



LDF Food Group, Inc.

LDF Support Group, Inc.

LDF Sales & Distributing, Inc.

Revised January 1, 2005

Medical Benefits For Part-Time Employees

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SCHEDULE OF MEDICAL BENEFITS FOR PART-TIME EMPLOYEES

DEDUCTIBLE AMOUNT PER CALENDAR YEAR

Per Person\$150.00*
 Per Family.....\$450.00*

* For expenses incurred while engaged in an illegal act or activity (including illegal drug usage, under the influence of alcohol, etc.), this is a deductible of \$1,000.00 per person, per calendar year.

Additional Deductible:

Per Each Hospital Emergency Room Visit\$150.00, then regular deductible and coinsurance apply.
 (unless Hospital confinement occurs within 24 hours of Emergency Room Visit)

COINSURANCE PERCENTAGE PER CALENDAR YEAR

Benefit: PPO Providers 70% of covered expenses per covered person per calendar year.
 Non-PPO Providers 50% of covered expenses per covered person per calendar year.

Coinsurance out-of-pocket maximum per Calendar Year (excluding deductibles):
 Well-Baby Care (as defined) for covered dependent children from birth to two years of age100% of the allowable charge, not subject to the deductible.

Per Person \$1,000
 Per Family..... \$3,000

Benefits will be payable at 100% of covered expenses for the rest of the calendar year after the out-of-pocket maximum has been met, up to the maximum benefit payable under this plan.

Prescription Drugs:

1. Retail pharmacies in the Innoviant pharmacy network will be the Preferred Providers for all prescription drugs. Employees utilizing Innoviant network pharmacies will receive the discounted price. To obtain the discount, the Employee must present the Medical ID card to the pharmacy at the time of purchase and pay the full discounted price. The pharmacy will submit the claim automatically for reimbursement in accordance with all the terms of the Plan.
2. Covered prescription drugs purchased at any other pharmacy will not receive a discount.
3. Mail Order: Prescription drugs are also available on a discounted basis through the Innoviant arrangement with Walgreens Health Initiatives. Up to a 90 day supply of maintenance prescription drugs may be purchased through this arrangement at a discounted price. The claim will be submitted automatically for reimbursement in accordance with all the terms of the Plan.

Maximum Benefit:

The lifetime maximum benefit for all treatment for each covered individual is \$10,000.00. The lifetime maximum benefit for treatment of nervous and mental, and alcohol and drug related conditions for each covered individual is:

	<u>PPO</u>	<u>Non-PPO</u>
Inpatient		
4 days, covered charges payable at.....	50%	50%
Outpatient		
15 visits, covered charges payable at.....	50%	50%

DEFINITIONS

"Ambulatory Surgical Center" means a facility licensed as a free-standing or ambulatory surgical center. It does not include the out-patient department of a Hospital.

"Claim Administrator" means Fiserv Health - Kansas.

"Creditable Coverage" means coverage under a group plan including a government or church plan, individual or group health insurance coverage, Medicare, Medicaid, state provided health care including risk pools, military sponsored health care, Peace Corps health benefit plans, a health program of the Indian Health Service or a tribal organization, and any other public health plan.

"Convalescent Hospital" means a duly licensed institution meeting the conditions of participation for an extended care facility under Medicare, Title XVIII, of the Social Security Act enacted and amended.

"Dependent" means:

1. The spouse of an Employee not legally separated or divorced, and who resides in the United States.
2. The unmarried dependent child or children of an Employee, who resides in the United States, from birth to age 19, but extending to age 25 while attending an accredited educational institution on a full-time basis. Eligible children will be covered as the dependents of only one Employee.
3. The unmarried child(ren) under age 19 who are named as "alternate recipients" in a Qualified Medical Child Support Order approved by this Plan.

The word "child" means, in addition to the employee's own or lawfully adopted child, any stepchild or other child who is dependent upon the employee and resides with the employee in a regular parent-child relationship. Adopted children will be eligible for coverage on the date the child is placed with the covered employee.

"Emergency" means the sudden and unexpected onset of a medical condition, a severe injury or the acute exacerbation of a chronic condition, which is threatening to life, limb, or sight, and which requires immediate medical or surgical treatment, or which manifest painful symptoms requiring immediate palliative efforts to relieve suffering.

"Employee" means ① all active part-time employees working for LDF Sales & Distributing, Inc.; LDF Support Group, Inc.; LDF Food Group, Inc. and ② employees covered under this Plan at the time of their promotion to full-time status until such time as they have met the eligibility requirements of the full-time plan.

"Employer" means LDF Sales & Distributing, Inc.; LDF Support Group, Inc. and LDF Food Group, Inc.

- "Enrollment Date"** means
- A. For someone who enrolls during or within 60 days after their waiting period, Enrollment Date means the start of their waiting period.
 - B. For someone who enrolls more than 60 days after their waiting period, Enrollment Date means the date the employee actually enrolls himself and/or his eligible dependents.

"Hospital" means any of the following types of institutions:

1. The acute care section of a licensed general hospital. ("Acute care section" means the section(s) of the hospital in which the average length of stay is 15 days or less.)
2. A psychiatric section of a licensed general hospital.
3. Licensed privately operated psychiatric hospitals.
4. Licensed health care institutions.

"Hospital" does not include: rest homes, places that are primarily for the care of convalescents, nursing homes, skilled nursing facilities or health resorts.

"Incurred Date" means the date service is provided. However, with respect to a period of continuous in-patient Hospital services, the incurred date shall mean the initial date of hospital confinement until the earlier of the date such Hospital confinement ends or twelve months from the end of the plan year in which such Hospital confinement started.

"Intensive Care Unit" means a section, ward or wing within the hospital which is separated from other hospital facilities and:

1. is operated exclusively for the purpose of providing professional care and treatment for critically ill patients, and
2. has special supplies and equipment necessary for such care and treatment available on a stand-by basis for immediate use, and
3. provides room and board and constant observation and care by registered professional nurses or other highly trained hospital personnel, excluding any hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

"Physician" means any practitioner of the healing arts licensed or certified to practice in his state.

"Plan Administrator" means The LDF Support Group, Inc.

"Preferred Provider" means any provider of health care services contracting with Health Partners of Kansas (Kansas), Preferred Community Choice (Oklahoma), or HealthSmart (Texas) as of the day the expenses in question are incurred.

"Preferred Provider Hospital" means:

For Texas Employees - any Plan specific Hospital (Baptist – St. Anthony) contracting with HealthSmart or any Hospital contracting with Health Partners of Kansas as of the day the expenses in question are incurred.

Effective June 5, 1993 - For Oklahoma Employees - any Hospital contracting with Preferred Community Choice as of the day the expenses in question are incurred.

For all other Employees - any Hospital contracting with Health Partners of Kansas as of the day the expenses in question are incurred.

"Prior Condition" means a condition (physical or mental) regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the Enrollment Date.

"Second Surgical Opinion" means a second opinion and necessary related testing regarding the need for surgery. The second opinion must be received from a Physician who treats the type of condition for which surgery is advised, who is not scheduled to do the surgery and who has no business or financial relationship with the physician recommending or performing the surgery. Benefits will also be payable for a third opinion if the first two opinions conflict.

“Well Baby Care” means the following services that are administered to a newborn child:

- a. Charges by a Hospital for usual, ordinary nursing care and incidental charges in connection with services normally rendered to a well newborn child.
- b. Charges for initial examination and testing by a Physician while benefits are payable under (a) above.
- c. Charges for surgical fees for circumcisions by a Physician.
- d. Office calls and immunizations up to age two years.

Charges incurred by a newborn child for any illness, accident or defect and charges incurred by a newborn child confined to a Hospital whose mother has been discharged from such Hospital following termination of pregnancy, shall not be considered Well Baby Care.

BENEFIT LIMITATION FOR PRIOR CONDITIONS

No benefits will be paid for expense incurred for care or treatment of a Prior Condition until the end of a twelve consecutive month period measured from the Enrollment Date.

The Benefit Limitation For Prior Conditions does not apply to adopted children covered under this Plan within 31 days of the date they are eligible.

The Benefit Limitation For Prior Conditions does not apply to pregnancies.

The length of time a person was insured under Creditable Coverage will apply toward the Benefit Limitations For Prior Conditions under this plan. Any period of Creditable Coverage prior to a continuous 63-day period during which the person was not covered under any Creditable Coverage will not apply toward the Benefit Limitation For Prior Conditions.

If a Covered Person had continuous coverage under this Plan and the Prior Plan, all limits regarding Prior Conditions refer to the date the person became covered under the Prior Plan.

COVERED EXPENSES

Covered expenses generally include all reasonable and customary charges actually incurred for necessary and essential care and treatment for accidental injury or sickness recommended by a licensed physician or surgeon, including, but not limited to:

1. Hospital daily room and board (includes routine nursery and professional charges for well-baby care from birth until the mother's confinement ends).
2. Services and supplies furnished by a hospital.
3. Treatment by a physician or surgeon.
4. Hospital out-patient expense for treatment of an accident or sickness, and out-patient surgery.
5. Services of a registered nurse, and treatment by a licensed physical therapist other than a person related by blood or marriage, or who ordinarily resides in the insured's home.
6. Anesthesia and its administration.
7. Dental treatment for a fractured jaw, for accidental injury to sound natural teeth due to an accident occurring while insured, and for hospital charges for room and board, nursing care, and miscellaneous fees while in a hospital in-patient solely for dental care.
8. X-rays (but not dental x-rays), radiation therapy, and laboratory tests for diagnosis or treatment.
9. Licensed ambulance service to and from the nearest hospital where necessary care and treatment can be rendered.
10. Drugs and medicines which require a prescription, and are dispensed by a licensed pharmacist or physician, unless otherwise excluded.
11. Whole blood or plasma.
12. Artificial limbs or eyes (except replacements).
13. Cast splints, trusses, braces (but not dental braces) and crutches.
14. Oxygen and rental of equipment for its administration.
15. One routine eye examination per year (\$35.00 maximum covered expense), not subject to the calendar year deductible.
16. Routine immunizations (including office calls and well-baby care expenses) for dependent children under two years of age. These expenses will be paid at 100% of the allowable charge, not subject to the calendar year deductible.

EXCLUSIONS

Comprehensive Major Medical Benefits are not payable for any loss in connection with or as a result of:

1. Accidental bodily injury or sickness arising out of or in the course of any employment for wage or profit to the extent you are covered, or are required to be covered by Workers' Compensation or Occupational Disease Act or Law.
2. Services, supplies, or treatments provided by or covered under any governmental plan or law under which the individual is, or could be covered, or provided by any hospital or institution which does not require the individual to pay for such expenses in the absence of coverage. Any expenses which are, or could be written off by any providers of service will not be considered covered expenses under the Plan, and no benefits will be payable for such expenses.
3. War, or any act of war (declared or undeclared), service in the Armed Forces of any country and participation in an assault, felony, strike, civil disorder, riot, illegal occupation or the intentional act of another during an altercation in which the covered person participated other than as a spectator.
4. Any drug, except that prescribed by a physician, approved by the Federal Drug Administration, and dispensed by a licensed pharmacist, including narcotics or hallucinogens.
5. Eye glasses, contact lenses, Radial Keratotomy, or Keratomileusis, or any similar surgeries.
6. Dental treatment, except as shown under covered expenses.
7. Custodial care or rest cures.
8. Services rendered by immediate relatives or members of the household of the covered person.
9. Cosmetic surgery, except when due to an accident which occurred while covered under the Plan, or for the correction of an abnormal congenital condition in a child born while the mother is covered under the Plan.
10. Services or supplies related to sex changes, sexual malfunctions, or inadequacies, or the reversal of sterilization procedures.
11. Routine physical examinations.
12. Any contraceptive device or means (mechanical or pharmaceutical) for any reason.
13. Benefits will be coordinated with expenses paid by any plan providing benefits for, or by any reason of hospital care or treatment, medical, dental, or other health services as a result of injuries arising out of a motor vehicle accident, to the extent that such benefits are payable under any medical expense payment provisions (by whatever terminology used - including such benefits mandated by law) of any automobile or motor vehicle insurance policy.
14. Any medical procedure, prosthesis, appliance, or the use of equipment that is considered to be experimental or unproven by a professional medical-advisory committee.
15. Expenses incurred which are in excess of the usual and customary charges for the same services or supplies, and expenses incurred for services or supplies which are determined to be medically unnecessary.
16. In vivo or in vitro fertilization or any other fertilization procedure.
17. Hearing aids or the fitting of hearing aids.

18. Expenses due to intentionally self-inflicted injury, suicide, or attempted suicide.
19. Temporomandibular Joint Syndrome (TMJ), myofacial syndrome, or any disorders or deformity of the mandible or maxilla as related to mastication, speech, and alignment or related disorders.
20. Charges for blood donors.
21. Charges for autopsies.
22. Charges for vision therapy or for apparel, orthotics (including casting) or shoes, for any reason.
23. Pregnancy of a Dependent Child (including normal pregnancy, childbirth, and any complications of pregnancy).
24. Acupuncture and admissions for acupuncture, except when used as an anesthetic.
25. Expenses incurred due to the negligence of a third party, or otherwise, if such expenses are or could be compensable by a liability or medical carrier, or would have been compensable if said covered person had not released said third party from liability for such expenses.
26. Expenses incurred for the diagnosis and treatment of dislocations, strains, sprains or misplacements of vertebrae, except for the first 15 visits or \$1,000.00 (whichever is lesser) per person in any calendar year, or when requiring the administration of general anesthesia, an open cutting operation or confinement in a hospital.
27. Obesity, weight reduction or dietetic control inclusive of surgical treatment for morbid obesity (i.e. gastric bypass surgery).
28. Treatment by hypnosis, except as part of the physician's treatment of a mental illness or when hypnosis is used in lieu of an anesthetic.
29. Expenses incurred more than 12 months prior to the date the claim for benefits is filed.
30. A voluntary abortion.
31. Inpatient treatment of nervous and mental, alcohol and drug related conditions, except as provided in the Schedule of Benefits.
32. Human growth hormone, proton pump inhibitors and non-sedating oral antihistamines.
33. Expenses in excess of the maximum allowance accepted by Preferred Providers for the same service in the area where the service is performed; this will not apply when expenses are incurred due to an emergency, to conditions that cannot be treated by a Preferred Provider or to covered persons residing or attending school more than 50 miles from a Preferred Provider; however, this provision will apply to persons who are admitted to a Hospital due to an Emergency if they do not transfer to an available Preferred Provider Hospital once they are medically stable, and to covered persons residing or attending school more than 50 miles from a Preferred Provider if such person travels the same or further distance to a Non-Preferred Provider than to an available Preferred Provider.
34. Expenses incurred for durable medical equipment in excess of \$2,500.00 per covered person per Calendar Year.
35. Expenses incurred for physical therapy in excess of \$1,500.00 per covered person per Calendar Year.
36. The first \$150.00 of Hospital Emergency room charges per visit, unless Hospital confinement occurs within 24 hours of such visit.
37. Expenses incurred for the diagnosis or treatment of sleep apnea.

GENERAL PROVISIONS

ELIGIBILITY:

EMPLOYEES

1. All part-time Employees are eligible to participate in this Plan upon the completion of one month of active employment.
2. All part-time Employees who have terminated coverage and are reemployed by the Employer within six months of the date of termination of employment, are eligible to again participate in the Plan with the following provisions:
 - a. The Effective Date of coverage shall be the first day of the month coinciding with or next following 180 days from the date of reemployment, provided the enrollment forms are completed and given to the Employer on or before 60 days following the first day of the month following 180 days from the date of reemployment by the Employer or in accordance with the "Late Requests" provisions of the Plan.
 - b. The election of coverages which was in effect immediately prior to the date of termination of employment with the Employer shall be reinstated.
 - c. If the individual has a "change in family status" prior to the date of reemployment by the Employer, the terms of this provision shall not apply.
 - d. If the individual has a "change in family status" after the date of reemployment by the Employer, the terms of the "Late Requests" provisions shall apply.

DEPENDENTS

Each Employee who is eligible for participation under this Plan shall be eligible to participate with respect to all dependents, as defined herein, in accordance with the following:

- A. If an Employee has such dependents on the date of his eligibility, then such dependents will be eligible for coverage on that date.
- B. If an Employee acquires such dependents after the date of his eligibility, then such dependents will be eligible for coverage on the date they are acquired.
- C. Spouses who are both eligible as Employees will be covered only as an Employee or Dependent, but not both simultaneously. Children will be considered dependents of only one parent.

SPECIAL DEPENDENT HANDICAPPED PROVISIONS ⁽¹⁾

Eligibility for an unmarried, dependent child who is mentally retarded or physically handicapped may be extended beyond the normal age limits if the Employer submits proof of their incapacity to the Plan Administrator within 31 days of the date of the child's coverage would otherwise terminate.

Note: ⁽¹⁾ This provision was effective March 10, 1989.

Remarks:

- The provisions described in these pages present a brief outline of benefits. It should not be relied on as evidence of coverage nor as a contract of insurance. Complete details of coverage are provided in the master policies.
- Administration and Claims Processing:
Fiserv Health - Kansas
P. O. Box 2697
Wichita, KS 67201

EFFECTIVE DATE

EMPLOYEES

Coverage under this Plan shall become effective for each eligible employee in accordance with the following conditions:

An Employee shall be covered under this Plan on:

- a. the first day of the month coinciding with or next following the date of his eligibility, provided the enrollment form is signed on or prior to that date.
- b. the first day of the month coinciding with or next following the date the forms are signed, if the enrollment forms are signed within 60 days after the date of his eligibility.
- c. if the enrollment forms are signed later than 60 days after the date of his eligibility, see Late Requests.

DEPENDENTS

Coverage under this Plan shall become effective for each eligible Dependent in accordance with the following conditions:

- a. If the Employee has eligible dependents on the date he first becomes eligible, the dependents' coverage becomes effective:
 - (1) the date the Employee's coverage is effective, provided the enrollment forms are signed on or prior to the date the Employee is eligible.
 - (2) if the enrollment forms are signed within 60 days after the date the Employee is eligible - on the first day of the month coinciding with or next following the date the forms are signed.
 - (3) if the enrollment forms are signed later than 60 days after the date the Employee is eligible - see Late Requests.
- b. If the Employee first acquires an eligible Dependent after the date of his eligibility, the Dependent's coverage becomes effective:
 - (1) For Other Than Newborns
 - (a) on the first day of the month coinciding with or next following the date the dependent becomes eligible, provided the enrollment forms are signed on or prior to that date.
 - (b) if the enrollment forms are signed within 60 days after the date the Dependent becomes eligible - on the first day of the month coinciding with or next following the date the forms are signed.
 - (c) if the enrollment forms are signed later than 60 days after the date the Dependent becomes eligible - see Late Requests.
 - (2) For Newborns
 - (a) on the date of birth, continuing only until the mother's confinement ends and covering only professional and nursery charges for well-baby care during that time, unless the required enrollment forms are signed.

- (b) if the enrollment forms are signed within 60 days after the date of birth - on the date of birth.
- (c) if the enrollment forms are signed later than 60 days after the date of birth - see Late Requests.

(3) For Adopted Children

The date the child is placed with the Employee, provided the enrollment forms are signed within 60 days after the date of placement. The pre-existing conditions limitation of this Plan will not apply to adopted children covered under this Plan within 31 days after the date of placement. If the enrollment forms are signed more than 60 days after the date of placement, the provisions listed under b. (1) above will apply.

- c. If an Employee is already enrolled for Dependent coverage and acquires a new eligible Dependent, coverage for the new Dependent becomes effective on the date the Dependent becomes eligible.

LATE REQUESTS

If an employee fails to elect to participate in this program for himself and/or his dependents within 60 days of first becoming eligible to participate and he later wishes to apply for coverage for himself and/or his dependents, the following rules apply:

1. If the employee has elected not to enroll himself or his eligible dependents because the Employee or his Dependents had other Creditable Coverage, and if the other Creditable Coverage terminates due to the exhaustion of COBRA coverage, or the Loss Of Eligibility or because employer contributions ceased, he will have a special enrollment period of 60 days beginning on the date the other coverage ended. No waiting period will apply. Coverage will become effective on the first day of the month beginning after the date the Plan receives the completed enrollment form.

Loss Of Eligibility means that coverage has been lost as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment. Loss Of Eligibility does not include a loss of coverage due to failure of the covered person to pay premium on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

2. If the Employee has elected not to enroll himself or his eligible dependents for any reason, he will have a special enrollment period of 60 days beginning on the date of marriage, birth, adoption or placement for adoption. No waiting period will apply. If a spouse does not enroll at the time of marriage, the spouse can elect to be covered at the time of a birth or adoption.

If coverage is chosen during this time frame, it will be effective:

- For a marriage, on the first day of the month beginning after the date the Plan receives the completed enrollment form.
- For a birth, the date of birth.
- For an adoption or placement for adoption, the date of adoption or placement.

3. If the employee has elected not to enroll himself or his eligible dependents within 60 days of first becoming eligible to participate, he will not be allowed to enroll in this plan unless he fully meets the requirements of A. or B. above.

UTILIZATION REVIEW PROGRAM

WHAT IS A UTILIZATION REVIEW PROGRAM? A program which utilizes independent physicians and registered nurses to review, in advance, any proposed non-emergency hospitalization that has been recommended for you or one of your insured family members. In addition, the program monitors the length of stay for both pre-certified, non-emergency hospitalizations and emergency hospital stays.

WHAT IS ITS PURPOSE? To avoid unnecessary hospital confinements, and to be certain that needed confinements are handled as expediently as possible. Ultimately, the health insurance industry is convinced that this type of monitoring system will result in lower premium charges for all participants.

WHAT IS REQUIRED OF YOU?

FOR NON-EMERGENCY HOSPITALIZATION: If you or one of your family members are advised by a physician to enter a hospital, either you or your physician must call the toll free telephone number shown on your I.D. card at least 48 hours prior to the recommended hospitalization. The phone will be answered by a registered nurse, who will ask several questions in order to certify coverage of the forthcoming confinement.

FOR EMERGENCY HOSPITALIZATION: The toll free telephone number must be called within 48 hours after the emergency confinements begins.

WHAT HAPPENS IF THE REQUIRED TELEPHONE CALL IS NOT MADE WITHIN THE PRESCRIBED TIME: YOUR PLAN BENEFITS WILL BE SUBJECT TO AN ADDITIONAL DEDUCTIBLE OF \$200.00 PER HOSPITAL CONFINEMENT. In addition, failure to make the required call could result in denial of benefits if the charges are later determined to be medically unnecessary.

All Preferred Providers are obligated by contract to make this call for you. If you elect to use a non-preferred provider, the obligation is yours.

COORDINATION OF BENEFITS

A. DEFINITIONS

Coordination of Benefits: Taking other Plans into account when paying benefits under this Plan.

Plan: Any plan that provides benefits or services for medical, dental or vision care on a group basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans and plans required or provided by statute, except Medicaid. "Plan" shall be treated separately for each contract or other program for benefits or services. "Plan" shall be treated separately for that part of a Plan which reserves the right to coordinate with benefits or services of other Plans and that part which does not.

Allowable Expenses: Necessary, usual and customary expenses incurred. A part of the expenses must be paid under at least one of the Plans. When a Plan provides benefits by services, the cash value of each service will be treated as both an Allowable Expense and a benefit paid.

B. WHEN COORDINATION OF BENEFITS APPLIES

Coordination will apply when benefits that would be paid under all Plans exceed Allowable Expenses incurred.

C. LIMITATION OF BENEFITS UNDER COORDINATION

When Coordination of Benefits applies, benefits payable under this Plan may be reduced. Benefits will be reduced so that the sum of the benefits paid under this Plan, plus benefits payable under all other Plans, does not exceed total Allowable Expenses. Benefits 'payable' under other Plans include benefits that would be paid had you made claim.

D. RULES FOR COORDINATION OF BENEFITS PROVISION

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

1. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.
2. A plan that does not contain a coordination of benefits provision that is consistent with this RULES FOR COORDINATION OF BENEFITS PROVISION is always primary. There is one exception: coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-networks benefits.
3. A plan may consider the benefits paid or provided by another plan only when it is secondary to that other plan.

4. Order of Benefit Determination

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

a. Non-Dependent or Dependent

The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is;

- (1) Secondary to the plan covering the person as a dependent; and
- (2) Primary to the plan, covering the person as other than a dependent (e.g. a retired employee),

then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

b. Child Covered Under More Than One Plan

- (1) The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - (i) The parents are married;
 - (ii) The parents are not separated (whether or not they ever have been married); or
 - (iii) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.
- (2) If both parents have the same birthday, the plan that has covered either of the parents longer is primary.
- (3) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.
- (4) If the parents are not married or are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parent's spouses (if any) is:
 - (i) The plan of the custodial parent;
 - (ii) The plan of the spouse of the custodial parent;
 - (iii) The plan of the non-custodial parent; and then
 - (iv) The plan of the spouse of the non-custodial parent.

c. Active or Inactive Employee

The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection 4(a).

d. Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

e. Longer or Shorter Length of Coverage

If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.

(1) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within twenty-four (24) hours after the first ended.

(2) the start of a new plan does not include:

(i) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(3) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

f. If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

E. COORDINATION BENEFITS NOT CHARGED TO BENEFIT LIMIT

If benefits paid under this Plan are reduced because of coordination, each will be reduced proportionately. Only the amount actually paid will be charged against any benefit limit.

F. RIGHT TO EXCHANGE INFORMATION

Information may be released to, or obtained from, any other organization or person necessary for Coordination of Benefits. This will not require the consent of, or notice to, any person insured. The Employee is required to provide information necessary for Coordination of Benefits.

G. RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

Coordination may result in another plan making payments which should have been made by this Plan. This Plan will then pay the other Plan all such amounts which would otherwise have been paid directly to the Employee.

H. RIGHT TO RECEIVE PAYMENTS

If coordination results in overpayments, the Plan has the right to recover the excess amounts paid.

**CONTINUATION OF COMPREHENSIVE
MAJOR MEDICAL AND DENTAL BENEFITS**

An Employee shall have the right to continue medical and dental coverage for himself and his eligible covered Dependents for up to 18 months if he loses his coverage due to voluntary termination, strike, layoff, discharge (other than for gross misconduct) or a reduction in work hours. However, if the Employee or any of his dependents are determined to be disabled under Social Security at the time of the qualifying event, medical and dental coverage may be continued for up to 29 months.

The following individuals also have the right to continue medical and/or dental coverage for up to 36 months after their coverage would otherwise terminate:

1. Surviving spouses and children of covered employees,
2. Divorced or legally separated spouses (and children) of covered employees,
3. Covered spouses and children of medicare eligible covered employees, and
4. Covered dependent children who become ineligible.

Remarks:

1. Individuals whose coverage is being continued will be offered the same benefits offered to other individuals covered under this plan.
2. Continued coverage will not be conditioned upon evidence of insurability.

CONTINUATION OF HEALTH COVERAGE NOTICE AND ELECTION

General Notice

A group health plan subject to the requirements of COBRA must provide written notice to each covered employee and spouse (if applicable) within 90 days after coverage under the Plan commences of the right to continue coverage. If a Qualifying Event occurs during the first 90 days of coverage under the Plan and before the general notice has been distributed, the Plan may provide only the COBRA election notice, as described below. In lieu of, or in addition to, such written notice, the Plan Administrator is hereby providing the general notice to the employee by delivery of the Summary Plan Description.

The Plan may notify a covered employee and the covered employee's spouse with a single general notice addressed to their joint residence, provided the Plan's latest information indicates that both reside at that address. However, when a spouse's coverage under the Plan begins later than the employee's coverage, a separate general notice must be sent to the spouse within 90 days after the spouse's coverage commences.

Please note that it is important for the Plan Administrator to be kept informed of the current addresses of all Covered Persons under the Plan who are, or may become, Qualified Beneficiaries.

Notice of Qualifying Event

Continuation of health coverage shall be available to an employee and/or his covered dependents upon the occurrence of a Qualifying Event.

To continue health coverage, the Plan Administrator must be notified in writing of a Qualifying Event by:

1. the Employer, within 30 days of the later of: (a) the date of such event, or (b) the date of loss of coverage due to the event, if the Qualifying Event is:
 - i. for a covered dependent, the covered employee's death;
 - ii. the covered employee's termination (other than for gross misconduct) or reduction in hours;
 - iii. for a covered dependent, the covered employee's entitlement to Medicare.

2. the employee or a Qualified Beneficiary, within 60 days of the later of (a) the date of such event, (b) the date of loss of coverage due to the event, or (c) the date on which a Qualified Beneficiary is informed through the Plan's Summary Plan Description or general notice of both his obligation to provide notice and the procedures for providing such notice, if the Qualifying Event is:
 - i. for a spouse, divorce, or legal separation from a covered employee;
 - ii. for a dependent child, loss of dependent status under the Plan; or
 - iii. the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of 18 (Or 29) months.

An employee or Qualified Beneficiary who does not provide timely notice to the Employer of one of the above such Qualifying Events may lose his rights under COBRA.

Upon termination of the employment or reduction in hours, a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to be disabled on such date, or at any time during the first 60 days of COBRA continuation coverage, will be entitled to continue coverage for up to 29 months if the Plan Administrator is notified of such disability within 60 days from the later of (and before the end of the 18-month period): (a) the date of determination, (b) the date on which the Qualified Event occurs, (c) the date on which the Qualified Beneficiary loses coverage, or (d) the date on which the Qualified Beneficiary is informed through the Plan's Summary Plan Description or general notice of both the obligation to provide the disability notice and the Plan's procedures for providing such notice. If a Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, the non-disabled family members are also entitled to the disability extension.

A Qualified Beneficiary who is disabled under Title II or Title XVI of the Social Security Act must notify the Plan Administrator within 30 days from the later of: (a) the date of final determination that he is no longer disabled, or (b) the date on which the individual is informed through the Plan's Summary Plan Description or general notice of both the responsibility to provide such notice and the Plan's procedures for providing such notice.

Election Notice

The Plan Administrator must, within 14 days of receiving notice of a Qualifying Event, notify any Qualified Beneficiary of his right to continue coverage under the Plan. Notice to a Qualified Beneficiary who is the employee's spouse shall be notice to all other Qualified Beneficiaries residing with such spouse when such notice is given.

Election Procedures

A Qualified Beneficiary must elect continuation of health coverage within 60 days from the later of the date of the Qualifying Event or the date notice was sent by the Plan Administrator.

A new spouse, a newborn child, or a child placed with a Qualified Beneficiary for adoption during a period of COBRA continuation coverage may be added to the Plan according to the enrollment requirements for dependent coverage under the Eligibility section of the Plan. A Qualified Beneficiary may also add new dependents during an open enrollment period held once each year at a time and in accordance with the procedures established by the Plan Administrator.

Any election by an employee or his spouse shall be deemed to be an election by any other Qualified Beneficiary, through each Qualified Beneficiary is entitled to an individual election of continuation coverage.

Upon election to continue health coverage, a Qualified Beneficiary must, within 45 days of the date of such election, pay all required contributions to date to the Plan Administrator. All future contribution payments by a Qualified Beneficiary must be made to the Plan Administrator and are due the first of each month with a 30-day grace period. If the initial contribution payment is not made within 45 days of the date of the election, COBRA coverage will not take effect. If future contribution payments are not made within the allotted 30-day grace period, COBRA coverage will be terminated retroactively back to the end of the month in which the last full contribution payment was made.

Except as provided herein, if the initial coverage election and required contribution payments are made in a timely manner, as described in this section, coverage under the Plan will be reinstated retroactively back to the date of the Qualifying Event.

If a Qualified Beneficiary waives COBRA coverage, he may revoke the waiver at any time during the election period. The Qualified Beneficiary would be eligible for continuation of coverage prospectively from the date that the waiver is revoked, if all other requirements, such as timely contribution payments, are met.

Notice of Unavailability of Continuation Coverage

The Plan Administrator must provide a notice of unavailability to an individual within 14 days after receiving a request for continuation coverage if the Plan determines that such individual is not entitled to continuation coverage. The notice must include an explanation as to why the individual is not entitled to COBRA. This notice must be provided regardless of the basis of the denial and regardless of whether it involves a first or second Qualifying Event or a request for disability extension.

Early Termination Notice

The Plan Administrator must provide a notice to Qualified Beneficiaries when COBRA terminates earlier than the maximum period of COBRA applicable to the Qualifying Event as soon as practicable following its determination that continuation coverage shall terminate. This notice must contain the reason that continuation coverage has terminated earlier than the maximum period triggered by the Qualifying Event, the date of termination of continuation coverage, and any rights the Qualified Beneficiary may have under the Plan or under applicable law to elect alternative group or individual coverage (such as a conversion right).

TERMINATION OF CONTINUED COVERAGE:

Continued coverage will be terminated prior to the expiration date of the continuation period under the following circumstances. Continuation coverage would terminate on the earlier of:

1. The date the Employer terminates The LDF Companies Group Benefit Plan and no longer provides any group health plan to its employees;
2. The date the individual fails to pay the applicable premium on a timely basis;
3. The date the individual becomes covered under Medicare;
4. The date the individual becomes covered under any other group health plan. However, if the individual has pre-existing conditions for which benefits are limited or excluded under such other group health plan, continued coverage will not be terminated until such time as full benefits are payable for the individual's pre-existing conditions, or as otherwise provided, whichever is earlier.
5. To extend the 18-month continuation period to 29 months, qualified beneficiaries must notify the Plan Administrator within 60 days of obtaining Social Security's determination of disability and such notification must be made before the end of the initial 18-month continuation period.

A conversion option is available for covered individuals upon termination of continued coverage (Medical only).

CONTINUATION COVERAGE DURING A MILITARY LEAVE OF ABSENCE

If a covered Employee is on a military leave of absence for more than 30 days during which the veteran's reemployment rights are guaranteed by federal law, a covered Employee may elect continuation coverage. Under these circumstances a covered Employee may continue coverage for a covered Employee and any Dependents covered under this Plan before leaving for military service for the lesser of:

- 18 months for a leave which begins prior to December 10, 2004,
- 24 months for a leave which begins on or after December 10, 2004, or
- until the end of the period during which veteran's reemployment rights are guaranteed by federal law.

Upon the reinstatement of a veteran's coverage upon reemployment after a military leave, no waiting period, pre-existing conditions limitations or other exclusions shall apply that would have otherwise applied if coverage had terminated for any reason other than military service. Furthermore, continuation coverage under this Plan shall not apply to any illness or injury the U.S. Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of duty in the U.S. uniformed services while on a military leave.

TERMINATION OF COVERAGE

EMPLOYEE

An Employee's coverage under this Plan shall terminate on the earliest of:

1. The date this Plan terminates.
2. The date the Employee no longer meets the definition of "Employee" herein.
3. The end of the period for which the required contribution was last paid by the Employee.
4. The date the Employee enters active service in the Armed Forces of any country.
5. The date the Employee's employment terminates.

DEPENDENTS

A Dependent's coverage under this Plan shall terminate on the earliest of:

1. The date the Employee's coverage terminates.
2. The end of the period for which the required contribution was last paid by the Employee.
3. The date the Dependent enters active service in the Armed Forces of any country.
4. The date the Dependent no longer meets the definition of "Dependent" herein.

FAMILY AND MEDICAL LEAVE ACT PROVISIONS

1. An Employee who takes a leave of absence governed by the Family and Medical Leave Act may continue coverage under this Plan during the approved leave period.
2. An Employee who takes a leave of absence governed by the Family and Medical Leave Act and elects not to continue coverage under this Plan during the approved leave period will have coverage reinstated on the date he returns to active service with the Employer, provided he returns to active service immediately upon the expiration of the approved leave period. If an Employee does not return to active service immediately upon the expiration of the approved leave period, the Employee will need to reapply for benefits as a new Employee and serve the required eligibility period.

LEAVE OF ABSENCE PROVISIONS

1. An Employee who takes a leave of absence in accordance with the Employer's policies (for any qualifying reason, including FMLA leave, Worker's Compensation Leave, personal leave, but not including military leave) may continue Medical coverage under this Plan during the approved leave period, for up to six months, provided the Employee continues to make timely payments of his share of the cost to the Employer.
2. If timely payments of the Employee's share of the cost are not made, coverage under this provision will terminate at the end of the month for which premium was last timely paid to the Employer. At that time, this Plan's COBRA provisions will apply.
3. If timely payments of the Employee's share of the cost are made throughout the six-month leave of absence period, coverage under this provision will terminate at the end of the month in which the six-month leave of absence is completed. At that time, this Plan's COBRA provisions will apply if the Employee does not return to active service.

MEDICARE PROVISIONS (COBRA)

This provision applies only: while the Employee is Actively at Work and not retired; and while the Employee and his covered spouse, if any, are at least 65 years of age.

To the extent that the Employee, or his spouse, are not eligible for Medicare benefits due to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), benefits under the Contract will be paid primary to Medicare.

RIDER PROVIDING BENEFITS PRIMARY TO MEDICARE FOR END STAGE RENAL DISEASE

This rider is added to and made a part of the Plan and is subject to all of the terms and provisions of this Plan except as stated below.

Benefits payable for end stage renal disease (ESRD) will be primary to Medicare for a 30-month period, if the Employee or his Dependent:

1. are entitled to Social Security benefits solely on the basis of ESRD; and
2. began treatment for ESRD on or after February 1, 1990.

The 30-month period, referred to above, will begin on the earlier of:

1. the date on which the Employee or his Dependent becomes entitled under 42 USCS, Section 426-1;
2. the date on which the Employee or his Dependent would have been entitled even if application under Medicare hadn't been made.

At the end of the 30-month period, ESRD benefits will be primary under Medicare and secondary under this Plan.

MINIMUM MATERNITY BENEFITS STATEMENT

Group health plans and health insurance issuers generally may not, under Federal law, 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 attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

CLAIMS PAYMENTS

PAYING BENEFITS FROM THE PLAN

This provision provides for the efficient and proper payment of benefits from this Plan. Payment by the Plan Administrator is based on data furnished by the Employee. In order to collect benefits under this Plan, the Employee must first provide information as to the validity of the claim for benefits. The initial claim must be submitted to the Plan Administrator within 12 months of the date on which the expense was incurred.

For ease of administration a "Request for Benefits" form is provided when requested from the Plan Administrator. This form, when completed, contains the essential information necessary to decide on the validity of a claim for benefits. Occasionally, further information may be necessary and the Employee will provide this to the Plan Administrator as requested.

The Plan Administrator will pay all eligible Medical Benefits directly from the Plan to the service provider unless satisfactory documentation is furnished to the Plan Administrator indicating that the service provider has been paid. If benefits are not payable, the Employee will be advised in writing by the Plan Administrator.

A determination regarding payment of eligible benefits will be made within 60 days from receipt of all the necessary information on the claim for benefits.

All benefit interpretations of the Plan will be determined exclusively by the Plan Administrator or such other person or corporations as may be designated by the Plan Administrator from time to time.

APPEAL PROVISIONS

EMPLOYEE COMPLAINTS

Only Employees may submit claims for benefits (for themselves and on behalf of their covered dependents), and benefits will only be paid to the Employee or the actual provider of services. Employees and covered dependents have the right to elect group health care benefits (including any combination of medical, dental, and prescription benefits) as offered by the Employer under **The LDF Companies Group Benefit Plan for Part-time Employees (the “Plan”)**, and Employees’ and dependents’ rights will be determined under the Plan’s provisions and in conjunction with the complaint and claims procedures outlined below. Claims will also be considered filed by the Employee if communications and requests for benefits come from an individual that the Employee has designated as an authorized representative to act on his behalf with respect to a claim. In the event that the Employee designates an authorized representative to act on his behalf, the Plan will send all notifications, requests for further information, appeal decisions, and all other communications to the authorized representative.

For the purposes of the complaint and claims appeal sections, any reference to “days” will refer to calendar days, not business days.

The Plan Administrator or its designated Claim Administrator, Fiserv Health - Kansas, is here to listen and help. Because the Plan wants the Employee to be completely satisfied with the member services assistance received, the Plan has established a process for addressing Employee concerns and solving Employee problems. If a covered person has a concern regarding a person, a service, the quality of care, or wants to inquire about what benefits are covered under the Plan, please call the phone number on the Benefit Identification card, the Explanation of Benefits, or the Claim Form and explain the concern to one of the Plan’s member services representatives. The Employee may also express that concern in writing. The Plan Administrator will do its best to resolve the matter on initial contact. If more time is needed to review or investigate the concern, the Plan Administrator will get back to the Employee as soon as possible, but in any case within 30 days. The Plan Administrator will not consider any of these communications to be a “claim” for benefits. A formal claim for benefits must meet certain other standards which are described in the section titled “When an Employee Files a Claim.”

WHEN AN EMPLOYEE FILES A CLAIM

When the Employee files a “claim,” he has the right to a speedy decision. “Claim” status also gives the Employee the option of appealing any adverse decision regarding the claim. The Employee will have filed a “claim” when he submits one of the Plan’s Claim Forms or if he takes one of the actions listed below. In the case of the submission of a Claim Form, a “claim” will be considered filed when it is received by the appropriate person/department listed below. The Plan also recognizes the following actions and submission of forms as “claims:”

- A request by the Employee for benefits through preauthorization or a utilization review determination in cases where *use of either preauthorization or utilization review is required in order to obtain a particular benefit*. (Preauthorization requirements are outlined elsewhere in Plan materials.)
- Requests by the Employee’s formally-designated authorized representative for preauthorization or a utilization review determination in cases where *use of either preauthorization or utilization review is required in order to obtain a particular benefit*. (Preauthorization requirements are outlined elsewhere in Plan materials.) The Plan will take reasonable steps to determine whether an individual claiming to be acting on the Employee’s behalf is, in fact, validly empowered to do so under the circumstances, and the Plan will require that the Employee complete and file a form identifying any person authorized to act on the Employee’s behalf with respect to a claim. However, when inquiries by a health care provider relate to payments due to the provider—rather than due to the Employee—under managed care contracts (where the health care provider has no recourse against the Employee for the amounts) such inquiries by a health care provider will not be considered “claims” by the Plan.

- Requests for benefits (in the case of a claim involving urgent care) by a health care provider with knowledge of the covered person's medical condition. For urgent care claims, the Employee is not required to complete a form and formally designate a health care provider as a representative with respect to a claim.
- Submission of a medical bill for reimbursement or payment under the terms of the Plan.

The Employee may request the Plan's Claim Form from the Plan Administrator by contacting Fiserv Health - Kansas. After the Employee has completed the Claim Form, it must be submitted to the following address:

Claim Department
LDF Companies
c/o Fiserv Health - Kansas
P.O. Box 2697
Wichita, KS 67201
Attention: Christopher Hall

All submitted claims and appeals will fall into one of the three categories described below. The handling of the initial claim or later appeal will be governed, in all respects, by the appropriate category of claim or appeal, and each time the claim or appeal is examined, a new determination will be made regarding the category into which the claim or appeal falls at that particular time.

- An **urgent care** claim is one that involves serious jeopardy of life or health of the patient, or the ability of the patient to regain maximum function or, in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be managed without the treatment at issue. Determination of "urgent care" status requires that the judgment of a prudent layperson with average knowledge of health and medicine be applied, except where a physician with knowledge of the patient's medical condition determines that the claim involves urgent care.
- A **non-urgent pre-service** claim is one that, under the terms of the Plan, requires approval of the particular benefit or procedure prior to obtaining medical care.
- A **post-service** claim is a claim that is neither an urgent care claim nor a non-urgent pre-service claim.

INITIAL CLAIM DECISION

After the Employee submits a claim, the Plan must make a decision on the claim within a prescribed period of time.

Urgent Care Claims

For urgent care claims, the Plan Administrator must notify the Employee of the benefit determination (adverse or favorable) as soon as possible, but not later than 72 hours after receipt of the claim by the Plan. The notification will be given orally, and the Plan will send the Employee written or electronic notification within three (3) days after the oral notification.

If the claim is incomplete but is properly filed, an Employee of the Plan Administrator will orally notify the Employee as soon as possible (but not later than 24 hours) after the receipt of the claim, of the specific information necessary to complete the claim. The Employee will have at least **48 hours** to provide the specified information necessary to complete the claim submission. The Plan's time limit for making a determination will be suspended from the time that it provides notice to the Employee of the incomplete claim until the date on which he responds to the request for additional information. The Employee will be notified of the Plan's decision as soon as possible, but no later than 48 hours after the earlier of either the time the Plan receives the specified information or the expiration of the time given to the Employee to provide the specified information.

If the Employee fails to follow the Plan's filing procedures because the request for benefits does not: 1) identify the patient; 2) note a specific medical condition or symptom; 3) describe a specific treatment, service, or product for which approval is requested; 4) arrive in the correct department and is not sent to the correct person, THE EMPLOYEE WILL NOT HAVE SUBMITTED A CLAIM. An Employee of the Plan Administrator or its designated Claim Administrator will orally notify the Employee, within 24 hours, that he has failed to follow the filing procedures, and will be reminded of the proper filing procedures.

Requests for Extension of Treatment

The Employee's request to extend a course of treatment beyond a particular period of time or number of treatments is a claim, and the Plan will decide the claim as soon as possible, taking into account the medical exigencies (the particular circumstances and requirements). The Plan will notify the Employee of its benefit determination (adverse or favorable) within 24 hours after receipt of the claim by the Plan (as long as the claim is submitted to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments). But, if the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and will be decided as soon as possible, taking into account the medical exigencies (the particular circumstances and requirements), but not later than 72 hours after received by the Plan. The Plan will orally notify the Employee of its decision, and the Plan will send written or electronic notification within three (3) days after the oral notification.

Non-Urgent Pre-Service Claims

For non-urgent pre-service claims, the Plan Administrator or its designated Claim Administrator must notify the Employee (in writing or electronically) of the benefit determination (adverse or favorable) as soon as possible, but not later than 15 days after receipt of the claim by the Plan. One 15-day extension of this time period is possible under certain circumstances.

If the claim is incomplete but is properly filed, an Employee of the Plan Administrator will notify the Employee (in writing or electronically) as soon as possible after the receipt of the claim, of the specific information necessary to complete the claim. If the Plan needs more time to make a decision on the claim because of the incomplete filing, the Plan may claim a 15-day extension of time if the Plan sends the Employee a notice specifically describing the circumstances requiring the extension, the date the Plan expects to make a decision, and a description of the information it requires to decide the claim. The notice of extension will be sent to the Employee before the initial 15-day period ends. If the Employee fails to submit the missing information to complete the claim, it will be denied. The period for appealing the denied claim (denied because the Employee does not supply the missing information) will begin to run at the end of the 45 days within which the Employee is required to supply the missing information. The Plan's time limit for making a determination will be suspended from the time that it provides notice to the Employee of the incomplete claim until the date on which he submits the missing information. The Employee will have 45 days from the receipt of the notice of incompleteness in which to complete the filing by supplying the specified information. The Plan will then have the benefit of the 15-day extension of time after it receives the specified information.

If the Employee fails to follow the Plan's filing procedures because the request for benefits does not: 1) identify the patient; 2) note a specific medical condition or symptom; 3) describe a specific treatment, service, or product for which approval is requested; 4) arrive in the correct department and is not sent to the correct person, THE EMPLOYEE WILL NOT HAVE SUBMITTED A CLAIM. An Employee of the Plan Administrator will orally notify the Employee within five (5) days, that he has failed to follow the filing procedures, and will be reminded of the proper filing procedures.

Requests for Extension of Treatment

The Employee's request to extend a course of treatment beyond a particular period of time or number of treatments is a claim, and the Plan will decide the claim as soon as possible and within the time limits

applicable to non-urgent pre-service claims.

Post-Service Claims

For post-service claims, the Plan Administrator or its designated Claim Administrator will notify the Employee in writing or electronically of the benefit determination as soon as possible, but not later than 30 days after receipt of the claim by the Plan. One 15-day extension of this time period is possible under certain circumstances.

If the claim is incomplete but is properly filed, an Employee of the Plan Administrator or its designated Claim Administrator will notify the Employee (in writing or electronically) as soon as possible after the receipt of the claim, of the specific information necessary to complete the claim. If the Plan needs more time to make a decision on the claim because of the incomplete filing, the Plan may claim a 15-day extension of time if the Plan sends the Employee a notice specifically describing the circumstances requiring the extension, the date the Plan expects to make a decision, and a description of the information it requires to decide the claim. The notice of extension will be sent to the Employee before the initial 30-day period ends. If the Employee fails to submit the missing information to complete the claim, the claim will be denied. The period for appealing the denied claim (denied because the Employee does not supply the missing information) will begin to run at the end of the 45 days within which the Employee is required to supply the missing information. The Plan's time limit for making a determination will be suspended from the time that it provides notice to the Employee of the incomplete claim until the date on which the Employee submits the missing information. The Employee will have 45 days from the receipt of the notice of incompleteness in which to complete the filing by supplying the specified information. The Plan will then have the benefit of the 15-day extension of time after it receives the specified information.

Requests for Extension of Treatment

The Employee's request to extend a course of treatment beyond a particular period of time or number of treatments is a claim, and the Plan will decide the claim as soon as possible and within the time limits applicable to post-service claims.

Submission of a Medical Bill for Payment

If the Employee's claim is in the form of a medical bill that is submitted to the Plan for payment, the Plan will pay the benefit according to Plan provisions. This may mean that less than 100% of the medical claim is payable by the Plan. In each case where the Plan pays benefits or determines that it is not responsible for the medical claim, the Employee will receive an Explanation of Benefits which will outline the basis for the Plan's payment. The Employee will receive a written or electronic "denial" notification. In addition, the Plan's payment of less than 100% of the submitted claim (under the terms of the Plan) will entitle the Employee to appeal the decision under the rules governing adverse claim determination.

IF AN EMPLOYEE CLAIM IS DENIED

If the Employee's claim is denied, the Plan or its designated Claim Administrator will notify the Employee in writing or electronically (oral notification followed by written notification in the case of urgent care claims) why the claim was denied, and the Plan will provide additional information that will help the Employee pursue the right to appeal the adverse determination. If the Employee chooses to appeal the Plan's adverse benefit determination, the appeal will be governed by rules that assure the Employee a "full and fair" review.

If the Employee is denied benefits based upon the Plan's finding that the Employee is/was ineligible for benefits, the denial of benefits gives the Employee the opportunity to appeal the Plan's decision.

Termination or Reduction of Benefit

If the Plan decides to reduce or terminate the Employee's previously-approved course of treatment, the Plan's decision will be treated as an adverse benefit determination, and the Plan will provide the

Employee reasonable advance notice of the reduction or termination to allow the Employee to appeal the Plan's decision before the benefit reduction or termination takes place. If the Employee decides to appeal the Plan's decision, the Employee must follow the rules for appealing a Plan's decision.

APPEALING AN EMPLOYEE INITIAL CLAIM DECISION

The Employee must submit a written request (An oral request for review is acceptable for urgent care claims and may be made by calling the toll-free number on the Employee's benefits identification card, the Explanation of Benefits, or the Claim Form and asking the Plan to register an oral appeal.) to the Plan **within 180 days** of receipt of a denial notice in order to initiate an appeal.

When the Employee appeals an adverse determination, the Plan will provide a "full and fair review" which will include the following features:

1. The Employee will have the opportunity to submit written comments, documents, records, and other information related to the claim.
2. At the Employee's request (and free of charge), the Employee will be provided with reasonable access to (and copies of) all documents, records, and other information relevant to the Employee's claim for benefits. Included in this category are any documents, records or other information in the claim file, whether or not those materials were relied upon by the Plan in making its adverse determination. The Employee also has the right to review documentation showing that the Plan followed its own internal processes for ensuring appropriate decision making.
3. The review of the claim will take into account all comments, documents, records, and other information submitted by the Employee relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
4. Any appeal of an adverse determination will not afford deference to the initial adverse determination, and the review will be conducted by a designated Plan representative who did not make the original determination and does not report to the Plan representative who made the original determination.
5. In deciding an appeal of any adverse benefit determination that is based on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the medical judgment. This health care professional will not be the same professional who was originally consulted in connection with the adverse determination; neither will this health care professional report to the health care professional who was consulted in connection with the adverse determination.
6. The Plan will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination of the claim, whether or not that advice was relied upon in making the benefit determination.

After the Employee submits the claim for appeal, the Plan must make a decision on the claim within a short period of time.

Urgent Care Claims

The Plan's expedited appeal process for urgent care claims will allow the Employee to request (orally or in writing) an expedited appeal, after which, all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Employee by telephone, fax, or other expeditious method. The Plan Administrator will notify the Employee (in writing or electronically)

of the benefit determination as soon as possible, but not later than 72 hours after the Plan receives the request for review of the prior benefit determination

Non-Urgent Pre-Service Claims

For non-urgent pre-service claims, the Plan Administrator or its designated Claim Administrator must notify the Employee (in writing or electronically) of the benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days.

Post-Service Claims

For post-service claims, the Plan Administrator or its designated Claim Administrator must notify the Employee (in writing or electronically) of the benefit determination within a reasonable period of time, but not later than 60 days.

IF AN EMPLOYEE APPEALED CLAIM IS DENIED

If the Employee's appealed claim is denied, the Plan will send the Employee written or electronic notification that will tell the Employee why the appealed claim was denied.

HIPAA PRIVACY REGULATION REQUIREMENTS

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to allow the Disclosure of Protected Health Information (PHI) as defined under HIPAA, to the Plan Sponsor.

This Plan will generally Use the Covered Persons' Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose the Covered Persons' PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose the Covered Persons' PHI as required by law and as permitted by authorization. Refer to the Plan's privacy notice for more information about the permitted Uses and Disclosure of PHI, the individuals' right and this Plan's legal duties regarding PHI.

The **USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA** within this section of the document specifies the terms under which the Plan may share PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of the Covered Persons' PHI. The Plan Sponsor will ensure that adequate separation exists between this Plan and the Plan Sponsor and that proper safeguards are established. This includes specifically identifying the Employee (s) or classes of Employees who will have access to PHI.

This Plan agrees that it will only disclose the Covered Persons' PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms contained in the **USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA** portion of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

HIPAA DEFINED TERMS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate are entities (i.e. Fiserv Health - Kansas) that perform or assist in the performance of any of the activities or functions of the Covered Entity involving the Use and Disclosure of Individually Identifiable Health Information, including claim processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, repricing, legal, actuarial, accounting, consulting, data aggregation management, administrative accreditation or financial services.

Covered Entity are entities directly impacted by the limitations placed on the access, Use and Disclosure of PHI. They include:

- Health care providers who actually perform the health care services (i.e. Physicians, Hospitals and clinics);
- Health Plans that provide reimbursement or Payment for such health care services; and
- Health care clearinghouses that transmit PHI in electronic format as part of the HIPAA electronic data interchange (EDI) requirements.

De-identified is information that does not identify an individual and under which no reasonable basis exists to believe that the information can be used to identify an individual.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Health Care Operations include general administrative and business functions necessary for the Covered Entity to remain a viable business. These activities include:

- conducting quality assessment and improvement activities;
- reviewing the competence or qualifications and accrediting/licensing of health care professionals and plans;
- evaluating health care professional and health plan performance,
- training future health care professionals;
- insurance activities relating to the renewal of a contract for insurance;
- conducting or arranging for medical review and auditing services;
- compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- contacting of health care providers and patients with information about treatment alternatives, and related functions that do not entail direct patient care; and

- activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the Health Plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information that is transmitted by electronic media; or maintained in any medium that is considered electronic media, or transmitted or maintained in any other form or medium.

Summary Health Information is information that may be Individually Identifiable Health Information that summarizes claims history, claims experience or the type of claims experience of a Covered Person with the following identifiers removed:

- Names;
- Geographic units - information more specific than a state (five-digit zip codes are allowed);
- Dates – any month or day (except the year) directly relating to individuals or their treatment including birth date, admission date, or date of death. Listing the individuals' age is allowed with the exception of individuals over the age of 89. For individuals over the age of 89, any month, day or year that reveals the individuals' age to be over 89, must be removed;
- Numbers - Social Security numbers, phone numbers, fax numbers, vehicle identifiers and all other identifying numbers as required by the regulations.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA

This section establishes the terms under which the Plan may share the Covered Persons' PHI with the Plan Sponsor, and limits the Uses and Disclosure that the Plan Sponsor may make of the Covered Persons' PHI.

This Plan shall disclose the Covered Persons' PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor shall Use and/or Disclose the Covered Persons' PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations, which it performs on behalf of this Plan.

This Plan agrees that it will only Disclose the Covered Persons' PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section [Amendment] have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to **ALL** of the following restrictions that apply to the Use and Disclosure of the Covered Persons' PHI. The Plan Sponsor:

- (a) Will only Use and Disclose the Covered Persons' PHI for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations;
- (b) Will require each of its subcontractors or agents to whom the Plan Sponsor may provide the Covered Persons' PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to their PHI;
- (c) Will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;
- (d) Will promptly report to this Plan any impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;
- (e) Will allow the Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the designated record set that is in the Plan Sponsor's custody or control. The HIPAA Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;
- (f) Will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Persons' PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA regulations;
- (g) Will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. The Covered Person has a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan related purposes such as Payment of benefits or Health Care Operations;
- (h) Will make its internal practices, books and records relating to the Use and Disclosure of the Covered Persons' PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;
- (i) Must, if feasible, return to this Plan or destroy all of the Covered Persons' PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs their PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;
- (j) Will ensure that adequate separation exists between this Plan and the Plan Sponsor so that the Covered Persons' PHI will be used only for the purpose of plan administration;

(k) Will use reasonable efforts to request only the minimum necessary type and amount of the Covered Persons' PHI to carry out functions for which the information is requested.

This Plan requires the Plan Sponsor to certify that SEE ATTACHMENT is/are the only Employee (s) who will access and use the Covered Persons' PHI. The Plan Sponsor must further certify that such Employee will only access and use PHI for the purposes set forth to perform necessary administrative functions.

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive the Covered Persons' PHI. If any of these Employees or workforce members Use or Disclose the Covered Persons' PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

Anyone who suspects an improper Use or Disclosure of PHI may report the occurrence to this Plan's Privacy Official at SEE ATTACHMENT for phone number.

SUMMARY PLAN DESCRIPTION

This Information, together with your certificate of insurance, constitutes the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974 (ERISA).

If this information and your certificate of insurance do not answer your questions about the plan, please contact the Plan Administrator shown in Item 5.

1. This Plan is provided for the employees of: The LDF Companies
2. Plan Name and Type: The LDF Companies Group Benefit Plan
A. Medical Benefits
3. Employer Identification Number (EIN): 48-1010639
4. Plan Number: A. 501
5. Name of Plan Administrator and Legal Process Agent:
Dennis L. Kirkhart
LDF Support Group, Inc.
2959 North Rock Road, 5th Floor
Wichita, Kansas 67226-1117
316-636-5575 or 866-602-0862
6. Plan Eligibility Requirements: A description of the plan's requirements for eligibility to participate and to receive benefits is described in your Employee Certificate.
7. End of Plan Year: December, 31.
8. The plans are financed by contributions from the employee and employer based on rates established by the Plan Administrator.
9. Type of Administration and Funding Medium:
A. Self-Insured
10. Description of Benefits: A description of the benefits is contained in your Plan certificate of insurance.
11. Circumstances Which May Affect Benefits: Circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits are contained in your certificate of insurance.
12. Claims Procedures: Upon request, the Plan Administrator will furnish claim forms and instructions for filing a claim. Within sixty days of receipt of a properly completed claim form and any additional information needed to substantiate the validity of the claim, the insurance carrier will either pay the required benefits or provide the participant with notice in writing that the claim has been denied, setting forth the reasons for denial.
13. Appeal of Denied Claims: After receiving notice that the claim has been denied, the participant may file a written request within 180 days with the insurance carrier for a review of their decision. A review will then be made of all materials submitted and the insurance carrier will within 60 days of the written request, mail the participant (1) their decision concerning that claim, or (2) notification that there will be a delay. If the insurance carrier notifies the participant that there will be a delay and explains the reasons for the delay, the insurance carrier will have 60 days more in which to mail their decision to the participant.

ERISA STATEMENT OF RIGHTS

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reasons for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

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

Administered by:

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