period, but not more than 30 days, after the Appeals Committee received the request for the review.

- Post-Service Care Claims. Decisions on review of Post-Service Care Claims appeals will be made and communicated to the Claimant within a reasonable period, but not more than 60 days, after the Appeals Committee received the request for the review.

- Concurrent Claims. Decisions involving Concurrent Care Claims by a Claimant will be made and communicated to the Claimant as soon as possible, but in no event later than the following time periods after the Appeals Committee received the request for the review: (a) 72 hours for Pre-Service Urgent Care Claims; (b) 30 days for Pre-Service Non-Urgent Care Claims; or (c) 60 for Post-Service Care Claims.

- Calculating Time Periods. The period of time within which the Appeals Committee's determination is required to be made will begin at the time an appeal is submitted in accordance with the Plan's procedures, without regard to whether all information necessary to make the determination accompanies the filing.

Notice Of Determination On Review. The Appeals Committee will provide a Claimant with a written or electronic notice of its benefit determination on review. The notice of denial will be drafted in a manner calculated to be understood by a Claimant and will contain the following information: (a) the specific reasons for the denial; (b) reference to the specific Plan provisions on which the benefit determination is based; (c) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits; (d) a statement which provides that the Claimant has the right to bring an action under ERISA after he or she first exhausts the Plan's administrative remedies described in Section 7; (e) any internal rule, guideline, protocol, or similar criterion that was relied on in making the determination (or a statement that it was relied upon and that a copy will be provided free of

charge, upon request); and (f) if the determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Decisions On Review Are Final. The decision by the Appeals Committee will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law.

Legal Actions. No legal or similar action relating in any way to a claim for benefits under the Plan may be brought by, or on behalf of, any Participant or Claimant or their authorized representatives until the Plan's administrative remedies (the claims and appeals process described above) have been exhausted. Also, no legal action may be brought against the Plan, Plan fiduciaries, the Employers (including its employees and shareholders) more than *one year after the date* the Plan's administrative remedies were exhausted.

No Plan provision will be considered to be waived, and there will be no estoppel against the enforcement of a Plan provision, except pursuant to a written instrument of the party charged with the waiver or estoppel. No written waiver will be considered a continuing waiver unless specifically stated in the waiver, and each waiver will operate only with respect to the specific term or condition waived, and will not constitute a waiver of a term or condition for the future or as to any act other than the act specifically waived.

Limitation On Actions For Benefits. Notwithstanding any contrary provision in the Plan, legal action (or any similar action) relating to a claim for benefits under the Plan may not be commenced by a Participant or Claimant (or their authorized representatives) against the Plan Administrator, the Appeals Committee, the Plan, CFC or any affiliate (including their shareholders and employees or Associates) later than one year after the Plan's claims/appeals process has been exhausted.

Appointment Of Authorized Representative. A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint a representative, a Participant must complete a form acceptable to the Plan Administrator. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

Compliance with Regulations. It is intended that the Plan's claims procedures be administered in accordance with the claims procedure regulations of the Department of Labor set forth in 29 CFR Section 2560.503-1, as interpreted by the Plan Administrator.

9. Physical Examination And Autopsy

Physical Examinations. The Plan reserves the right to have a physician of its own choosing examine any Participant whose condition, Sickness, or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

Autopsy. The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

SECTION 8 SUBROGATION AND RECOVERY

Capitalized words and phrases used in this section are defined in Section 9. In order to fully understand this section, you should review the applicable definitions.

1. General

- **Agreement To Be Bound By The Plan's Terms.** As a condition of participating in the Plan, and receiving benefits under the Plan, an Individual agrees that by accepting, or benefiting from, Plan Benefit Payments he or she is on notice of, understands, and will: (a) be bound by the Plan's provisions including those in this Section 8; and (b) fully cooperate with the Plan in protecting the Plan's rights and shall do nothing to prejudice those rights, which includes, but is not limited to, signing and delivering any and all instruments, papers, and reimbursement agreements required by the Plan, doing whatever is requested or necessary in order to fully execute and to fully protect the Plan's rights, and doing nothing that would interfere with or diminish the Plan's rights.

- **Application Of The "Made-Whole" And "Common Fund" Doctrines Is Precluded.** The Plan precludes the operation of the "made-whole" and "common fund" doctrines, or any similar doctrines in connection with the Plan's right of recovery and subrogation rights described in Items 2 and 3 below. This generally means that the Plan is entitled to the right of first reimbursement (or first lien) on any Award, Settlement, Or Damages an Individual is, or may, become entitled to, or receives regardless of whether the Individual has been compensated for his or her damages or expenses (including his or her attorneys' fees or costs), and regardless of the manner in which the parties, courts, or any other entities, classify or characterize such claims, recoveries, awards, settlements, or damages. This also means that the Plan's right of first reimbursement (or first lien) will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise. The Plan will not pay, offset any recovery, or in any way be responsible for any fees or costs associated with pursuing a claim unless the Plan agrees to do so in writing.

- **Requirement To Notify The Plan Immediately.** An Individual must immediately notify the Plan Administrator whenever an Injury or Sickness arises as a result of

an accident, a person's negligence, or any other circumstance which may entitle the Individual to an Award, Settlement, Or Damages. Some common situations are auto accidents, medical malpractice, accidental injuries, negligence, and use of defective products.

- **No Settlements Without Prior Approval From The Plan Administrator.** An Individual may not accept any settlement that does not fully compensate the Plan for the Amount Owed To The Plan. An Individual must notify the Plan Administrator in writing of any proposed settlement and obtain the Plan Administrator's written consent before signing any release or agreeing to any settlement.

2. Right Of Recovery

- The Plan has the right to recover the Amount Owed To The Plan from any Award, Settlement, Or Damages that an Individual is, or may, become entitled to, or receives, as a result of an accident, a party's fault or negligence, or any other circumstance under which an Individual has Right To Recover Against Any Other Party.

- The Plan automatically has a right of first reimbursement (or first lien), against any other parties, with respect to the Amount Owed To The Plan, and that amount shall be deemed held in constructive trust for the benefit of the Plan until the Plan receives full-payment of that amount. Upon receipt of an Award, Settlement, Or Damages by an Individual (or his or her attorney or any other party), the Amount Owed To The Plan must immediately be paid to the Plan. As described in Item 1 above, the Plan's right of first reimbursement (or first lien) supersedes any right that an Individual has to be "made whole." The Amount Owed To The Plan will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise. The Plan will not pay, offset any recovery, or in any way be responsible for any fees or costs associated with pursuing a claim unless the Plan agrees to do so in writing.

- The Plan may deduct the Amount Owed To The Plan, or the amount of an Individual's Award, Settlement, Or Damages, whichever is less, from any future benefits that may become payable to the Individual under the Plan if the Amount Owed To The Plan is not repaid or otherwise recovered by the Plan, or the Individual or his legal representative fail to cooperate with the Plan.

- In the event an Individual fails to disclose to the Plan the amount of any Award, Settlement, Or Damages, the Plan may deduct the Amount Owed To The Plan from any future benefits that may become payable to the Individual under the Plan.

- The Plan is entitled to recover the Amount Owed To The Plan, or the amount of an Individual's Award, Settlement, Or Damages, whichever is less, directly from the providers to whom the Plan paid benefits. In that circumstance, it may be the Individual's obligation to pay the provider the full billed amount. The Plan would not have any obligation to pay the provider.

3. Subrogation Rights

- The Plan has the right to assert rights on an Individual's behalf to obtain an Award, Settlement, Or Damages. Specifically, through subrogation, the Plan is entitled to assert an Individual's claim, demand, action, or Right To Recover Against Any Other Party, with respect to the Subrogation Amount. The Subrogation Amount is immediately owned to the Plan and shall be deemed held in constructive trust for the benefit of the Plan until the Plan receives full payment of that amount.

- As provided in Item 1 above, the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and any similar doctrines, in connection with the Plan's subrogation rights.

- The Plan does not require an Individual to pursue a claim against another party. However, the Plan reserves the right to directly pursue recovery against another party on an Individual's behalf, should he or she elect not to pursue an Award, Settlement, Or Damages against or from a party.

- The Plan's subrogation provisions will apply without regard to the Plan's coordination of benefits provisions, unless those provisions would result in a larger recovery amount for the Plan.

4. Individual's Separate Agreement Obligation

As a precondition to receiving benefits under the Plan, an Individual may be required to enter into a separate agreement with the Plan in which he or she agrees to: (a) immediately reimburse the Plan for any Amount Owed To The Plan from any Award, Settlement, Or Damages; and/or (b) assign direct payment to the Plan of any Amount Owed To The Plan from any Award, Settlement, Or Damages.

5. If An Individual Does Not Comply With This Section

If an Individual takes the position that he or she has not agreed to be bound by the provisions of this Section 8, or does not comply those provisions, the Plan Administrator, in its sole and absolute discretion with respect to the Amount Owed To The Plan or the Subrogation Amount, may: (a) deny payment of any present or future claims for Plan benefits by, or for, the Individual up to those amounts; (b) deny or reduce any present or future benefits otherwise payable under the Plan for the Individual up to those amounts; and/or (c) deny or reduce present or future benefits to which the Individual may otherwise be entitled under any other CFC group benefit plan or arrangement.

SECTION 9 DEFINITIONS

The following terms, whether capitalized, will have the meanings set forth below unless otherwise indicated by the context, as determined by the Plan Administrator.

Actively At Work means being regularly scheduled to work at least 30 hours a week for CFC.

Allowable Expenses means, for purposes of Section 6, any necessary, reasonable and customary expenses for Services which are at least partially covered under the Plan. If none of the plans involved consider expenses as necessary, reasonable and customary charges, the expenses are not Allowable Expenses.

Ambulance Service means a legally licensed company with a recognized vehicle or airplane for the transportation of the sick or injured.

Amount Owed To The Plan means, for purposes of Section 8, Plan Benefit Payments plus other costs in related to collecting Plan Benefit Payments from a third party or an Individual.

Associate Contributions means the amount an Eligible Associate is required to pay to cover himself or herself and his or her Dependents (as applicable) under the Plan. This amount is determined by the Plan Administrator and may change at any time without prior notice.

Award, Settlement, Or Damages means, for purposes of Section 8, an amount including, but not limited to: (a) a full or partial award, settlement, damages (whether equitable, legal, compensatory, etc.), compensation, benefits, or other payment of any kind; (b) an amount paid by formal court award, informal compromise, redemption agreement, application for benefits, or otherwise; (c) an amount paid in a lump sum, installment, or annuity payments; and (d) amounts of any type, kind, nature, or character, regardless of whether the amount identifies or covers the Plan Benefit Payments, otherwise relates to health benefits, or is specifically limited to certain kinds of damages or payments.

Birthing Center means a place that is licensed by an appropriate agency, such as the Department of Health, and staffed by at least one Doctor licensed in the field of obstetrics, one Doctor licensed in the field of pediatrics and any number of Nurses who perform the following: (a) prenatal exams; (b) standard lab exams; (c) instruction on nutrition and hygiene; and (d) post-natal visits to a mother and child.

Change In Status means the occurrence of one of the following events, as determined and permitted by the Plan Administrator.

- A change in a Participant's (or Eligible Associate's) marital status including marriage, death of a Spouse, divorce and legal separation.
- A change in a Participant's (or Eligible Associate's) number of Dependents including birth, death, adoption, Placement for Adoption and legal guardianship.

- A change in the employment status of a Participant (or Eligible Associate), his Spouse or Dependents including termination or commencement of employment and a change from part-time to full-time status (or vice versa).
- An event that causes an individual to satisfy or cease to satisfy the Plan's Dependent requirements.
- A change in residence which affects Plan coverage.
- A significant change in the cost of Plan coverage.
- A significant curtailment (or addition or significant improvement) of Plan coverage.
- A change in coverage under another employer's medical plan.
- An event which affects an Eligible Associate's, Dependent's or Participant's eligibility for coverage under another company's health plan or Medicare or Medicaid.
- A loss of group health plan coverage under a governmental or educational institution plan.
- An event with triggers HIPAA special enrollment rights.
- A judgment, order or decree requires coverage for a Child under the Plan or another health plan.
- Any other event the Plan Administrator determines is advisable and consistent with applicable law.

Children or Child means: (a) natural children of a Covered Associate; (b) adopted children upon Placement For Adoption with a Covered Associate; (c) foster children upon placement with a Covered Associate; and (d) stepchildren who depend on a Covered Associate for support and reside with the Covered Associate in a parent/child relationship.

Chiropractic Services means a Doctor of Chiropractic's Services to treat neuromuscular-skeletal conditions. Chiropractic Services do not include a Doctor of Chiropractic's Services to treat any organ system disease or pathology or to treat a Child under the age of 10 for any reason.

Claimant means the Participant who has filed a claim for benefits under the Plan.

Code means the Internal Revenue Code of 1986, as amended.

Common Accident means an accident in which a Covered Associate and one or more of his or her Covered Dependents, or two or more of the Covered Associate's Covered Dependents, are Injured in the same accident.

Covered Associate means an Eligible Associate who is a Participant.

Covered Dependent means an eligible Dependent who is a Participant.

Covered Expense means expenses for a Provider's Usual And Customary Services rendered to a Participant to treat an Injury or Sickness for which coverage is provided under the Plan.

Current Employment Status means, for purposes of Section 6, that an individual is: (a) Actively At Work with CFC; (b) is treated as an active employee for payroll tax purposes with respect to amounts paid to that individual as compensation; or (c) has a business relationship with CFC as an independent contractor.

Dependent means the individuals described below unless provided in Paragraph (e) below.

(a) General Definition. Dependent means:

(1) a Spouse; and

(2) unmarried Children under age 19 (unless disabled under Paragraph (c) below) provided such Children satisfy either (i) or (ii):

(i) have the same principal place of abode as the Eligible Associate for more than one-half of the relevant calendar year and do not provide more than one-half of their own support for the year, as determined under Code §152; or

(ii) receive more than one-half of their support in the relevant calendar year from the Eligible Associate (subject to the exceptions contained in Code §152), and are not a qualifying child for any taxpayer in that year. The term "qualifying child" has the same meaning as in Code §152, as that term is revised by the amendments, in Section 207(9) of the Working Families Relief Act of 2004, to Code §105(b), and related subsequent guidance.

(b) Full-Time Students. Dependent will also mean Children from age 19 to 25 (unless disabled under Paragraph (c) below) provided that, during at least 5 calendar months of the relevant calendar year, they satisfy the following conditions:

(3) are attending an accredited and state licensed technical school or institution of higher education on a fulltime basis;

(4) are unmarried and have never been married; and

(5) satisfy either (iii) or (iv):

(iii) if under age 24, satisfy either Paragraph (a)(2)(i) or (a)(2)(ii) above;

or

(iv) if age 24, satisfy Paragraph (a)(2)(ii) above.

Covered Dependents who are full-time students may be required to submit copies of their current school schedules to the Plan Administrator at least once a Plan Year. Failure to do so may result in a cancellation of Plan coverage.

(c) Disabled Children. Dependent will also mean Children after their 19th or 25th (in the case of Dependents who were full-time students) birthdays, provided the Children otherwise satisfy the requirements of Paragraph (a) above, and satisfy the following conditions:

(1) are unable to engage in any substantial gainful occupational activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months. Dependents are not considered disabled unless proof of the disability is provided as required by the IRS; and

(2) became physically or mentally disabled prior to the attainment of age 19 or 25 (in the case of Dependents who were full-time students), and were Participants prior to the attainment of such age or date and continuously thereafter.

Coverage will continue for disabled Children until such Children:

- (1) no longer have a disability;
- (2) become covered by another group plan or government plan (if permitted by law);
- (3) cease to be a Covered Dependents due to other provisions of the Plan; or
- (4) if the Covered Associate, of whom the individual is Child, fails to properly provide, in a timely manner, the Plan Administrator with proof of the Child's disability and dependency as described below.

The Participant must furnish proof of a Child's disability and dependency to the Plan Administrator within 30 days of the Child's 19th or 25th birthday (in the case of a Dependent who was a full-time student). The Plan Administrator may require, at reasonable intervals following the Child's 19th or 25th (in the case of a Dependent who was a full-time student) birthday, subsequent proof of the Child's disability and dependency and may request to have the Child examined. If, upon the Plan Administrator's request, a Participant fails to provide such proof, or refuses to permit the medical examination of the Child by a medical provider chosen by the Plan Administrator, the Child will be considered no longer disabled and will no longer qualify as a Dependent.

(d) Qualified Medical Child Support Orders. Dependent also includes a Child for whom health care coverage is required by a QMCSO.

(e) Restrictions. An Eligible Associate cannot be a Dependent.

(f) **Reimbursement.** A Participant (or former Participant) is required to reimburse the Plan for any benefits paid by the Plan on behalf of an individual who is identified as a Dependant and the individual is not a Dependant.

Diagnostic Tests mean tests including X-ray examinations, magnetic resonance imaging ("MRIs"), computerized axial tomography ("CAT") scans, microscopic, laboratory and other tests as determined by the Plan Administrator. Diagnostic Tests do not include Genetic Testing.

Doctor means any doctor of medicine ("M.D."), osteopathy ("D.O."), podiatry ("D.P.M."), chiropractic ("D.C."), dental surgery ("D.D.S."), or medical dentistry ("D.M.D."), duly qualified, currently licensed, and acting within the scope of his or her license at the time and place the service is rendered. The term Doctor does not include a Participant, any person who is a spouse, parent, child, brother or sister of the Participant, or a Christian Science practitioner.

Durable Medical Equipment means reusable medical equipment that is ordered by a Doctor for use in the home. Examples of Durable Medical Equipment include, but are not limited to, transport devices, CPAP/BIPAP machines, TENS unit, Neuromuscular Stimulators and Hospital beds.

Eligible Associate means an individual who is Actively At Work for CFC as a common-law employee and who is considered by CFC, in its sole and absolute discretion, to be an employee (and Associate) for purposes of the Plan. An individual who performs services for CFC as a leased employee, a temporary employee, a co-op employee, an intern, a seasonal employee or an individual in any other capacity not considered by CFC to be an employee (and Associate) for purposes of the Plan, is not considered an employee (or Associate) retroactively or prospectively. An independent contractor is not an employee (or Associate) for purposes of the Plan. A determination that an individual is CFC's employee (or Associate) for any purpose (including employment tax purposes) by a court or any administrative agency, will have no bearing on the determination of whether an individual is an employee (or Associate) for purposes of coverage under the Plan (either retroactively or prospectively) if CFC does not consider the individual to be an employee (or Associate) for purposes of the Plan.

Emergency Situations means situations including: (a) a major Injury or Sickness such as heart attack or serious wound; (b) unconsciousness; (c) bleeding that will not respond to elevation or direct pressure; (d) stupor, drowsiness or disorientation that cannot be explained; (e) shortness of breath; (f) severe pain; and (g) poisoning.

Employer Contributions means the amount CFC pays toward the cost of Plan coverage for Eligible Associates and their Dependents. This amount is determined by the Plan Administrator and may change at any time.

Enroll, Enrolls, Enrolled or Enrollment means to properly apply for Plan coverage electronically online or by using the forms prescribed by the Plan Administrator, and to agree to pay the Associate Contributions for Plan coverage. An individual is not Enrolled in the Plan

until: (a) an online application is properly completed; or (b) the prescribed application forms are properly completed, received and approved by the Plan Administrator.

Entitled To Medicare means that an individual either is receiving Medicare benefits, or would receive Medicare benefits if he or she applied to the Social Security Administration for such benefits.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Formulary Brand-Name Drug means a Prescription Drug sold under an advertised product name and on the Plan's formulary. The formulary is list of brand-name Prescription Drugs that the Plan determined are effective for treating conditions and typically cost less than other brand-name Prescription Drugs. Participants can get a list of Formulary Brand-Name Drugs by going to CFCNet, clicking on "My Company" and then choosing "Benefits."

Generic Drug means a Prescription Drug not sold under an advertised product name, but that has the same active ingredients as its brand-name equivalent. Generic Drugs are typically sold at substantial discounts and, according to the FDA Office of Generic Drugs, are identical to a brand-name Prescription Drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use.

Genetic Counseling means a process involving the guidance of a specially trained professional in the evaluation of family history, medical records, and/or Genetic Test results, in assessing the risk of genetic diseases, understanding the ramifications of diagnosis, and explanation of available treatment options available.

Genetic Testing means testing used to determine the presence or absence of a specific gene or set of genes to assess the risk of certain inheritable diseases to predict the possibility of future illnesses.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Hospice Care Services means room and board (at a Hospice Facility), related Services provided to a Participant near the end of life, and Inpatient or Outpatient hospice care provided to a Participant and to family members.

Hospice Facility means a facility that provides Hospice Care Services, including a hospice that is a freestanding facility or is within a Hospital.

Hospital means an institution which is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") and: (a) operates pursuant to law; (b) primarily and continuously provides medical care and treatment of sick and injured persons on an Inpatient-basis; (c) has facilities for medical and surgical diagnosis and treatment by, or under the supervision of, a staff of Doctors; and (d) provides 24 hour-a-day nursing service by, or under the supervision of, a Nurse.

Hospital does not mean any institution which is primarily used as: (a) a nursing home or convalescent home; (b) a specialized hospital, which is a place for the treatment of Mental Or Nervous Illness or Sickness, Substance Abuse Disorders, tuberculosis, drug addiction or alcoholism; (c) a place for rest, custodial care, rehabilitation or the aged; or (d) an institution or agency operated by the United States or its agencies, unless a Participant is charged for services, is being treated by a Veterans Administration facility for a non-service connected Injury or Sickness, and is an armed forces retiree, or his or her Dependent.

Hospital Intensive Care Unit (“ICU”) means a section, ward or wing within a Hospital which is separated from other Hospital facilities and: (a) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients; (b) has special equipment necessary for such care and treatment available on a standby basis for immediate use; and (c) provides room and board and constant observation and care by Nurses or other specially trained Hospital personnel.

Hospital Miscellaneous Charges means the Usual And Customary amounts charged by a Hospital for the Services for diagnosis or treatment of an Injury or Sickness (except Services of a Doctor and drugs or supplies not consumed or used in the Hospital) for a Participant who is an Inpatient. Hospital Miscellaneous Charges also includes Services in connection with a surgical procedure for an Outpatient.

Individual means, for purposes of Section 8, a Participant, former Participant or individual receiving (or who received) Plan coverage due to COBRA, USERRA or any similar laws, and the guardians and estates of any of them.

Injury means a condition which results independently of Sickness and all other causes and is a result of an externally violent force.

In-System means a Doctor, pharmacy or other Provider who agreed to provide Services at discounted prices.

Inpatient means a Participant who is confined to a Hospital, Mental-Nervous Hospital or Substance Abuse Facility, for at least 24 hours in connection with a Sickness, Injury, Mental Or Nervous Illness or Substance Abuse Disorder.

Inpatient Hospital Medical Treatment means medical treatment, other than surgery by a Doctor, for a Participant who is an Inpatient.

Inpatient Hospital Services means the following with respect to a Participant who is an Inpatient: (a) Hospital room and board and general nursing Services, not to exceed the Hospital’s standard semi-private room rate; (b) Hospital Intensive Care Unit charges not to exceed 2 times the Hospital’s standard semi-private room rate; (c) Hospital Miscellaneous Charges; (d) Ambulance Service charges; (e) operating and recovery room charges; and (f) charges for anesthesia and its administration.

Inpatient Hospital Services do not include Hospital room and board for a non-Emergency Situation weekend Hospital admission (i.e., Friday or Saturday).

Maternity Services means Hospital or Birthing Center room and board, special Services (as determined by the Plan Administrator), circumcision and Doctor's attendance. Maternity Services does not include breast pumps.

Medical Dental Services means Services which include the following: (a) office visits and other Services to diagnose and repair Injury to a natural tooth; (b) the excision of partially or totally impacted third molars; and (c) Services rendered to treat a Sickness which is not solely dental in nature. Medical Dental Services do not include any other dental services, including radiology, use of anesthesia by a physician and office visits unless determined to be Medically Necessary.

Medical Necessity or Medically Necessary means a determination by the Plan Administrator that services, procedures, and supplies: (a) are consistent with the treatment of a Sickness or Injury; (b) are provided in accordance with generally accepted medical practice and professional standards, considering the customary practices of Providers in the community where the Services are provided; and (c) are not provided solely for the convenience of a Participant or Provider. The fact that a Provider may recommend or approve Services does not make those Services Medically Necessary.

Medicare means the federal Medicare program under Title XVII of the Social Security Act of 1965, as amended.

Mental-Nervous Hospital means a legally licensed institution for Participants with Mental Or Nervous Illnesses, with continuous care provided by Doctors and Nurses on a 24-hour basis.

Mental Or Nervous Illness means any Sickness, disease or condition that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. Mental Or Nervous Illness will not include Substance Abuse Disorders.

Necessary Cosmetic Surgery means Services which include the following: (a) the repair of an Injury; (b) correction of a congenital defect or abnormality of a Child; and (c) corrective cosmetic surgery required in the treatment of a covered Sickness. Necessary Cosmetic Surgery does not include elective surgery and procedures that are not connected to a specific covered Injury or Sickness, including surgery and procedures for rhinoplasty, septoplasty or blepharoplasty.

Non-Formulary Brand-Name Drug means a drug sold under an advertised product name that is not on the Plan's formulary. These drugs have the highest Participant co-pays.

Non-Occupational Injury means an Injury which does not arise from and which is not caused or contributed to by, or as a consequence of, any Sickness, disease or Injury which arises out of or in the course of any employment or occupation for compensation or profit.

Non-Occupational Sickness means a Sickness or disease that does not arise out of or in the course of any work for pay or profit nor in any way results from such work. However, if proof (which is acceptable to the Plan Administrator) is furnished that an individual covered under a Workers' Compensation law (or any other law of similar purpose) is not covered for a particular disease under that law, the disease is considered "non-occupational" regardless of its cause.

Nurse means a registered nurse (R.N.), registered practical nurse (R.P.N.), licensed vocational nurse (L.V.N.) or a licensed practical nurse (L.P.N.).

Open Enrollment Period means the annual period specified by the Plan Administrator during which Eligible Associates, and Covered Associates, may Enroll in the Plan. Also, Plan coverage elections may generally be changed during an Open Enrollment Period.

Other Plans means, for purposes of Section 6, any of the following plans and arrangements: (a) group insurance or any other arrangement for coverage of individuals or a group on an insured or uninsured basis; (b) any prepayment coverage to which an employer or labor union makes contributions; (c) a labor management trustee plan, union welfare plan, employer organization plan or employee organization plan; (d) any governmental program or coverage required to be provided by statute, unless such plan specifically excludes coordination or represents coverage for students sponsored by or provided through a school or other educational institution; or (e) coverage for expenses due to accidental bodily Injury or Sickness where payment as a judgment, settlement or otherwise is made by any person or persons considered responsible for such Injury or Sickness or by their insurers.

Out-Of-System means a Doctor, pharmacy or other Provider who does not have an agreement to provide Services and Prescription Drugs at discounted prices.

Outpatient means a Participant who is not confined to a Hospital, or Mental-Nervous Hospital, for 24 or more hours in connection with a Sickness, Injury or Mental Or Nervous Illness.

Outpatient Medical Treatment means medical treatment, other than surgery by a Doctor, for a Participant who is an Outpatient and includes Ambulance Service charges.

Participant means an Eligible Associate and his or her eligible Dependents who are Enrolled in, and covered under, the Plan.

Period Of Skilled Nursing Facility Confinement means one or more periods of confinement in a Skilled Nursing Facility that begin within the earlier of 30 days after discharge from the Hospital, or 7 days after confinement in a Skilled Nursing Facility, for the same Sickness or Injury. A Period Of Skilled Nursing Facility Confinement ends on the earlier of the date a Participant is completely recovered from the Injury or Sickness for which he or she is confined in the Skilled Nursing Facility, or if the Participant is a Covered Associate, the day he or she returns to being Actively At Work for CFC.

Physical Therapy means a Doctor prescribed program of rehabilitation (performed by a licensed physical therapist) intended to significantly improve, develop, or restore physical function.

Placement For Adoption or Placed For Adoption means the assumption and retention by an Associate of a legal obligation in the state of the Associate's domicile for total or partial support of a minor in anticipation of adoption of the minor. A minor's placement with an Associate ends on the termination of an Associate's legal obligation.

Plan means the Cincinnati Financial Corporation Health Plan, as may be amended from time to time.

Plan Administrator means The Cincinnati Insurance Company and its successors.

Plan Benefit Payments mean, for purposes of Section 8, the amount of previous benefit payments from the Plan, or benefit payments that will be made (or, if greater, the reasonable value of the previous payments or payments that will be made) to or on behalf of an Individual.

Plan Document means this document which governs the Plan, as may be amended from time to time. The Plan Document constitutes the entire agreement between CFC, Participants and anyone who satisfies the Plan's eligibility requirements. The Plan Document supersedes all other prior documents, agreements, undertakings, both written and oral, with respect to Plan benefits.

Plan Year means the period beginning January 1 and ending December 31.

Predecessor Plan means any health plan sponsored by CFC prior to the adoption of the Plan.

Prescription Copayment means the applicable amounts payable by a Participant for Prescription Drugs. The Plan Administrator determines the amounts of the Plan's Prescription Copayments, and may change those amounts at any time.

Prescription Drugs means drugs purchased with a written prescription from a Doctor. Prescription Drugs do not include:

- allergy extracts;
- anabolic steroids;
- biological serum;
- blood or blood plasma;
- cox-2 inhibitors unless the Participant is at least age 65, or, in the past 120 days, a Doctor has prescribed one of the following for the Participant: (1) glucocorticoid; (2) Coumadin; or (3) a proton pump inhibitor, H2-receptor antagonist or sucralfate, and a non-selective NSAID;

- diet pills or drugs used to treat obesity or promote weight loss;
- drugs consumed or administered in the place where dispensed;
- drugs intended for use in a Doctor's office or settings other than home use;
- drugs purchased outside the United States which are not approved by the United States Food and Drug Administration;
- experimental drugs or those labeled "caution—limited by federal law investigational use";
- fluoride products;
- immunization agents;
- medical devices and Durable Medical Equipment;
- non-legend or over-the-counter drugs (other than proton pump inhibitors and non-sedating antihistamines purchased with a written prescription from a Doctor);
- oral fertility drugs;
- ostomy Services;
- oxygen or its administration;
- Peridex;
- Propecia;
- Rogaine;
- therapeutic devices, support garments or other non-medical substances; and
- vitamins (except prenatal Prescription Drugs).

The Plan Administrator will designate which Prescription Drugs are covered by the Plan, and may change the drugs that are covered by the Plan at any time. Some Prescription Drugs require a Participant to obtain preauthorization from the Plan, as determined by the Plan Administrator.

Provider means any authorized person or entity providing health care Services to a Participant within the scope and authority granted by a Participant and the licensing board with authority over the person or entity. A Provider does not include a Christian Science practitioner.

Qualified Beneficiary means a Covered Associate or Dependent who was covered under the Plan on the day before a Qualifying Event. A Qualified Beneficiary may include a Child who is born to or Placed For Adoption with the Covered Associate during a period of COBRA coverage. A Covered Associate can only be a Qualified Beneficiary if the Qualifying Event is the termination of the Covered Associate's employment with CFC (for any reason other than gross misconduct), or a reduction in the Covered Associate's hours of employment with CFC.

Qualified Medical Child Support Order (“QMCSO”) means a medical child support order that creates or recognizes the existence of an alternate recipient’s right to, or assigns to an alternate recipient the right to, receive benefits to which a Dependent is entitled under the Plan. In order for such an order to be a QMCSO, it must clearly specify the following items.

- The name and last known mailing address (if any) of a Participant and the name and mailing address of each alternate recipient covered by the order.
- A reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which the type of coverage is to be determined.
- The period of coverage to which the order relates.
- The Plan’s legal name.
- A national medical support notice (“NMSN”) will be considered a QMCSO if it clearly specifies the following items.
- Contains the following information: (a) name of an issuing state agency; (b) name and mailing address (if any) of a Participant; (c) name and mailing address of one or more alternate recipients (or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipients); and (d) identity of an underlying child support order.
- Identifies either the specific type of coverage or all available group health coverage. If the Plan Administrator receives an NMSN that does not designate either specific types of coverage or all available coverage, the Plan Administrator will assume that all are designated.
- Informs the Plan Administrator that, if the Plan has multiple options and the Eligible Associate is not Enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be Enrolled under the Plan’s default option (if any).
- Specifies that the period of coverage may end for the alternate recipient only when similarly situated Dependents are no longer eligible for coverage under the Plan, or upon the occurrence of certain specified events.

However, an order will not be recognized as “qualified” if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Participants, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908.

Qualifying Event means any of the following events: (a) a Covered Associate’s death; (b) a Covered Associate’s termination of employment with CFC (other than by reason of gross misconduct); (c) a reduction of a Covered Associate’s hours of employment with CFC; (d) a Covered Associate’s divorce or legal separation; (e) a Covered Associate becomes entitled to Medicare; or (f) a Dependent Child ceases to satisfy the Plan’s dependency requirements.

Right To Recover Against Any Other Party means, for purposes of Section 8, that an Individual has the right to recover damages or expenses from another party, such as an individual, partnership, corporation, government, or other entity, as well as against that party's respective insurance carriers or governmental fund, for directly or indirectly causing or contributing to the Individual's Injury or Sickness. This includes the Individual's rights to recover from his or her insurance carrier pursuant to any type of insurance policy, program, plan or arrangement.

Routine Prenatal Care means routine medical Services provided in connection with a normal pregnancy.

Services means the Medically Necessary services, supplies and/or equipment (as applicable) rendered or provided to a Participant (or transplant donor) to treat an Injury or Sickness, or perform a procedure, for which coverage is provided under the Plan unless otherwise specifically provided herein.

Sickness means bodily illness, disease, psychiatric disorders and congenital abnormalities of a Participant. A Sickness, which is the same or is related to another existing or previously existing Sickness or disease process will be considered the same Sickness.

Skilled Nursing Facility means a convalescent nursing home that provides skilled nursing care, rehabilitation Services and/or other related health Services, and is certified as a skilled nursing facility by Medicare.

Skilled Nursing Facility Services means:

- Skilled Nursing Facility room and board, and general nursing Services, not to exceed a daily limit of 50% of the standard semi-private room rate charged by the Hospital in which a Participant was an Inpatient immediately prior to his or her Skilled Nursing Facility confinement;
- miscellaneous Skilled Nursing Facility Services as determined by the Plan Administrator; and
- Ambulance Service charges for transportation between a Skilled Nursing Facility and Hospital.

Speech Therapy means therapy by a licensed speech therapist when ordered by a Doctor, and determined to be Medically Necessary to:

- restore speech to a Participant who has a speech or language disorder that is the result of a Sickness or Injury that caused a loss of previously existing speech function; or
- to help remedy a Participant's speech delay that is caused by or associated with a specifically diagnosable developmental or congenital Sickness, Injury or condition.

Spouse means a person of the opposite sex from the Covered Associate who: (a) is the Covered Associate's wife or husband pursuant to a legal union between one man and one woman as

husband and wife evidenced by a validly issued marriage license (and does not include common-law marriages); and (b) is not legally separated or divorced from the Covered Associate.

Sterilization Procedures means elective procedures, which include vasectomy and tubal ligation. Sterilization Procedures do not include vasectomy reversal, tubal ligation reversal or sex transformation types of procedures.

Subrogation Amount means, for purposes of Section 8, Plan Benefit Payments and attorneys' fees plus other costs related to the Plan asserting rights on an Individual's behalf.

Substance Abuse Disorders means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning. Substance Abuse Disorders are not considered a Mental Or Nervous Illness or Disorder.

Substance Abuse Facility means an agency (or freestanding facility or a Hospital) that is certified by the applicable state (or similar) agency for the treatment of Substance Abuse Disorders.

TMJ Treatment means Services rendered to treat Temporomandibular Joint Syndrome, which includes braces, splints and surgery.

Total Contribution Amount means the sum of the Employer Contributions and the Associate Contributions.

Transplant Services means organ and marrow transplants to a Participant that are recognized by the American Medical Association as being non-experimental. Transplant Services include Services for a Participant-organ recipient and reasonable Services for the organ donor.

Usual And Customary means the smaller of: (a) a Provider's customary charges for Services rendered when there is no health coverage available; or (b) the general level of charges for comparable Services made by other Providers in the same county or greater area as is necessary to obtain a representative cross section of Providers of the Services.

Vision Care Services means only examinations for diseases of the eyes. Vision Care Services do not include: (a) routine examinations for vision care; (b) examinations for diagnosis of astigmatism, myopia or hyperopia; (c) the cost of contact lenses and eyeglasses, other than the initial purchase of eyeglasses and contact lenses necessitated by and fitted after cataract surgery; or (d) surgeries for radial keratotomy, PRK, laser surgery or any other surgical or other procedure for the correction of nearsightedness, farsightedness, astigmatism or similar conditions.

Vision Therapy Services means Services ordered by a Doctor and performed by a licensed optometrist or orthoptist, for: (a) amblyopia; (b) strabismus; (c) non-strabismus disorder of

binocular eye movements; (d) non-presbyopic accommodative inability for Participants over age 12; (e) heterophoria (if causing asthenopia or fusion with defective stereopsis); and (f) nystagmus. Vision Therapy Services do not include treatment of traumatic brain Injury, dyslexia and learning disabilities, or any treatment or Services for a diagnoses not listed above.

Well Child Care means charges which are not incurred as the result of an Injury or Sickness or in connection with the diagnosis of an Injury or Sickness from a Participant's birth to age 18. Well Child Care includes Doctor visits in connection with routine exams, immunizations and inoculations.

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