UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF MISSISSIPPI
WESTERN DIVISION

03 JUN 27 P.1 2:5.

In re:
MISSISSIPPI CHEMICAL CORPORATION, *et al.*,
Debtors

JOINTLY ADMINISTERED
CASE NO. 03-02984-WEE
CHAPTER 11

MOTION OF BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, INC. TO COMPEL ASSUMPTION OR REJECTION OF EXECUTORY CONTRACT OR, ALTERNATIVELY, TO PERMIT IMMEDIATE TERMINATION OF CONTRACT

Blue Cross & Blue Shield of Mississippi, Inc. ("BCBSMS"), a creditor herein, moves this Court pursuant to 11 U.S.C. §§ 365 and 503, and Fed.R.Bankr.P. 6006, 9013 and 9014, through counsel, for an order (a) compelling the Debtor to assume or reject the executory contract more particularly described herein within a period set by the Court and provide adequate assurance of future performance, and (b) deeming said contract rejected in the event adequate assurance payments are not timely made as ordered by the Court. In support hereof BCBSMS would show as follows:

1. Mississippi Chemical Corporation and the affiliated cases of Mississippi Nitrogen, Inc.; MissChem Nitrogen, L.L.C.; Mississippi Chemical Company, LP; Mississippi Chemical Management Company; Mississippi Phosphates Corporation; Mississippi Potash, Inc.; Eddy Potash, Inc.; Triad Nitrogen, L.L.C; and Melamine Chemicals, Inc. commenced their cases under Chapter 11 of the United States Bankruptcy Code on May 15, 2003, by filing their Voluntary Petitions for relief herein. By Order of this Court dated May 16, 2003, the affiliated cases are jointly administered under Mississippi Chemical Corporation Case No. 03-02984-WEE.

2. Prior to the commencement of this case, Debtors applied to BCBSMS for a Group Medical Plan As Amended and Restated Generally Effective January 1, 2003 ("Contract"), for Debtors' eligible employees and dependents for which application was made to and accepted by BCBSMS. The Contract is an executory contract within the meaning of Bankruptcy Code § 365. A

copy of the Contract is attached as Exhibit "A". The Debtors have not sought or obtained Court approval to assume the Contract.

3. BCBSMS continues to perform under the Contract.

4. Good cause exists for this Court to compel the Debtors to assume or reject the Contract and to provide adequate assurance of future performance within a reasonable time.

WHEREFORE, BCBSMS respectfully requests that this Court enter an order:

(a) Sustaining its motion and requiring the Debtors to assume or to reject the Contract within five (5) days of a hearing on this motion, or if no hearing is held, within five (5) days of the date of entry of an order granting the relief requested; and

(b) Sustaining its motion and requiring and/or permitting Debtors to immediately bring current all outstanding amounts due BCBSMS under the Contract and to provide any adequate assurance payments required or ordered; and

(c) Sustaining its motion and deeming the Contract rejected if Debtors do not assume the Contract within the time period set forth above and does not timely make future adequate assurance payments.

(d) For such other relief in law or equity as warranted in the premises.

DATED this the 27th day of June, 2003.

Respectfully submitted,

BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, INC.

By its attorneys:
BENNETT LOTTERHOS SULSER & WILSON, P.A.

By: _____
Marcus M. Wilson

Marcus M. Wilson
Mississippi Bar Number 7308
BENNETT LOTTERHOS SULSER & WILSON, P.A.
One Jackson Place, Suite 1400
188 East Capitol Street
Post Office Box 98
Jackson, Mississippi 39205-0098
Telephone: (601) 944-0466
Facsimile: (601) 944-0467
mwilson@blswlaw.com

CERTIFICATE OF SERVICE

I, Marcus M. Wilson, do hereby certify that I have this day forwarded, by United States mail, postage prepaid, a true and correct copy of the **MOTION OF BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, INC. TO COMPEL ASSUMPTION OR REJECTION OF EXECUTORY CONTRACT OR, ALTERNATIVELY, TO PERMIT IMMEDIATE TERMINATION OF CONTRACT** to the persons listed on the attached Fourth Amended Shortened Service List Filed June 18, 2003, this the 27th day of June, 2003.

Marcus M. Wilson

EXHIBIT

"A"

GROUP MEDICAL PLAN

As Amended and Restated
Generally Effective January 1, 2003

MISSISSIPPI CHEMICAL CORPORATION

YAZOO CITY, MISSISSIPPI

INTRODUCTION

Mississippi Chemical Corporation (the "Company") adopted a self-insured medical plan known as the Mississippi Chemical Employee Health Protection Plan for the benefit of its eligible employees, effective October 1, 1982. Said plan has from time to time been amended and restated. As of February 1, 1995, the name of said plan was changed to the Group Medical Plan (the "Plan"). Effective April 1, 1996, the portions of the Plan covering employees of Mississippi Potash, Inc. and Mississippi Phosphates Corporation were divided into separate plans, each governed by its own document. The Company amended, restated and continued the remaining portion of the Group Medical Plan effective as of April 1, 1996, and again, effective January 1, 1998. The Company has determined that it is in its best interest to again amend the Plan to incorporate prior amendments, to revise the benefits provided, to comply with current law, and to make other changes. Now, therefore, pursuant to the powers reserved in the Plan, the Company has, by execution of this document, amended and restated the Plan in its entirety, generally effective January 1, 2003 (except as otherwise provided), subject to the terms and conditions hereinafter set forth. Any rights, benefits and obligation of any party under the Plan prior to January 1, 2003, shall be determined in accordance with the provisions of the Plan as in effect on the date such rights, benefits or obligation arose. The Plan is intended to provide non-taxable benefits and coverage to Members and to comply with provisions of ERISA governing welfare plans, and shall be construed accordingly.

TABLE OF CONTENTS

ARTICLE I
DEFINITIONS

Except as otherwise required by the context, definitions set forth herein shall be equally applicable to both the singular and plural forms of the terms defined. Throughout the Plan, masculine pronouns shall be deemed to include references to both masculine and feminine pronouns. The table of contents and headings of articles and paragraphs are for convenience of reference only and shall not affect the meaning of, or be considered a part of, the Plan. Members must refer to Article III, Benefits Provided, and Article IV, Limitations and Exclusions, for further details on Covered Medical Expenses.

1.1 **Acute Care** means short-term diagnostic and therapeutic services rendered in a Hospital for a patient who is ill from a disease or injury of an acute nature. The period of Acute Care continues until the patient is stable enough to be transferred to a long-term facility for rehabilitation or maintenance care or until the patient can be discharged to home care.

1.2 **Alcohol Abuse Treatment Facility** means a licensed facility that is engaged in providing detoxification and rehabilitation treatment for alcohol abuse and is approved by the Employer, Claims Administrator or the Utilization Management Firm.

1.3 **Allowable Charge** means, with respect to benefits hereunder for a prescription drug, the lesser of the submitted charge or the amount established by the Claims Administrator, in its sole discretion, based on an analysis of provider charges, as the maximum amount to be paid by the Plan for such drugs.

1.4 **Alternative Benefit Plan** means an agreement to provide benefits for services not routinely covered under this Plan.

1.5 **Benefit Period** means a period of one calendar year commencing each January 1 or, if shorter, the period within such calendar year during which the Member is covered hereunder. Any Covered Medical Expenses incurred by a Member during the calendar months of October, November, and December that apply toward the Deductible Amount for that calendar year may be applied against the Deductible Amount for the next succeeding calendar year.

1.6 **Billed Charge** means a billed charge incurred on or after the effective date of a Member's coverage hereunder, and before the termination of the Member's coverage hereunder, for a service or supply to such Member, which is covered by the Plan, is Medically Necessary because of illness, disease, congenital defect, or accidental bodily injury, and is performed or prescribed by a Physician.

1.7 **Claims Administrator** means the entity providing consulting services in connection with the operation of the Plan, including the processing and payment of claims and other such functions as agreed to from time to time by the Company and the Claims Administrator. As of January 1, 2003, the Claims Administrator is Blue Cross Blue Shield of Mississippi.

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

1.9 **Community Pharmacy Plus Network** means a network consisting of participating pharmacies that agree to charge no more than the Allowable Charge established for prescription drugs.

1.10 **Company** means Mississippi Chemical Corporation, a Mississippi corporation, or its successor.

1.11 **Continuation Coverage** means coverage provided hereunder pursuant to Section 2.3 at the option of a Member following a qualifying event.

1.12 **Coverage Options** means the medical coverage options offered by the Company under the Plan. Members may select one Coverage Option for each Plan Year. The Coverage Options are (i) $200 per person deductible; $600 per family deductible; $1,000 per person per calendar year out-of-pocket limit, ("Option A"), (ii) $500 per person deductible; $1,500 per family deductible; $2,500 per person per calendar year out-of-pocket limit, ("Option B"), (iii) $1,000 per person deductible; $3,000 per family deductible; $5,000 per person per calendar year out-of-pocket limit, ("Option C") and, (iv) no medical coverage provided by the Company (the "Opt-Out Coverage Option"). Members may also select Employee-Only coverage or Employee plus various levels of Dependent Coverage with respect to each Coverage Option. The Company will notify eligible Employees of the Coverage Options that will be offered each year and eligible Employees will have the opportunity to select a Coverage Option on the benefit enrollment form provided to the Member by the Company for the upcoming Plan Year.

1.13 **Covered Medical Expense** means the lesser of a Billed Charge or a corresponding Maximum Charge, in each case subject to the limitations and exclusions set forth in Articles III, IV and V.

1.14 **Deductible Amount**

(a) "Deductible Amount" means the first $200, $500, or $1,000 of Covered Medical Expense incurred with respect to a Member within a Benefit Period, depending on whether the Member has elected Coverage Option A, B, or C for such Benefit Period, except no more than three (3) times the per person Deductible Amount must be satisfied in each Benefit Period for a family under Dependent Coverage. However, no Member may contribute more than the Deductible Amount to satisfy the maximum amount required of a family in a Benefit Period.

(b) In the event more than one Member included in Dependent Coverage incurs charges for Covered Medical Expenses as a result of injuries received in the same accident, then only one Deductible Amount shall be applied to the aggregate of charges for Covered Medical Expenses that are incurred by such Members as a result of injuries received in the same accident.

(c) Prescription drugs shall be subject to the deductibles set forth in Section 3.3(c)(1).

1.15 **Dental Implants** means devices specifically designed to be placed surgically within the mandibular or maxillary bone as a means of providing for dental replacement.

1.16 **Dependent(s)** means an Employee's lawful spouse; dependent unmarried children under 19 years of age and, if full-time students, under 26 years of age; and dependent children eligible for Incapacitated Coverage.

(a) The term "children" means natural children and: (i) adopted children or children who have been placed by a court of competent jurisdiction in the Employee's home for the purpose of adoption; (ii) step-children; (iii) any children designated under the terms of a "Qualified Medical Child Support Order" (QMCSO) (a copy of the Company's QMCSO procedures shall be provided to Members, free of charge, upon request); and (iv) children for whom the Employee has been appointed legal guardian by a court of competent jurisdiction.

In the case of (i), (ii) and (iv) but not (iii) above, such children must be living in a regular parent-child relationship with the Employee and be dependent upon the Employee for support and maintenance. In the case of (iv) above, a regular parent-child relationship will be deemed not to exist if either of the child's parents also resides with the Employee.

(b) An unmarried child from attainment of age 19 to attainment of age 26 must attend a licensed or accredited school on a full-time basis (as defined by the school) to be considered a Dependent (with the exception of coverage provided under Section 1.16(c)). For coverage under the Plan to continue during vacation periods, the child must be scheduled to enter school on a full-time basis on the next enrollment date.

(c) "Incapacitated Coverage" means coverage provided for a Dependent child, regardless of age, who became permanently mentally or physically disabled prior to the attainment of age 19 (or prior to the attainment of age 26 if he or she is or was a full time student at the time he or she became incapacitated), is not married, is so incapacitated as to be incapable of self-sustaining employment, and is dependent upon the Employee for more than one-half his or her financial support. The Employee need not have been a Member in the Plan at the time his or her Dependent became incapacitated. Neither a reduction in work capacity nor inability to find employment is, of itself, sufficient to qualify on individual for Incapacitated Coverage. The Claims Administrator and/or Employer may require proof of such incapacitation from time to time. A Dependent child eligible for Incapacitated Coverage may continue coverage.

(d) The term "Dependent" does not include any person who is eligible for coverage as an Employee. When husband and wife are both Employees, and both elect to participate in the Plan, then the Employee with the longest period of service with an Employer shall be the eligible Employee for purposes of the Plan and the other spouse shall be covered as a Dependent under the Plan unless the Employee who would be considered the Dependent elects otherwise in writing. In addition, when

husband and wife are both covered under the Plan as Employees, either, but not both, may elect to cover Dependents.

(e) The term "Dependent" does not include any individual who does not qualify as the Member's spouse or dependent under Code Section 105(b).

1.17 **Dependent Coverage** means: (i) Employee Plus Child Coverage (the coverage selected by the Employee hereunder for such Employee and the Employee's child); (ii) Employee Plus Spouse Coverage (the coverage selected by the Employee hereunder for such Employee and the Employee's spouse); or (iii) Employee Plus Family Coverage (the coverage selected by the Employee hereunder for such Employee and the Employee's family).

1.18 **Drug Abuse Treatment Facility** means a licensed facility that is engaged in providing detoxification and rehabilitation treatment for drug abuse and is approved by the Employer, Claims Administrator and/or Utilization Management Firm.

1.19 **Durable Medical Equipment** means items that are used to serve a medical purpose, can withstand repeated use, are generally not useful to a person in the absence of illness, injury, or disease, and are appropriate for use in the patient's home. Hot tubs, swimming pools, Whirlpools, lift chairs, or air purifiers shall not be considered to be Durable Medical Equipment.

1.20 **Employee** means a person employed on a regular basis by an Employer and whose normal work schedule includes at least twenty (20) hours of work per week. The term "Employee" shall not include temporary employees; any employee who is providing services pursuant to an oral or written contract or lease arrangement with an unrelated employer, whether or not such person is later determined to be a common law employee of the Employer; any person designated by an Employer as an independent contractor (without regard to such person's status for federal income tax purposes and without regard to any subsequent determination that such employee is a common law employee); any person who performs services for an Employer as an independent contractor; any other person or class of persons designated by an Employer to be excluded from coverage hereunder; or any person who is a former employee of an Employer (including a retiree or a former employee who is receiving disability or other benefits) unless this Plan specifically provides, or the Employer otherwise agrees in writing, that such person is to be treated as an Employee hereunder. Individuals covered by a collective bargaining agreement under which employee benefits were the subject of good faith bargaining shall not be treated as Employees and shall not be eligible for coverage hereunder unless the collective bargaining agreement specifically requires their coverage hereunder.

1.21 **Employee Assistance Plan (EAP)** means a program sponsored by an Employer to provide Employees and their Dependents counseling and outpatient mental and nervous treatment.

1.22 **Employee-Only Coverage** means coverage for an Employee only.

1.23 **Employer** means the Company and such other entities which Company may designate in writing from time to time to participate in the Plan. Such designation may include a

limitation as to the classes or groups of employees of such other entity which may participate in the Plan.

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

1.25 **Excess Charge** means the excess of a Billed Charge over a corresponding Maximum Charge.

1.26 **Experimental/Investigative** means any procedure, treatment, or course of treatment that is: (a) not proven in an objective manner to have benefit for the patient; (b) restricted to use at facilities engaged primarily in carrying out scientific studies; (c) requires federal or any other governmental agency approval; or (d) not yet generally recognized as accepted dental practice. In determining whether a particular procedure is experimental, the Plan Administrator shall consider (among other things) commissioned studies, opinions and references to or by the American Medical Association, the U.S. Food and Drug Administration, the U.S. Department of Health and Human Services, the Health Care Financing Administration, the National Institutes of Health, the Counsel of Medical Specialty Societies, or other associations or federal programs or agencies that have the authority to approve dental testing or treatment.

1.27 **Home Health Care Agency** means an agency or organization that meets fully every one of the following requirements:

(a) It is primarily engaged in providing skilled nursing services and other appropriate therapeutic services and is licensed to do so by the appropriate licensing authority when licensing is required;

(b) It has policies established by a professional group associated with the agency or organization; the professional group includes at least one Physician and at least one R.N. to govern the services provided, and such services are provided under the full-time supervision of a Physician or R.N.;

(c) It maintains a complete medical record for each patient; and

(d) It has a full-time administrator.

1.28 **Home Infusion Therapy** means services and Supplies required for the administration of a home infusion therapy regimen. These services and Supplies must be: (a) Medically Necessary for the treatment of the disease; (b) ordered by a Physician; (c) determined by the Utilization Management Firm to be capable of safe administration in the home; (d) provided by a home infusion therapy provider and coordinated and pre-certified by the Utilization Management Firm; (e) ordinarily provided in lieu of inpatient Hospital therapy; and (f) determined by the Utilization Management Firm to be more cost effective than inpatient therapy.

1.29 **Hospital** means a short-term, acute-care, general hospital which:

(a) Is a licensed institution;

(b) Provides inpatient services and is compensated by or on behalf of its patients;

(c) Provides surgical and medical facilities primarily to diagnose, treat, and care for the injured and sick; except that a psychiatric hospital will not be required to have surgical facilities;

(d) Has a staff of physicians licensed to practice medicine; and

(e) Provides 24-hour nursing care by registered nurses.

A facility which serves, other than incidentally, as a nursing home, custodial care home, rest home, rehabilitative facility or place for the aged is not considered a Hospital.

1.30 **Individual Case Management** means a service offered by the Utilization Management Firm that is administered by medical professionals and focuses on unusually complex, difficult or lengthy illnesses, injuries or courses of treatment. After consultation with the Member's Physicians and subject to acceptance by the Member and/or the Member's family and the Employer, the Individual Case Management staff will develop a long-term treatment program to achieve the most efficient and effective use of medical resources. Under this program, benefits may be provided for Home Infusion Therapy or other services not otherwise provided under this Plan.

1.31 **Inpatient Rehabilitation Services** means rehabilitation services that can not be adequately performed in an Outpatient setting.

1.32 **L.P.N.** means licensed practical nurse.

1.33 **Life-Threatening Situation** means an injury or illness that will likely result in death if not treated immediately. Whether a Life-Threatening Situation exists shall be determined by the treating Physician.

1.34 **Lifetime Maximum Benefits** means the amount set forth in Article III as the maximum benefit amount available under this Plan to any one Member during his lifetime.

1.35 **Maximum Charge** means the amount established by the Claims Administrator, in its sole discretion, as the maximum amount to be paid by the Plan for a service or supply for which a Billed Charge is incurred. Without limitation, in determining Maximum Charges, the Claims Administrator may consider payment rates negotiated with health care providers, or usual, customary and reasonable charges for similar services.

1.36 **Medical Policy** means formal written guidelines developed by the Claims Administrator regarding new and existing medical and surgical procedures, products, drugs, technology and tests. These guidelines are determined by review of currently available peer reviewed scientific literature as well as input from practicing professionals. Claims

Administrator relies on Medical Policy for reaching decisions on matters of: (a) Medical Necessity; (b) covered services under this Plan; (c) appropriate adjudication of claims; (d) Utilization Management; and (e) quality assessment programs. The specific guidelines found in the Medical Policy are not set out in their entirety in this Plan.

1.37 **Medical Supplies or Supplies** means supplies provided under the Plan that are Medically Necessary disposable items, primarily serving a medical purpose, have therapeutic or diagnostic characteristics essential in enabling a patient to effectively carry out a Physician's prescribed treatment for illness, injury, or disease, and are appropriate for use in the patient's home, if used in the home.

1.38 **Medically Necessary** describes services or Supplies required to identify or treat an illness or injury which a Physician has diagnosed or reasonably suspects when such services or Supplies, including services or Supplies provided by an emergency room or otherwise on an emergency basis, are: (a) consistent with the suspected diagnosis or treatment of the patient's condition, illness, or injury; (b) in accordance with standards of good medical practice; (c) required for reasons other than the convenience of the patient or his Physician; (d) the most appropriate supply or level of service which can be safely provided to the patient; (e) generally accepted and customarily recognized as an appropriate treatment for the diagnosed illness or injury and (f) not Experimental/Investigative. When applied to the care of an inpatient, it further means that the patient's medical symptoms or condition require that the services cannot safely or efficiently be provided to the patient as an outpatient. The fact that a Physician has prescribed, ordered, recommended, or approved a service or supply does not in itself make it Medically Necessary. "Medical Necessity" has a correlative meaning.

1.39 **Member** means a person covered by the Plan, whether as an Employee, as a Dependent, as a person covered by Continuation Coverage, or as a person who is a former employee entitled to coverage pursuant to specific provisions of the Plan or other written agreement of the Employer.

1.40 **Nervous and Mental Health Care Facility** means a facility approved by the Claims Administrator, Utilization Management Firm and/or an Employer as a provider of treatment for Nervous/Mental Conditions or, in the case of a facility located in a state other than Mississippi, a facility approved by the Blue Cross and Blue Shield Plan in such state.

1.41 **Nervous/Mental Condition** means a disturbance of intellectual and emotional functions to a degree of severity at which: (a) the presence of anxiety and/or depression is significantly beyond minor behavior aberrations, or (b) the patient's mental state has broken with reality.

1.42 **Nonparticipating Provider** means a Physician, Hospital, Alcohol Abuse Treatment Facility, Drug Abuse Treatment Facility, Home Health Care Agency, or other provider of medical services that has not directly or indirectly agreed with the Claims Administrator for a Maximum Charge to a Member for a service, supply or category of services or supplies covered by the Plan, to which the Claims Administrator has not agreed to make direct

payment, and that the Claims Administrator and Employer have not designated a Participating Provider for purposes of the Plan.

1.43 **Opt-Out Coverage Option** means the Coverage Option, if selected by the Employee, that will provide the Employee and his Dependents with no coverage under this Plan.

1.44 **Outpatient Cardiac Rehabilitation** means the process by which a person with cardiovascular disease is restored to their optimal function states, including their physiological, psychological, social, vocational, and emotional states. Cardiac Rehabilitation services include formal exercise sessions, risk factor education, and behavior modification counseling.

1.45 **Participating Provider** means a Physician, Hospital, Alcohol Abuse Treatment Facility, Drug Abuse Treatment Facility, Home Health Care Agency, Nervous and Mental Health Care Facility, or other provider of medical services that has directly or indirectly agreed with the Claims Administrator for a Maximum Charge to a Member for a service, Supply or category of services or Supplies covered by the Plan, to which the Claims Administrator has agreed to make direct payment and/or that the Claims Administrator and Employer have designated as a Participating Provider for purposes of the Plan.

1.46 **Physician** means a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is legally qualified and licensed to practice medicine and perform surgery at the time and place service is rendered. A Doctor of Dental Surgery (D.D.S.), Doctor of Surgical Chiropody (D.S.C.), Doctor of Podiatry (Pod D.), Clinical Psychologist (Ph.D.), Chiropractor (D.C.) and an Optometrist (O.D.), when duly licensed and practicing within the scope of his license, is deemed to be a Physician for purposes of this Plan. No other practitioners are deemed to be Physicians.

1.47 **Plan** means the Group Medical Plan as set forth herein and as it may hereafter be amended from time to time.

1.48 **Plan Year** means the twelve month period beginning on January 1 and ending on December 31 each year.

1.49 **Prosthetic Appliance** means an appliance that replaces all or part of a body organ, or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning body part.

1.50 **R.N.** means registered nurse.

1.51 **Rehabilitative Care** means the coordinated use of medical, social, educational or vocational services, beyond Acute Care, for the purpose of upgrading the physical functional ability of a patient disabled by disease or injury so that the patient may independently carry out ordinary daily activities.

1.52 **Residential Treatment Facility** means a treatment facility that is not a Hospital and provides a twenty-four (24) hour program of care by qualified therapists, including but not

limited to, fully licensed mental health professionals, psychiatrists, psychologists and licensed certified social workers for individuals referred to such facility.

1.53 **Review Panel** means the person or persons designated from time to time by the Plan Administrator or its designee.

1.54 **Second Surgical Opinion** means a consultative opinion and directly related diagnostic services to confirm the need for elective surgery. Second (or third) opinion consultant must not be the Physician who first recommended elective surgery.

1.55 **Semiprivate Rate** means the rate charged by the Hospital for a room containing two or more beds.

1.56 **Substance Abuse Treatment** means treatment for the uncontrollable or excessive use or abuse of alcohol, drugs or other chemicals and the resultant physiological and/or psychological dependency which develops with continued use.

1.57 **Utilization Management Firm** means the entity providing certification, concurrent and retrospective review of Plan administration, Individual Case Management and such other services as agreed to from time to time by the Company and the entity. The entity must be licensed in the applicable state if such licensing is required and may or may not be the Claims Administrator.

ARTICLE II
SCHEDULE OF ELIGIBILITY

2.1 **Eligibility Determination**. Determination of eligibility requirements for participation in the Plan is the responsibility of the Employer. The Claims Administrator will accept enrollment information and changes as furnished by the Company and/or Employer in accordance with provisions set out below. To participate in the Plan, the Employee must enroll in the Plan in accordance with Section 2.2 below and must make contributions in accordance with Article VIII below.

2.2 **Enrollment and Effective Date of Coverage**. An Employee who is eligible to enroll in the Plan must select a Coverage Option prior to the beginning of each Plan Year as specified on the benefit enrollment form provided by the Company. If an Employee who was not covered under the Plan in the immediately prior year does not complete a benefit enrollment form by the deadline established by the Plan Administrator, such Employee will be deemed to have elected Employee-Only Coverage benefits under Coverage Option A. If an Employee who was previously covered under the Plan does not complete a benefit enrollment form, such Employee will be deemed to have elected Coverage Option A consistent with the family coverage option such Employee had in the immediately prior year. Except as otherwise provided below, an Employee's enrollment elections for the Plan Year (including any deemed elections) are binding for the entire Plan Year.

(a) Employee-Only Coverage. If an individual becomes an Employee and enrolls for coverage within 30 days thereafter, the effective date of his coverage under the Plan is the date he becomes an Employee.

(b) Dependent Coverage.

(1) If an individual becomes an Employee and enrolls for Dependent Coverage within 30 days thereafter, the effective date of coverage under this Plan for such individual and his enrolled Dependents will be the date such individual becomes an Employee.

(2) An Employee can change from Employee-Only coverage to Dependent Coverage or enroll additional Dependents within 30 days after acquiring Dependent(s) by marriage, birth, adoption or placement for adoption. Coverage for newly acquired Dependent(s) through birth, adoption or placement for adoption will be effective on the date of the birth or adoption. Coverage for newly acquired Dependent(s) through marriage will be effective as soon as administratively possible, but no later than the first day of the month after the request for enrollment is received.

(3) Incapacitated Coverage will be provided to a covered Dependent who is certified by a Physician as eligible for Incapacitated Coverage hereunder.

(c) Effect of Code Section 125 Regulations on the Plan. Elections to add or drop coverage on a pretax basis under the Mississippi Chemical Corporation Flexible Benefit Plan ("Flexible Benefit Plan") (the Company's Code §125 cafeteria plan) are subject to the restrictions stated in such plan, in accordance with Code §125 and regulations thereunder. In addition to the changes described above, the Plan shall allow changes in elections to the extent that corresponding election changes are allowed by the Flexible Benefit Plan.

(d) Termination of Coverage. Except as expressly provided otherwise below or in Appendices to the Plan, coverage hereunder will terminate immediately as of the date the Employee/Member ceases to be an Employee (as defined herein); the date as of which the Member fails to make any contributions required hereunder; or the effective date of termination of the Plan, or amendment of the Plan to eliminate coverage. Coverage for a Dependent also ends as of the date he or she ceases to be a Dependent, as defined in the Plan or any amendment thereto; the date the coverage of the Employee/Member whose Dependent he or she is ends; or the date as of which such Employee/Member elects to drop Dependent coverage.

(e) Eligibility When Both Spouses are Employees. If both spouses are Employees eligible for coverage hereunder, the spouse with the longer period of service with the Employer shall be considered the Employee, and the other spouse shall be treated as a Dependent, unless the other spouse elects in writing to have separate coverage as an Employee. Only one spouse may elect to enroll children as Dependents.

(f) Special Enrollment. An Employee and/or a Dependent who is eligible, but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at anytime if the following requirements are met:

(1) when the Employee declined enrollment for the Employee and/or Dependent, the Employee stated in writing that the reason for declining enrollment was coverage under another group health plan or other health insurance coverage; and

(2) either:

(i) when the Employee declined enrollment for the Employee and/or Dependent, the Employee and/or Dependent had Continuation Coverage under another plan and the Continuation Coverage under that plan has been exhausted; or

(ii) if the other coverage that applied to the Employee and/or Dependent when enrollment was declined was not Continuation Coverage, either the other coverage has been terminated because of eligibility for the coverage or employer contributions towards the coverage have been terminated. For this purpose, termination of

eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or any loss in eligibility after a period that is measured by any of the foregoing. Termination of eligibility does not include a loss due to the failure of the individual or the Member to pay premiums on a timely basis or termination of coverage for cause.

To enroll under the Special Enrollment provisions of this subsection, an individual must request enrollment not later than 30 days after the exhaustion of the other coverage. Enrollment is effective on the date such Employee completes all necessary forms for enrollment in the Plan and submits such forms to the Plan Administrator; however, such enrollment date shall not be later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

2.3 **COBRA Continuation Coverage**.

(a) Members shall have the option of receiving Continuation Coverage hereunder, in accordance with the continuation coverage provisions of Part 6 of Title I of ERISA (COBRA), without proof of insurability, if a qualifying event occurs.

(1) Employees and Dependents who are Members immediately before the qualifying event may elect Continuation Coverage for up to 18 months from the date of the qualifying event if coverage would otherwise be lost due to one of the following qualifying events:

(i) Reduction of the Employee's work hours.

(ii) The Employee's termination of employment for any reason (other than gross misconduct).

In addition, if a child who would otherwise qualify as a Dependent is born to, or placed for adoption with, an Employee or former Employee while Continuation Coverage is in force under this Section, such child shall be eligible for Continuation Coverage for the remainder of the 18 month period.

(2) The 18-month period may be extended to 29 months for any Member, or any related Members who have elected Continuation Coverage as a result of the same termination of employment qualifying event if the Member is determined to have been disabled under the Social Security Act effective as of a date within the first 60 days of Continuation Coverage. Notice of the Social Security disability determination must be received by the Claims Administrator or Employer within 60 days after such determination and before the end of the initial 18-month period of Continuation Coverage.

(3) If another qualifying event occurs during the 18-month or 29-month period of Continuation Coverage allowed because of a qualifying event described in Section 2.3(a)(1) or (2), then the period of Continuation Coverage can be extended for a period not to exceed 36 months from the date of the first qualifying event.

(4) Continuation Coverage for Dependents who are Members immediately before the qualifying event may be provided for up to 36 months from the date of the qualifying event if coverage would otherwise be lost due to one of the following qualifying events:

(i) Death of the Employee.

(ii) Legal separation or divorce of the Employee.

(iii) Loss of status as a Dependent child (i.e., due to attainment of maximum age for coverage, marriage, cessation of full-time studies or cessation of incapacitated status).

(iv) Entitlement of Employee to Medicare if loss of coverage of Dependents results.

(5) If a Member is receiving coverage pursuant to Section 2.5 below (regarding coverage provided to disabled Members), the 18-, 29-, or 36-month period of continuation coverage begins to run on the date that is 180 days following the date on which the covered Employee commences coverage under an Employer's short-term disability plan.

(b) The Member has 60 days from the date the Member would lose coverage as a result of the qualifying event, or from the date the Member receives notice of the right to Continuation Coverage, whichever date is later, to elect Continuation Coverage under this Plan. If loss of coverage would otherwise result because of a qualifying event described in Section 2.3(a)(3), the affected Member has 60 days to notify the Employer from the date of the qualifying event or the date loss of coverage occurs, whichever is later. A Member who has extended coverage under Section 2.3(a)(2) above must notify the Employer within 30 days after any final determination under the Social Security Act that the Member is no longer disabled. The Member who elects Continuation Coverage must pay the monthly premium charged therefor, which premium will not exceed 102% of the then-current premium equivalent as calculated by the Claims Administrator and Company; provided, however, if a Member's Continuation Coverage is extended under Section 2.3(a)(2) due to disability, Member's monthly premium for Continuation Coverage from the 19th through the 29th month (and through the 36th month if an additional qualifying event occurs during the disability extension) may be up to 150% of the then-current premium equivalent, as calculated by the Claims Administrator and Company, as long as the disabled qualified beneficiary is included in that coverage.

(c) Any Continuation Coverage premium payment owed for the initial Continuation Coverage period must be paid within 45 days of the date the Member elects Continuation Coverage. Any premium thereafter is due by the first day of the Continuation Coverage period to which the premium relates, and in no case later than 30 days after the due date.

(d) Continuation Coverage under this Plan may be terminated on the earliest of:

(1) Termination of this Plan and any other group health plans of the Employer;

(2) Failure of the Member to pay premium charged him within 30 days of the due date therefor (45 days for the initial coverage period);

(3) Coverage of the Member under another group health plan as an employee or otherwise, except that Continuation Coverage will continue hereunder with respect to any pre-existing condition excluded under such other group health plan;

(4) The Member's entitlement to Medicare;

(5) The end of the 18-, 29-, or 36-month Continuation Coverage period, whichever is applicable to the Member; or

(6) The month that begins more than 30 days after a final determination that a Member who was entitled to 29-month extended coverage due to disability under Section 2.3(a)(2) is no longer disabled under the Social Security Act.

(e) A Member who is absent from active employment by reason of service in the Uniformed Services (as defined in the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)), and his covered Dependents, may elect continuation coverage for the lesser of eighteen (18) months or until the date after the date on which the Member is required to apply for a return to a position of employment, according to the provisions of USERRA (or other similar federal law).

2.4 **Conversion Rights**.

(a) Members who elect Continuation Coverage are eligible, at the expiration of Continuation Coverage, to convert their coverage as described in this Section 2.4. Members who do not elect Continuation Coverage are eligible, at the expiration of their coverage under this Plan, to convert their coverage as described in this Section 2.4.

(b) When a Member's coverage under this Plan or under Continuation Coverage terminates, he is eligible for coverage under an individual non-group conversion contract then being offered by Blue Cross & Blue Shield of Mississippi, Inc., or,

if eligible for coverage under the Medicare program, under a Medicare supplemental insurance policy. Coverage and benefits under such individual policy are the sole responsibility of Blue Cross & Blue Shield of Mississippi, Inc.

(c) The conversion contract will not be a continuation of the benefits provided by this Plan. The benefits and fees may differ substantially from those provided hereunder. Copies of the available non-group conversion contracts may be obtained from Blue Cross & Blue Shield of Mississippi, Inc., Post Office Box 1043, Jackson, Mississippi 39215-1043.

(d) No conversion privileges are available to a Member upon termination of the Plan.

(e) Direct payment by the Member to Blue Cross & Blue Shield of Mississippi, Inc. for the full cost of coverage under the conversion contract must be made from the date the Member ceases to be eligible for coverage or Continuation Coverage under this Plan.

(f) Written application for the conversion contract must be made to Blue Cross & Blue Shield of Mississippi, Inc., in accordance with procedures and deadlines established by Blue Cross and Blue Shield of Mississippi, Inc.

2.5 **Continuation Coverage During Employee Disability**. If an individual who is covered hereunder as an Employee ceases to be an Employee and is at that time receiving disability benefits under an Employer's short-term disability plan or policy or long-term disability plan, such individual shall be entitled to coverage under this Plan so long as he is receiving disability benefits under the above-referenced disability plans and policies of the Employer, but not beyond the earlier of (i) 24 months from the date that coverage under this Section 2.5 commences or (ii) the date he becomes eligible for coverage under Medicare due to disability as determined under the Social Security Act or otherwise. Individuals meeting eligibility requirements for continuance under this Section 2.5 due to disability shall be treated as if they were Employees under this Plan for all purposes except Coordination of Benefits under Article VI hereof, so long as they maintain eligibility for said continuance. Coverage under this Section 2.5 shall run concurrently with COBRA Continuation Coverage under Section 2.3.

2.6 **Leave of Absence**. If an Employee is on leave under his Employer's policies, coverage under this Plan for him and his Dependents will continue in conformity with his Employer's policies for so long as the Employee complies with such policy(ies). Employees on leave under such policy(ies) shall be considered Employees for all purposes under this Plan. In the case of paid leave, such Employee contributions shall be made by payroll deduction on the same basis as an active Employee. In the case of unpaid leave, the Employee may elect to pre-pay contributions for an anticipated period of leave on a pre-tax basis subject to the terms of the Company's Code §125 cafeteria plan. Alternatively, an Employee on unpaid leave may elect to pay monthly contributions on an after-tax basis during the period of leave, or may elect to drop his coverage during such leave. In the case of leave under the Family and Medical Leave Act, an Employee who drops his coverage during a period of leave may elect to reenroll immediately upon return from leave; or shall be entitled to elect Continuation Coverage under Section 2.3 above, in the event he does not return to work at the end of such leave.

2.7 **Terminated and Retired Employees**. Upon termination of employment or retirement of an Employee, coverage hereunder will terminate as of the last day of active work. with the exception of coverage provided under Section 2.3 and in Appendices to the Plan.

ARTICLE III
BENEFITS PROVIDED

3.1 **Payment or Reimbursement of Covered Medical Expense**. Subject to the Deductible Amount as defined in Article I, to the maximum limitations hereinafter provided, and to other terms and provisions of this Plan, including but not limited to the limitations and exclusions of Articles III, IV and V, a Covered Medical Expense incurred by a Member during a Benefit Period will be paid or reimbursed as follows: (i) 80% of the Covered Medical Expense for Hospital room and board for a semiprivate or private room or a special care unit (e.g., an intensive care unit) and (ii) 80% of any other Covered Medical Expense (unless otherwise provided herein). The Plan shall make no payment or reimbursement, and the Member shall be solely responsible, for any Excess Charge.

The Plan has an out-of-pocket limit that varies, depending on the Coverage Option the Member selects. The out-of-pocket limit for Coverage Option A is $1,000, the limit for Coverage Option B is $2,500, and the limit for Coverage Option C is $5,000. When a Member incurs $1,000, $2,500 or $5,000 (depending on which Coverage Option the Member selected) of unreimbursed (out-of-pocket) charges for Covered Medical Expenses in excess of the Deductible Amount during a Benefit Period, 100% of the remaining Covered Medical Expenses during that Benefit Period for that Member will be paid or reimbursed hereunder, except as otherwise limited by the terms and provisions of the Plan, including but not limited to limitations and exclusions of Articles III, IV and V.

3.2 **Lifetime Maximum Benefits**. The Lifetime Maximum Benefits available hereunder to each Member shall be $2,000,000. The Plan also contains lower maximums for certain specific types of healthcare, such as Rehabilitative Care, transplants, organ donation, and substance abuse treatment benefits. Benefits applied against any other such maximum in the Plan shall be applied against the Lifetime Maximum Benefits as set forth in this Section. In the event the Lifetime Maximum Benefits for any Member are exhausted, $2,000 for use in future Benefit Periods shall be restored each January 1 following the Benefit Period in which such Lifetime Maximum Benefits were exhausted.

3.3 **Partial List of Covered Medical Expenses**. The term "Covered Medical Expenses" includes, but is not limited to, the lesser of Billed or Maximum Charges, as the case may be, for the following services and Supplies, subject to the terms and conditions of this Article III and the limitations and exclusions set forth in Articles IV, V and VI:

(a) Hospital services and Medical Supplies as follows:

(1) Hospital room and board (including dietary and general nursing services).

(2) Use of operating or treatment rooms.

(3) Anesthetics and their administration, subject to Section 3.13 below.

(4) Intravenous injections and solutions.

(5) Radiation therapy.

(6) Oxygen and its administration.

(7) Inpatient dental care, in addition to anesthesiologist, X-rays, and related charges, subject to Section 3.3(c)(7) below.

(8) Diagnostic services, such as clinical laboratory examinations, electrocardiograms, electroencephalograms and basal metabolism tests.

(9) Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization that are listed in the Hospital's formulary at the time of hospitalization, including charges for "take home" drugs.

(10) Dressings and Supplies, sterile trays, casts and orthopedic splints.

(11) Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and Supplies.

(12) Psychological testing when ordered by the attending Physician and performed by a full-time employee of the Hospital.

(13) Intensive, coronary and burn care unit services.

(b) Services of a Physician as follows:

(1) In-Hospital medical care.

(2) Medical care in the Physician's office, the patient's home or elsewhere.

(3) Surgery, including surgical supplies, subject to the limitations in Sections 3.12, 3.13 and 3.14 below.

(4) Administration of anesthesia.

(5) Diagnostic services, such as clinical laboratory examinations, X-ray examinations, electrocardiograms, electroencephalograms, and basal metabolism tests.

(6) Radiation therapy.

(7) Consultations.

(8) Psychiatric and psychological service for Nervous/Mental Conditions subject to limitations in Section 4.1(m).

(9) Emergency care or surgical services rendered in the Physician's office including but not limited to surgical and Medical Supplies, dressing, casts, anesthetic, tetanus serum and X-rays.

(10) Allergy injections.

(11) Second Surgical Opinion.

(c) Other Covered Medical Expenses

(1) Prescription drugs: After each Member satisfies a $50 annual prescription drug deductible, the Plan will pay 100% of Allowable Charges for generic drugs and 80% of Allowable Charges for brand name drugs. Allowable Charges may differ at Community PLUS and Non-Community PLUS pharmacies.

Once the $50 per Member deductible is satisfied, no Member shall be required to pay more than an additional $750 out-of-pocket for his or her portion of Allowable Charges for prescription drugs during a Plan Year. The $750 out-of-pocket limit shall also apply to each Member on an individual basis.

Charges for drugs, whether generic or brand name, will be Covered Medical Expenses only when such drugs may, under federal law, be dispensed only by written prescription and are approved for general use by the Food and Drug Administration. The drugs must be dispensed on or after the date the Member's coverage hereunder becomes effective by a licensed pharmacist upon the prescription of a Physician. Only those prescription drugs which are determined by the Claims Administrator to be Medically Necessary for the treatment of illness or injury will be covered. Benefits will be provided for injectable insulin and necessary insulin syringes.

The Company has a Managed Care Drug Formulary (hereinafter Formulary). The Formulary provides clinical and cost comparative information to Physicians servicing Members. In addition to being an information source on drugs, the use of the Formulary may generate savings from drug manufacturers. These savings are generated from prescription drug claims. Any savings as a result of the Formulary are utilized in the financing of this Benefit Plan. A Member's coinsurance/co-payment is calculated on the cost of the drugs prior to any discount or rebate that may be returned at a later date.

(2) Services of a qualified licensed professional physical therapist who holds membership in the American Physical Therapy Association.

(3) Services of an actively practicing R.N. or L.P.N. not related to the patient by blood or marriage when ordered by the attending Physician in cases requiring the technical skills of an R.N. or L.P.N.

(4) Rental or purchase of Durable Medical Equipment for therapeutic use, not to exceed $25,000 per calendar year for each Member.

(5) Prosthetic Appliances necessary for the alleviation or correction of conditions arising from accidental injury or illness, not to exceed $25,000 per calendar year for each Member, although Prosthetic Appliances for a specific purpose such as recreational or sporting activities, which goes beyond assisting a Member with day-to-day activities, is not covered.

(6) Ambulance service benefits:

Benefits will be available for the following covered ambulance services when Medically Necessary:

(i) Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

(A) From the place where the Member is injured by accident or stricken by illness to the nearest Hospital where treatment is to be given.

(B) From a Hospital where a Member is an inpatient to another Hospital or free-standing facility to receive specialized diagnostic or therapeutic services not available at the Hospital of origin and back to the Hospital of origin after such services have been rendered.

(C) From one Hospital to another Hospital when the discharging Hospital has inadequate treatment facilities and the receiving Hospital has appropriate treatment facilities.

(D) To a Hospital, a Physician's office or ambulatory surgical facility for outpatient care for an accidental injury or a medical emergency.

(ii) Covered ambulance service also includes transportation by air ambulance when, as determined by the Claims Administrator or Utilization Management Firm, Member's condition or the urgency of needed medical care precludes travel by surface transportation. Air ambulance service is helicopter transportation to the nearest institution with appropriate facilities for treatment of the Member's injury or illness. Fixed wing air transportation is for long distance

travel only and is not ordinarily considered to be an air ambulance service.

(iii) Charges for ambulance service will not be a Covered Medical Expense if provided for a Member's comfort or convenience.

(7) Dental care and treatment/dental surgery:

Benefits will be provided only for the following services or procedures:

(i) Excision of tumors or cysts (excluding dentigerous cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.

(ii) Dental care and treatment, including surgery and dental appliances, required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this Section, sound natural teeth are those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.) The Member must be covered under this Plan at the time of the accident and must have continuing coverage through the date the services are rendered. Accident means any injury caused by external force. The act of chewing does not constitute an injury caused by external force. To qualify as a Covered Medical Expense resulting from accidental injury, treatment must be initiated within 30 days from the date of the accident and completed within 365 days from the date of the accident.

(iii) Excision of exostoses or tori of the jaws and hard palate.

(iv) Incision and drainage of abscess and treatment of cellulitis.

(v) Incision of accessory sinuses, salivary glands, and salivary ducts.

(vi) Surgical procedures related to micrognathism and macrognathism provided prior approval is obtained and Medical Necessity is documented by appropriate X-rays and photographs.

(vii) When a Member undergoes a non-covered dental procedure that could be complicated by a non-dental disease or condition of the Member, Covered Medical Expenses will include room, board, and other Hospital services.

(8) Prescription shoes which are designed for and equipped with a diffy bar.

(9) Sterilization, contraceptive devices and prescription contraceptives.

(10) Treatment of temporomandibular joint disease.

(11) Pregnancy, childbirth and related conditions of (a) a female Employee who has Employee-Only Coverage or Dependent Coverage or (b) the wife of a male Employee who has Dependent Coverage to the same extent that benefits would be provided for an illness, disease or injury or (c) a female covered by Continuation Coverage other than as a Dependent child. The Plan shall treat as a Covered Medical Expense the minimum Hospital stays for mothers and newborns required by ERISA §711. Specifically, the length of Hospital stay shall be no less than 48 hours in the case of a normal vaginal delivery or 96 hours in the case of a cesarean section, unless the attending physician, in consultation with the mother, decides to discharge the mother or newborn child.

(12) Speech therapy on an outpatient basis, limited to 20 visits per calendar year for each Member.

(13) Home Health Care Agency Services Billed or Maximum Charges, as the case may be, for the following services shall be considered Covered Medical Expenses when provided to an essentially home-bound patient by a Hospital program for home health care or a Home Health Care Agency:

(i) Covered services:

(A) Professional services of an R.N. or L.P.N not related to the Member by blood or marriage.

(B) Physical therapy, occupational therapy and speech therapy.

(C) Medical and surgical Supplies.

(D) Prescribed drugs.

(E) Oxygen and its administration.

(F) Medical social service consultations.

(G) Health aide services furnished to a patient who is receiving covered nursing or therapy services or under a Physician's care.

(ii) Special exclusions and limitations:

(A) Benefits will be provided only for covered services prescribed by the patient's attending Physician.

(B) The patient must be essentially confined at home.

(C) Covered Medical Expenses will not include charges for: dietitian services; homemaker services; maintenance

therapy; dialysis treatment; purchase or rental of dialysis equipment; food or home-delivered meals; or transportation services.

(D) Covered Medical Expenses for Home Health Care Agency services must be approved by the Utilization Management Firm.

(14) Benefits required by the Women's Health and Cancer Rights Act of 1998. Specifically, Covered Medical Expenses include the following in connection with a mastectomy:

(i) Reconstruction of the breast on which the mastectomy was performed;

(ii) Surgery or reconstruction of the other breast to produce a symmetrical appearance; and

(iii) Prosthesis and physical complication of all stages of mastectomy, including lymphedemas.

(15) Sleep Studies:

(i) Benefits for Sleep Studies will only be provided when Covered Services are determined to be Medically Necessary by the Claims Administrator.

(ii) Covered Services must be recommended by a treating Physician.

(iii) Polysomnography and Multiple Sleep Latency Testing (MSLT) as well as any other services approved by the Claims Administrator must be performed in an approved sleep disorders center. Sleep Disorder Centers are facilities in which illnesses are diagnosed through the study of sleep.

(iv) The Sleep Disorder Center must be either freestanding or affiliated with a Hospital and must be accredited as a sleep disorder center by the American Academy of Sleep Medicine (AASM).

(v) Participating and Nonparticipating accredited facilities must adhere to the Claims Administrator's Medical Policy in order to support Medical Necessity for the Sleep Study.

(16) Occupational and physical therapy, limited to a total of 52 outpatient occupational and physical therapy visits per Member per Plan Year.

(17) Chiropractic treatments by a Chiropractor, limited to 52 outpatient treatments per Member per Plan Year.

3.4 **Special Accidental Injury Benefits**.

(a) If a Member incurs Covered Medical Expenses for treatment or services rendered or prescribed by a Physician as a direct result of a traumatic bodily injury sustained solely through accidental means and if treatment commences within 30 days after the date of such injury, payment or reimbursement will be made for Covered Medical Expenses actually incurred, but not to exceed a maximum allowance of $500 for all such Expenses incurred as the result of such injury. In no event will Covered Medical Expenses be paid pursuant to this Section 3.4 beyond a period of one year following the date of such injury. Once the $500 is exhausted, the Deductible Amount will apply and any other Covered Medical Expenses will be paid or reimbursed under any other provisions of the Plan which apply.

(b) Notwithstanding any other provisions of this Section 3.4, Covered Medical Expenses shall not be paid or reimbursed under this Section on account of services (rendered by a Physician, Hospital, or otherwise) or Supplies in connection with any dental care or treatment, dental or oral surgery, or dental appliances, except such charges made necessary within 30 days after accidental bodily injury sustained solely through external means and occurring while the patient is covered hereunder and limited further to dental treatment of injuries from such accident to natural teeth, including replacement of such teeth and setting of a jaw fractured or dislocated in such accident.

3.5 **Newborn Care**. When the condition of the child requires admission of the child to a Hospital for definitive or surgical reasons during or after the mother's maternity confinement, the child shall be eligible in its own right to Hospital, medical and surgical service benefits as provided and limited in the Plan, provided the newborn is enrolled as a Dependent in accordance with Section 2.2(b)(2) above.

3.6 **Rehabilitative Care**.

(a) Benefits for Inpatient Rehabilitation Services will only be provided when services are determined to be Medically Necessary by the Claims Administrator.

(b) Covered Services must be recommended by the treating Physician.

(c) A treatment plan outlining the goals of the Inpatient Rehabilitation Services must be submitted to the Claims Administrator by the Participating Provider before the initiation of the service.

(d) The Covered Services must have Utilization Management approval.

(e) Benefits are limited to 30 Inpatient days per Member per calendar year.

(f) The facility providing the Inpatient Rehabilitation Services must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF).

(g) No benefits will be provided if the Member receives services from a Nonparticipating Provider.

3.7 **Specified Human Organ and Tissue Transplant Benefits**. Subject to the other provisions of the Plan, Covered Medical Expenses include charges for treatment and care related to or required as a result of the transplant procedures outlined below:

(a) This Plan covers only the following organ or tissue transplant procedures: (1) Renal, (2) Heart, (3) Heart/Lung, (4) Liver, (5) Bone Marrow, and (6) other organ or tissue transplant procedures that the Utilization Management Firm determines to be Medically Necessary and effective procedures through the peer review process (which includes but is not limited to the review of peer review literature, second opinions and administrative policy in existence at the time of the request for the procedure). Procedures of this type will be considered on an individual basis. The aforementioned transplant procedures are subject to the following provisions:

(1) No benefits will be provided for a covered transplant procedure or a transplant evaluation unless the Member receives prior written approval from the Company, and the Utilization Management Firm pursuant to Section 5.5 below.

(2) Benefits for services related to or required as a result of a covered transplant procedure will be limited to a Lifetime Maximum of $250,000 per specific transplant type as defined in this section. Once the $250,000 is exhausted, no, further benefits will be provided for the specific transplant type. Benefits for high dose chemotherapy procedures performed in conjunction with any type of transplant procedure described herein are counted against the $250,000 limit for that transplant type.

(3) Benefits for surgical, storage and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ or tissue transplant procedure are limited to $10,000 per specific transplant type. The $10,000 is included in the Lifetime Maximum for each specific transplant as defined in Section 3.2 above.

(b) In addition to the provision set out in Section 3.7(a), benefits for tissue transplant procedures (autologous and allogeneic) will be further limited as follows:

(1) Benefits for bone marrow transplant (autologous and allogeneic), including any high dose chemotherapy treatment associated with such a transplant, are limited as follows:

(i) No benefits will be provided unless a prior approval for the bone marrow transplant is obtained in writing from the Company and the Management Utilization Firm.

(ii) Allogeneic bone marrow transplants or other forms of allogeneic stem cell rescue are not covered under the Plan except in the following cases:

(A) At least five of the six major histocompatability complex antigens match between the patient and the donor;

(B) The mixed leukocyte culture is non-reactive; and

(C) One of the following conditions is being treated:

1) Aplastic anemia;

2) Acute leukemia;

3) Hodgkin's lymphoma (Stage III A or IV B) and Stage IV intermediate or high grade lymphoma with bone marrow involvement;

4) Severe combined immunodeficiency,

5) Wiskott-Aldrich syndrome;

6) Infantile malignant osteoporosis;

7) Chronic myelogenous leukemia;

8) Stage III or IV Neuroblastoma in children over 1 year of age; or

9) Homozygous beta-thalassemia (thalassemia major).

(iii) All other uses of allogeneic or syngeneic bone marrow transplants or other forms of allogeneic stem cell rescue have been determined to be ineffective, not Medically Necessary, and/or Experimental/ Investigational, and thus are not covered under this Plan. These excluded transplants include, but are not limited to, the following cases:

(A) Cases in which four out of the six or fewer major histocompatibility complex antigens match;

(B) Cases in which mixed leukocyte culture is reactive;

(C) Polycythemia Vera;

(D) Intermediate or high-grade lymphoma other than Stage IV with bone marrow involvement and Hodgkin's lymphoma other than Stage III A or IV B;

(E) Multiple Myeloma; and

(F) Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus infection.

(iv) Autologous bone marrow transplants with or without autologous stem cell rescue, including any high dose chemotherapy treatment associated with such a transplant, are not covered under this Plan except for the following:

(A) Stage III or IV Hodgkin's disease which has recurred after an initial complete remission or is in first remission with poor prognostic factors, with no bone marrow involvement;

(B) Stage III or IV intermediate or high grade non-Hodgkin's lymphoma which has recurred after an initial complete remission, or is in first remission with poor prognostic factors, with no bone marrow involvement;

(C) Stage III or IV Neuroblastoma without bone marrow involvement;

(D) Acute lymphocytic or non-lymphocytic leukemia which has recurred after an initial complete remission or is in first remission with poor prognostic factors; and Germ cell tumors with no prospect for complete remission with standard dose therapy;

(E) Breast Cancer;

(F) Multiple Myeloma; and

(G) Ewing's Sarcoma (where tumor is metastatic or tumor is greater than 8 cm in size without metastases).

(v) Other forms of autologous bone marrow transplants or other forms of autologous stem cell rescue have been determined to be ineffective, not Medically Necessary, and/or Experimental/Investigational, and thus are not covered under this Plan. These excluded bone marrow transplants include, but are not limited to the following:

(A) Acute leukemia in first remission if poor prognostic factors are absent;

(B) Hodgkin's or non-Hodgkin's lymphoma in first remission if poor prognostic factors are absent;

(C) Intrinsic brain tumors;

(D) Ovarian cancer other than germ cell tumors;

(E) Lung cancer;

(F) Testicular cancer other than germ cell tumors;

(G) Colon cancer;

(H) Wilm's tumor; and

(I) Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus infection.

(c) Benefits specified in this Section 3.7(c) will be covered for solid organ and tissue transplant living donor coverage. If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient:

(1) Donor coverage includes expenses for:

(i) A search for matching tissue, bone marrow or organ.

(ii) Donor's transportation.

(iii) Charges for removal, withdrawal and preservation.

(iv) Donor's hospitalization.

(2) When only the recipient is a Member, the donor is entitled to the Benefits of this Benefit Plan which are not available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or other Blue Cross or Blue Shield coverage or any governmental program.

(3) When the donor is a Member, the donor is entitled to the Benefits of this Benefit Plan. No Benefits will be provided to the Non-Member transplant recipient.

(4) If any organ or tissue is sold rather than donated to the Member recipient, no Benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the Member's recipient Benefit Plan limit.

3.8 **Date Incurred**. A Covered Medical Expense shall be deemed to have been incurred on the date the service or supply shall have been received or rendered.

3.9 **Substance Abuse Treatment**. Billed or Maximum Charges, as the case may be, for Substance Abuse Treatment incurred by a Member will be Covered Medical Expenses paid or reimbursed as follows:

(a) 80% of the room and board charge for a semiprivate or private room in a Drug Abuse Treatment Facility or Alcohol Abuse Treatment Facility.

(b) 100% of inpatient and outpatient services, including room and board, provided by or through the Warren-Yazoo Mental Health Facility.

(c) 80% of all other Covered Medical Expenses.

The payment or reimbursement of Covered Medical Expenses with respect to all Substance Abuse Treatment incurred by a Member is subject to the limitations and exclusions set forth in Section 4.1(v) hereof.

3.10 **Nervous/Mental**.

(a) Billed or Maximum Charges, as the case may be, for treatment of structural or space occupying lesions of the brain causing intellectual or emotional disturbances are Covered Medical Expenses to be paid or reimbursed under other provisions of the Plan without limitation by this Section.

(b) Billed or Maximum Charges, as the case may be, for Nervous/Mental Conditions incurred by a Member will be paid or reimbursed as follows:

(1) 80% of Covered Medical Expenses for care on an inpatient basis provided, however, the payment or reimbursement of Covered Medical Expenses for care on an inpatient basis is limited to a maximum of thirty (30) annual days for each Member.

(2) 80% of Covered Medical Expenses for care on an outpatient basis; provided, however, the payment or reimbursement of Covered Medical Expenses for care on an outpatient basis is limited to a maximum of fifty-two (52) annual visits for each Member.

Covered Medical Expenses will not include career or job counseling, but may include counseling by an EAP or other provider of treatment for Nervous/Mental Conditions.

3.11 **Multiple Surgical Services**. When multiple Medically Necessary procedures (concurrent, successive, or other multiple surgical services) are performed at the same surgical setting, the Maximum Charge will be as follows:

(a) Primary Procedure.

(1) The primary, or major procedure, will be the procedure with the greatest value based on the Maximum Charge.

(2) Benefits for the primary procedure will be based on the lesser of the Maximum Charge or Billed Charge.

(b) Secondary Procedure(s).

(1) The secondary procedure(s) is a procedure(s) performed in addition to the primary procedure which adds significant time, risk or complexity to the Surgery.

(2) The secondary procedure(s) is paid at 50% of the lesser of the Maximum Charge or Billed Charge for the procedure.

(c) Incidental Procedure.

(1) The incidental procedure is one which is a routine part of a primary or secondary procedure or one for which the Medical Necessity for performing such procedure is not documented.

(2) No Benefits are provided for incidental procedures.

(d) Accidental Injury Cases.

In accidental injury cases, benefits will be based on the lesser of the Maximum Charge or Billed Charge for each Medically Necessary procedure(s) required to repair the injury received in an accident. The procedure(s) must be performed within 72 hours of the accident. Otherwise, multiple surgery guidelines apply as outlined in this Section.

3.12 **Assistant at Surgery**.

(a) The assistant surgeon is a Physician/surgeon who assists the primary surgeon in the performance of a covered surgical procedure. Benefits for an assistant surgeon will be provided only if the Utilization Management Firm determines that the Medical Necessity for an assistant surgeon is documented.

(b) When the need for an assistant surgeon is documented to be Medically Necessary, benefits will be based on 20% of the benefit payable for the surgical procedures.

3.13 **Anesthesia**.

(a) Benefits will be provided for general anesthesia service when requested by the attending Physician and performed by a nurse anesthetist or Physician, other than the operating Physician or the assistant, for covered surgical services. Benefits will also be provided for other forms of anesthesia services as defined and approved by Company.

(b) Benefits for administration of anesthesia will be based on the lesser of Billed Charge or Maximum Charge for anesthesia administration, as determined by the primary surgical procedure performed.

(c) Supervision of anesthesia administration included pre-operative, operative, and post-operative supervision of anesthesia care. Benefits for supervision of anesthesia administration will be less than those provided for administration of

anesthesia. These benefits will be based on the lesser of Billed Charge or Maximum Charge for anesthesia supervision as determined by the primary surgical procedure performed.

3.14 **Outpatient Cardiac Rehabilitation**.

(a) No benefits will be provided unless the Member or Provider receives Utilization Management approval for the services from the Claims Administrator.

(b) Rehabilitation services must be rendered by a facility that is a Participating Provider and holds a current certification from the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). No benefits will be provided when you receive services from a Nonparticipating Provider.

(c) Benefits must be recommended by the Member's treating Physician.

(d) A treatment plan outlining the goals of the Outpatient Cardiac Rehabilitation must be submitted to the Claims Administrator by the Participating Provider before the initiation of the services.

(e) Outpatient Cardiac Rehabilitation Services must be initiated within 3 months after the Member's discharge from the Hospital.

(f) The number of visits for Outpatient Cardiac Rehabilitation Services are based on the severity of the Member's condition; however, Members cannot exceed 36 visits per Calendar Year.

(g) No benefits will be provided for Pulmonary Rehabilitation (a multidisciplinary continuum of services directed to persons with pulmonary diseases and their families, usually by an interdisciplinary team of specialists, with the goal of achieving and maintaining the individual's maximum level of independence and functioning in the community).

3.15 **Nurse Practitioner Network**. When a Member covered under the Plan visits a Network Nurse Practitioner, he or she benefits from the following services:

(a) The Network Nurse Practitioner will directly bill the Claims Administrator for the Covered Medical Expenses of the Member. Non-Network Nurse Practitioners may require the Member to submit the claim to Member.

(b) The Network Nurse Practitioner will accept the amount of the Covered Medical Expense as payment in full for the services and Medical Supplies provided to the Member. The Network Nurse Practitioner will not balance bill the Member. A Non-Network Nurse Practitioner is not required to accept the amount of the Covered Medical Expenses as payment in full. This provider can balance bill the Member if the Billed Charge exceeds the Maximum Charge.

3.16 **Optometrist Network**. When Members covered under the Plan visit a Participating Optometrist (other than for routine eye exams and vision care), for treatment of conditions of the eye, he or she benefits from the following services:

(a) The Participating Optometrist will directly bill the Claims Administrator for Covered Services rendered to the Member. A Nonparticipating Optometrist may require the Member to submit the claim to the Plan.

(b) The Participating Optometrist will accept the amount of the Covered Medical Expense as payment in full for the services and Medical Supplies provided to the Member. The Participating Provider will not balance bill the Member. A Non-Participating Optometrist is not required to accept the amount of the Covered Medical Expense as payment in full. This provider can balance bill the Member if the Billed Charge exceeds the Maximum Charge.

Optometrist services and supplies are subject to the limitations of Section 4.1(f).

3.17 **Chiropractic Network**. When Members covered under the Plan visit a Participating Chiropractor, he or she benefits from the following services:

(a) The Participating Chiropractor will directly bill the Claims Administrator for Covered Services rendered to the Member. A Nonparticipating Chiropractor may require the Member to submit the claim to the Plan.

(b) The Participating Chiropractor will accept the amount of the Covered Medical Expense as payment in full for the services and Medical Supplies provided to the Member. The Participating Provider will not balance bill the Member. A Non-Participating Chiropractor is not required to accept the amount of the Covered Medical Expense as payment in full. This provider can balance bill the Member if the Billed Charge exceeds the Maximum Charge.

Chiropractic treatments are subject to the limitations of Section 3.3(c)(17).

3.18 **Wellness/Preventive Care**. Wellness and Preventive Care is available only through Participating Providers and subject to the limitations set forth in this Section.

(a) Diabetes Treatment. The following shall be treated as Covered Medical Expenses:

(1) Equipment, Supplies for the monitoring of blood glucose and insulin administration.

(2) Self-Management Training/Education and Medical Nutrition Therapy (Limited to $250 per Calendar Year maximum).

(3) For Members diagnosed as diabetic by a Physician, one routine eye exam per Plan Year and one routine foot care exam per Plan Year.

(b) Outpatient Preventive/Wellness Benefit: 100% of the Covered Medical Expenses for preventive/wellness Physician office visits and other services, limited to $200 per Member per calendar year.

(c) Immunizations for Children: 100% of the Covered Medical Expenses for immunizations through the date the Member is 24 months of age.

(d) Mammography: 100% of the Covered Medical Expense for one (1) screening per Calendar year for female Members 35 years of age or older.

ARTICLE IV
LIMITATIONS AND EXCLUSIONS

Notwithstanding any other provisions of this Plan, benefits will be limited and conditioned as follows:

4.1 **No Payment Or Reimbursement Shall Be Provided Hereunder For The Following.**

(a) Services or Supplies because of any illness or injury arising out of or in the course of any occupation or employment entitling the Member to benefits under any workers' compensation, occupational disease or employer liability law, or for which the Member's employer accepts liability.

(b) Services or Supplies for which a Member is not legally responsible to pay.

(c) Services or Supplies because of diseases contracted or injuries sustained while covered under the Plan as a result of war, declared or undeclared, or any act of war.

(d) Except as provided in Section 3.3(c)(7), services of a Physician for dental care and treatment and dental surgery, dental appliances or Dental Implants.

(e) Hospital services and Supplies as provided in Section 3.3(a), for dental care and treatment and dental surgery unless the inpatient Hospital stay was deemed Medically Necessary due to the age of the patient or the complexity of the procedure.

(f) Eyeglasses, hearing aids or for examination or fittings therefor, with the exception of eye exams for diabetic Members, as outlined in Section 3.18(a).

(g) Services or Supplies for cosmetic purposes, or complications arising from cosmetic procedures, or reversal of cosmetic procedures, or complications arising from reversal of cosmetic procedures, except for correction of defects incurred by the patient while covered hereunder through traumatic injuries or diseases requiring surgery and as provided in Section 3.3(c)(14).

(h) Services or Supplies not Medically Necessary for treatment of injury, congenital defect or illness.

(i) Treatment, services or Supplies for obesity unless Medically Necessary.

(j) Convalescent, custodial or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a Physician for a Member who is mentally or physically disabled as a result of retarded development or body infirmity, or who is not under specific medical, surgical or psychiatric treatment

to reduce his disability to the extent necessary to enable him to live outside an institution providing care; neither shall benefits be provided if the Claims Administrator or Utilization Management Firm determines that the Member was admitted to a Hospital for his own convenience, or that the care or treatment provided did not relate to the condition for which the patient was hospitalized, or that the Hospital stay was excessive for the nature of the injury or illness.

(k) Hospice care or services.

(l) Services or Supplies provided under any federal, state or governmental plan or law including but not limited to Medicare, if the Member is eligible for, and elects to obtain primary coverage under, Medicare Part A or B (Title XVIII, Social Security Act, as amended), to the extent charges for such services or Supplies are paid or payable under Medicare; however, benefits of this Plan will be provided when so required by federal law.

(m) Treatments for Nervous/Mental Conditions of a patient in excess of the number of treatments provided for in Section 3.10.

(n) Podiatry services, Supplies or treatments not constituting or not in association with "surgery" within the generally accepted meaning of that term by the medical profession; non-covered services include, but are not limited to, treatment of subluxations of the foot and routine foot care, such as cutting or removal of corns or calluses, the trimming of nails, routine hygiene care and the like.

(o) Any injury growing out of an act or omission of another party for which injury that party or some other party makes settlement or is legally responsible; provided, however, that if the Member is unable to recover from the responsible party, benefits of this Plan shall be provided, unless otherwise provided in Section 11.11.

(p) Claims under more than one part of this Plan, including any amendatory riders hereto, whether issued simultaneously herewith or later. Benefits will be allowed only on the basis of the part providing the greatest allowance.

(q) Procedures, services or Supplies which are Experimental/Investigative in nature.

(r) "Sitter"-type services and private duty nurses, unless approved by the Utilization Management Firm.

(s) Services and Supplies related to infertility, artificial insemination and in-vitro fertilization, irrespective of any claim of Medical Necessity.

(t) Treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies, regardless of Medical Necessity.

(u) Elective termination of pregnancy unless Medically Necessary.

(v) Substance Abuse Treatment except:

(1) Covered Medical Expenses will not be paid or reimbursed in excess of $7,500, during any Benefit Period.

(2) Covered Medical Expenses will not be paid or reimbursed in excess of $15,000 lifetime maximum benefits.

(3) Out-of-pocket charges for Covered Medical Expenses incurred for Substance Abuse Treatment cannot be used to satisfy the out-of-pocket limitations of Section 3.1 of this Plan.

(w) Outpatient prescription drugs that are determined by the Claims Administrator not to be Medically Necessary for the treatment of illness or injury. These drugs include but are not limited to the following:

(1) Drugs used for cosmetic purposes or weight reduction.

(2) Investigative/Experimental drugs, and drugs used other than for the FDA approved diagnosis.

(3) Fertility drugs.

(4) Drugs that do not require a prescription.

(5) Nutritional supplements.

(6) Immunizations for prevention of infectious diseases (measles, polio, etc.), except as allowed for children under Section 3.18.

(x) Preventive procedures, including routine check-ups, gynecological examination/pap smears and mammography screening, except as provided under Section 3.18 above.

(y) Expenses incurred before the Member's coverage hereunder begins, or after his coverage ceases.

(z) Services or Supplies relating to pregnancy or childbirth of any Dependent other than a Member who is the spouse of the Employee.

(aa) Services or Supplies related to reversal of sterilization.

(bb) Services or Supplies related to penile implants or enlargements, or complications arising therefrom or from reversal thereof.

(cc) Home infusion treatments, unless they meet the definition of "Home Infusion Therapy," or other home health care, except specifically covered elsewhere in the Plan.

(dd) Immunizations for prevention of infectious diseases (measles, polio, etc.), except as allowed under Section 3.18.

(ee) Any treatment, services or Supplies which are due to or result from the Member's commission of or attempt to commit an assault, felony, or other illegal act.

(ff) Any treatment, services or Supplies which are due to or result from the Member engaging in any illegal occupation.

(gg) Services received at a Residential Treatment Facility for the treatment of nervous/mental disorders, Substance Abuse Treatment, and eating disorders.

(hh) Expenses relating to construction in a home, in order to accommodate Durable Medical Equipment.

(ii) Speech therapy visits in excess of the visits provided in Section 3.3(c)(12).

(jj) Occupational and physical therapy visits in excess of the visits allowed in Section 3.3(c)(16).

(kk) Chiropractic treatments by a Chiropractor in excess of the treatments allowed in Section 3.3(c)(17).

4.2 **In Addition No Benefits Shall Be Provided Hereunder For The Following**.

(a) Deductible Amount as defined in Section 1.14 hereof, and co-payment or out-of-pocket amounts required under the Plan.

(b) Travel, whether or not recommended by a Physician, except in the case of organ donors, as specifically provided in Section 3.7(c)(1)(ii).

(c) Services rendered by a Physician not practicing within the scope of his license.

(d) Hospitalization primarily for X-ray examinations, laboratory examinations, basal metabolism tests or electrocardiograms if it would not otherwise be necessary to occupy a Hospital bed.

(e) Diagnostic services for the testing of Human Immunodeficiency Virus (HIV) except as approved by the Claims Administrator as Medically Necessary.

(f) Any amount in excess of the applicable Covered Medical Expense.

ARTICLE V
UTILIZATION MANAGEMENT FIRM AND CERTIFICATION

The Utilization Management Firm will assist Physicians and Members in determining the appropriate level of care in a given circumstance.

5.1 **Certification Of Elective Admissions And Certain Non-Emergency Procedures**.

(a) It is the sole responsibility of the Member to ensure that his Physician or Hospital, or a representative thereof, notifies the Utilization Management Firm of the nature and purpose of any elective or non-emergency inpatient Hospital admission, Home Infusion Therapy, Rehabilitative Care, home health care, treatment for Nervous/Mental Conditions, or Substance Abuse Treatment, prior to such admission or treatment. The Utilization Management Firm will, after consultation with the treating Physician, determine whether or not the admission and elective services are Medically Necessary, the most appropriate setting for the elective service and the appropriate length of stay. Should a Member fail to notify the Utilization Management Firm in advance of any elective or non-emergency inpatient Hospital admission, the Hospital stay and elective services will nevertheless be reviewed by the Utilization Management Firm to determine whether or not the admission and elective services were Medically Necessary.

(b) Outpatient Procedures: When a Member utilizes a Participating or Non-Participating Provider, it is the Provider's responsibility to ensure compliance with all Medical Policy related to outpatient diagnostic and surgical procedures. It is within Claims Administrator's discretion to require the Provider or the Member to pre-certify certain outpatient diagnostic and surgical procedures. A Member seeking or receiving outpatient treatment for Nervous/Mental Conditions should notify the Utilization Management Firm or cause his provider to do so; however, no certification or approval will be required.

5.2 **Certification Of Other Procedures**. It is the sole responsibility of the Member to ensure that his Physician or Hospital, or a representative thereof, notifies the Utilization Management Firm of the nature and purpose of any transplant under Section 3.7 or of any other procedure or service for which certification is required by any provision of this Plan. The Utilization Management Firm will, after consultation with the treating Physician, determine whether or not such transplant or other procedure or service is Medically Necessary. Should a Member fail to notify the Utilization Management Firm in advance of any such transplant or other procedure or service, the Utilization Management Firm shall nevertheless review the same to determine its Medical Necessity.

5.3 **Certification Of Emergency Admissions**. It is the sole responsibility of the Member to ensure that his Physician or Hospital, or a representative thereof, notifies the Utilization Management Firm of any emergency inpatient Hospital admission within 48 hours of such admission, regarding its nature and purpose. In the event that the end of the notification

period falls on a holiday or weekend, the Utilization Management Firm must be notified on its next working day. The Utilization Management Firm will determine whether or not the emergency inpatient Hospital admission was Medically Necessary and will consult with the treating Physician regarding the appropriate length of stay for the Member. Should a Member fail to notify the Utilization Management Firm within 48 hours of any emergency inpatient Hospital admission, the Hospital stay and related services will nevertheless be reviewed by the Utilization Management Firm to determine whether or not the admission and services were Medically Necessary.

5.4 **Continued Stay Review**. It is expected that the Utilization Management Firm and treating Physician will establish a review date to determine the appropriateness of continued hospitalization beyond the length of stay and level of care initially determined to be Medically Necessary. It is the responsibility of the Utilization Management Firm to contact the Physician or Hospital, or a representative thereof, on or before the review date.

5.5 **Solid Organ And Tissue Transplant**. No benefits related to a solid organ or tissue transplant will be provided under the Plan unless, prior to Hospital admission for such transplant, the Company or Employer has received written approval therefor from the Utilization Management Firm. The Member must file a written request for approval of the transplant with the Utilization Management Firm and must provide it with adequate information to verify coverage, determine Medical Necessity, and approve of the Hospital at which the transplant will occur. The Utilization Management Firm will forward its written determination to the Member, the Employer and applicable providers.

5.6 **Individual Case Management**. The Employer, Company and/or Utilization Management Firm will select Members for the Individual Case Management program based on various criteria including diagnosis, severity and/or prior history of illness or injury, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available benefits.

5.7 **Alternative Benefit Plans**.

(a) When the Utilization Management Firm determines that benefits should be provided to cover specific services not otherwise covered under this Plan in order to achieve the most efficient and effective use of medical resources, an Alternative Benefit Plan will be recommended after consultation among the Utilization Management Firm, Member's treating Physician, the Member (or Member's representative), other Physicians as appropriate, and the Employer. The Alternative Benefit Plan will not be implemented until it has been reduced to writing and signed by the Member (or Member's representative), the treating Physician, other Physicians as appropriate, and the Employer.

(b) The Utilization Management Firm's determination that a particular Member's medical condition and circumstances render the Member a suitable candidate for an Alternative Benefit Plan will not obligate the Utilization Management Firm or the Employer to make the same or similar determination for any other Member;

nor will the provision of an Alternative Benefit Plan to a Member entitle any other Member to an Alternative Benefit Plan or be construed as a waiver of the Company's and Employer's right to administer and enforce this Plan in accordance with its express terms.

(c) Except as otherwise expressly provided in the written Alternative Benefit Plan, all terms and conditions of this Plan, including but not limited to Lifetime Maximum Benefits and all other limitations and exclusions, will be and remain in full force and effect with respect to a Member subject to an Alternative Benefit Plan.

(d) The benefits provided under an Alternative Benefit Plan are provided in lieu of the benefits to which the Member is entitled under this Plan.

(e) The Utilization Management Firm will terminate a Member's Alternative Benefit Plan upon any of the following occurrences:

(1) The Member receives care, treatment, services, or Supplies on account of the medical condition which is the subject of the Alternative Benefit Plan other than as set forth in the Alternative Benefit Plan.

(2) The Member exhausts his Lifetime Maximum Benefit under this Plan; the Member ceases to be eligible to receive benefits under the terms of this Plan; the Member is no longer covered under the terms of this Plan; this Plan is amended or terminated so as to eliminate the Member's eligibility to receive benefits and/or coverage under the terms of this Plan; or any other event occurs that, under the terms of this Plan, results in the Member's ineligibility to receive benefits and/or loss of coverage under this Plan.

ARTICLE VI
COORDINATION OF BENEFITS

6.1 **Coordination Of Benefits**.

(a) This Coordination of Benefits ("COB") article applies to This Plan when a Member has health care coverage under more than one plan. "This Plan," "Plan" and other capitalized terms used in this COB article are defined below.

(b) If this COB article applies, the Order of Benefit Determination Rules set forth in Section 6.3 should be applied first. Those Rules determine whether the benefits of This Plan are determined before or after those of another plan. Benefits will be coordinated on a calendar year basis. The benefits of This Plan:

(1) Will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another plan.

(2) But, may be reduced when, under the Order of Benefit Determination Rules, another plan determines its benefits first. That reduction is described in Section 6.4.

6.2 **Definitions Applicable Only To Article VI**.

(a) A "plan" means any health plan that provides services, supplies, or equipment for hospital, surgical, medical, or dental care or treatment, including but not limited to, coverage under group or individual insurance policies, non-profit health service plans, health maintenance organizations, subscriber contracts, self-insured group plans, pre-payment plans, automobile (including no fault auto insurance, by whatever name it is called, when not prohibited by law) or homeowners medical pay plans, and Medicare as permitted by federal law. This does not include Medicaid, hospital daily indemnity plans, specified diseases only policies, or limited occurrence policies which provide only for intensive care or coronary care in the hospital.

Each plan or other arrangement for coverage is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

(b) "This Plan" means the part of this Group Medical Plan, as from time to time amended, that provides benefits for health care expenses.

(c) "Primary Plan"/" Secondary Plan":

(1) "Primary Plan" means the plan under which a person's benefits are determined, in accordance with the Order of Benefit Determination Rules, before his benefits under another plan and without considering the other plan's benefits.

(2) "Secondary Plan" means the plan under which a person's benefits are determined, in accordance with the Order of Benefit Determination Rules, after his benefits under another plan, the benefits of the Secondary Plan being subject to reduction because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

(d) "Allowable Expense" means an expense for health care covered at least in part by one or more plans covering the person for whom the claim is made. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because a covered person does not comply with the Primary Plan's provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to Second Surgical Opinions, pre-certification prior to admissions or services, and preferred provider arrangements.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or Network provider has agreed to accept as payment in full. When an HMO or network plan is primary and the Covered Individual does not use an HMO or network provider, this Plan will not consider as an Allowable Expense any expense that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

When dental payments are available under vehicle insurance, this Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the Secondary Plan regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

(e) "Claim Determination Period" means the calendar year during which a person covered by This Plan is eligible to receive benefits under the provisions of This Plan.

(f) "Group Coverage" means plans or policies which can be obtained only because of employment with or membership in a particular organization, corporation, or other business entity.

(g) "Individual Coverage" means any plan, contract, or policy (other than Group Coverage) which provides benefits, care, or treatment for an illness or injury and which is sold directly to an individual.

The term "Individual Coverage" will include any conversion contract or policy issued directly to a person upon termination of group eligibility.

(h) "Coordination of Benefits" or "COB" means a mechanism, whether in This Plan or another plan, for determining priority among two or more plans applicable to the same claim.

6.3 **Order Of Benefit Determination Rules**.

(a) When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan if the other plan contains no provision for Coordination of Benefits. If This Plan and another plan both contain Coordination of Benefit provisions, the plan that provides Group Coverage will be the Primary Plan. If both plans provide Group Coverage or if both provide Individual Coverage, then This Plan is a Secondary Plan which has benefits determined after those of the other plan, unless:

(1) the other plan has COB rules coordinating its benefits with those of This Plan, and,

(2) both the other plan's COB rules and This Plan's COB rules, set forth in Section 6.3(b) below, require that This Plan's Benefits be determined before those of the other plan.

(b) This Plan provides for Coordination of Benefit payments, as follows:

(1) Non-dependent/Dependent: The benefits of the plan which covers the person as an employee (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(i) secondary to the plan covering the person as a dependent, and

(ii) primary to the plan covering the person as other than a dependent (e.g., a retired employee),

then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

(2) Dependent Child/Parents Not Separated or Divorced: Except as stated in Section 6.3(b)(3) below, when This Plan and another plan cover the same child as a dependent of different persons called "parents" within the meaning of This Plan and the other plan:

(i) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(ii) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

(3) Dependent Child/Separated or Divorced Parents: If two or more plans cover a person who is a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(i) First, the plan of the parent with custody of the child.

(ii) Then, the plan of the spouse of the parent with custody of the child.

(iii) Finally, the plan of the parent not having custody of the child.

However, if specific terms of a court decree, including a QMCSO, state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply when any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody: If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the Order of Benefit Determination Rules outlined in this article.

(5) Active/Inactive Employee: The benefits of a plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. 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 Section 6.3(b)(5) is ignored.

(6) 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 following will be the Order of Benefit Determination:

(i) First, the benefits of a plan covering the person as an employee or dependent (or as an employer's or subscriber's dependent).

(ii) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the Order of Benefits, the rule of the other plan will govern.

(7) Longer/Shorter Length of Coverage: If none of the above Coordination of Benefits rules determine the Order of Benefits, the benefits of the plan which covered an employee or subscriber longer are determined before those of the plan which covered that person for the shorter time.

6.4 **Effect On The Benefits Of This Plan**.

(a) This Section 6.4 applies when, in accordance with Section 6.3, This Plan is a Secondary Plan as to one or more other plans. In that event This Plan will provide benefits based on the difference between the amount the other plan or plans paid and the Maximum Charge for services covered under the terms of This Plan. Additionally, in the event the amount that the Primary Plan pays exceeds the Maximum Charge for services covered under the terms of This Plan, This Plan will incur no secondary liability. In no event will the amount This Plan provides as the Secondary Plan exceed the amount it would have provided as the Primary Plan. Benefits provided under This Plan pursuant to this COB provision are subject to the lifetime Maximum Benefits.

(b) Reduction in This Plan's benefits. The benefits of This Plan will be reduced when the sum of

(1) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision, and

(2) the benefits that would be payable for the Allowable Expenses under the other plans in the absence of COB provisions, whether or not claims are made,

would be more than the expense or charge which gave rise to the applicable claim for benefits. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than Allowable Expenses. Benefits provided under This Plan pursuant to this COB provision are subject to the Lifetime Maximum Benefits.

6.5 **Coordination With Medicare**.

(a) Under This Plan, each Employee, aged 65 or older, and each Employee's spouse aged 65 or older, may elect to have coverage under This Plan or under Medicare.

(1) When such Employee or such spouse elects coverage under This Plan, This Plan will be the Primary Plan with the Medicare program the Secondary Plan.

(2) This Plan will not provide benefits to supplement Medicare payments for an Employee aged 65 or older or for a spouse of an Employee aged 65 or older when such Employee or such spouse elects to have the Medicare program as the Primary Plan.

(b) Except as provided in Section 6.5(c), This Plan is the Primary Plan for an Employee under the social security retirement age, as defined in 42 U.S.C. § 416(1), or such Employee's Dependent under the social security retirement age, as defined in 42 U.S.C. § 416(1), who also has coverage under the Medicare program by reason of disability determined under the Social Security Act, and Medicare is the Secondary Plan.

(c) For Members under the social security retirement age, as defined in 42 U.S.C. § 416(1), who are also eligible for coverage under the Medicare program solely by reason of end-stage renal disease, the Medicare program will be the Primary Plan and This Plan the Secondary Plan except that during the first 30-month period that such persons are eligible for Medicare benefits solely by reason of end-stage renal disease, This Plan will be the Primary Plan and Medicare the Secondary Plan.

(d) When This Plan is the Primary Plan, it will provide regular benefits toward Allowable Expenses. When This Plan is the Secondary Plan, it will provide benefits not to exceed the difference between Allowable Expenses and the amount paid by Medicare (or the difference between the Medicare approved charge and the amount Medicare paid if assignment is accepted by the Physician); provided, however, if a Member is eligible for but does not maintain Medicare coverage (because of failure to pay premiums or otherwise to comply with requirements for maintaining Medicare coverage) when the Medicare coverage would be the Primary Plan hereunder, the benefits provided by This Plan will be limited to the amount This Plan would pay if such Member actually had Medicare coverage as the Primary Plan.

6.6 **Right To Receive And Release Needed Information**. The Claims Administrator has the right to decide to which facts it needs to apply these COB rules and the right to obtain needed facts from, or give them to, any other organization or person without notice to or consent from any other person. Submission of a claim for benefits under This Plan shall constitute permission of the claimant to the Claims Administrator to obtain or provide any facts relevant to a COB determination, and the claimant shall be obligated to cooperate with and assist the Claims Administrator in such determination in any manner reasonably requested by the Claims Administrator. The Claims Administrator has the right to deny claims until it receives "other insurance" information needed to administer the COB rules.

6.7 **Facility Of Payment**. A payment made under another plan may include an amount which should have been paid under This Plan. The Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case the payment made will be deemed to be the reasonable cash value of such benefits.

6.8 **Right Of Recovery**. If the amount of the payments made by the Claims Administrator is more than it should have paid under this COB provision, it may recover the excess. It may get such recovery or payment from one or more of:

(a) The persons it has paid or for whom it has paid.

(b) Insurance companies.

(c) Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

ARTICLE VII
AMENDMENT OR TERMINATION OF THE PLAN

7.1 **Amendments**. The Company has the right to amend, change or modify the Plan, in whole or in part, at any time and for any reason, including, without limitation, to make changes in eligibility for participation or the benefits herein provided (including changes to, or elimination of, the coverage, if any, provided to retired Employees). All amendments shall require approval by the Company's Board of Directors. The participation in the Plan of Employers other than the Company shall not limit the power of the Company to amend the Plan, and any amendment to the Plan shall be binding upon all other Employers except as otherwise specifically provided.

7.2 **Termination**. The Board of Directors of the Company reserves the right to terminate the Plan at any time and for any reason. The Board of Directors of the Company further reserves the right to remove, in its sole discretion, any Employer from participation in the Plan. In addition, any Employer may withdraw from participation in the Plan at any time and for any reason.

7.3 **Disposition Under Termination**. Should the Plan be terminated by the Company, such termination will become effective as of the date specified by the Board of Directors of the Company. However, after such termination, the Company shall continue to function as the Plan Administrator for the sole purpose of winding up the affairs of the Plan, which shall include continuing Plan benefits to the then-enrolled Members for Covered Medical Expenses incurred prior to such termination.

7.4 **Termination By Employer**. If an Employer is eliminated from participation or elects to withdraw from participation in the Plan, the Plan shall continue with respect to the Employees of other still participating Employers and their Dependents. The termination of the participation of any Employer by the Company shall be effective upon receipt by such Employer of written notice of the action of the Company effecting such termination; likewise, the withdrawal from participation in the Plan by any Employer shall be effective upon receipt by the Company of written notice of the action of such Employer effecting such withdrawal. After such termination or withdrawal, the Company shall continue to function as the Plan Administrator for the sole purpose of winding up the affairs of the Plan with respect to such terminated or withdrawn Employer, which shall include continuing Plan benefits to the then-enrolled Employees of such terminated or withdrawn Employer and their Dependents.

ARTICLE VIII
CONTRIBUTIONS

8.1 **Employee Contributions**. Employees shall pay the rate of contribution applicable to the Coverage Option selected by the Employee under the Plan, which the Company may prescribe from time to time, including contributions which may be required for Dependents. The rate of contributions paid by the Employee will vary depending on the Coverage Option the Employee selects. The Company shall advise eligible Employees of the rates of contribution for each Coverage Option and the rates of contribution for Employee-Only and various levels of Dependent Coverage under each of the Plan's Coverage Options. However, if an Employee selects the Opt-Out Coverage Option, the Employee and his Dependents will have no coverage under the Plan and no Employee contributions will be required.

The Company may establish different rates of contribution among separate groups or classes of Employees. In establishing such contribution classes and fixing the respective contribution rates, the Company may consider the variation (if any) in the amounts of benefits applicable to each class, the variations in the cost of medical and Hospital services among different geographical areas, and such other considerations as the Company may deem to be appropriate. The Company may amend class designation and contribution rates from time to time at its discretion.

8.2 **Changes In Contribution Class**. If an Employee's status changes from one contribution class to another (whether resulting in a greater or lesser contribution rate), the rate of contribution payable with respect to the new class shall become effective as of the beginning of the next pay period of such Employee. Election of and changes in any pre-tax Employee contributions are further subject to the terms and conditions of the Company's IRC §125 cafeteria plan.

8.3 **Participation Of Other Employers**. The Company and each participating Employer shall have the obligation to pay the contributions for its own Employees and their Dependents, and no other Employer shall have such obligation. Any failure by any Employer to live up to its obligation shall have no effect on any other Employer.

ARTICLE IX
ADMINISTRATION

9.1 **Administrator**. The Company shall be the Plan Administrator.

9.2 **Named Fiduciary**. The Company shall be the named fiduciary of the Plan and shall have the authority to control and manage the operation and administration of the Plan and to interpret the Plan in accordance with Section 9.3 below. Interpretations of the Plan by parties other than as provided in Section 9.3 below shall be void and of no effect as to the Plan and payments or reimbursements hereunder.

9.3 **Powers And Duties Of The Claims Administrator, The Utilization Management Firm, The Plan Administrator and Review Panel**. In order to effectuate the purposes of the Plan, the following parties shall have the discretionary authority to interpret and construe the Plan, to determine whether and to what extent Members are eligible for coverage and benefits under the Plan, to supply omissions and reconcile inconsistencies in the Plan, and to make equitable adjustments for any mistakes or errors made in the administration of the Plan, each in the area indicated and as otherwise specifically set forth herein:

(a) The Claims Administrator with respect to the initial processing and payment of claims, and the establishment of Maximum Charges and Allowable Charges;

(b) The Utilization Management Firm with respect to certification of the Medical Necessity of Hospital or medical treatment, services and Supplies;

(c) The Company or its designee with respect to the control and management of the operation and administration of the Plan and interpretation of the Plan, including determination of eligibility and coverage questions; or

(d) The Review Panel with respect to the review of denied claims;

and all such action or determinations made by the Claims Administrator, the Utilization Management Firm, the Company and the Review Panel in good faith shall not be subject to review by anyone, except as may be specifically provided herein. The Company shall exercise such other powers and perform such other duties as it may deem necessary, desirable, advisable or proper for the supervision and administration of the Plan.

An agent/broker has no authority to interpret, waive, alter or change the Plan or any of its provisions. If a Member has any questions, including contract terms, coverage or benefit questions, the Member should contact the Claims Administrator. An agent/broker has no authority to bind the Plan with any answer he or she may give.

9.4 **Delegation Of Responsibility**. The Company may delegate any of its fiduciary powers, responsibilities, duties and obligations under the Plan to other such persons who are not named fiduciaries to carry out such fiduciary responsibilities. Any delegation of fiduciary responsibility to other persons shall be by written agreement between the Company and the person designated.

9.5 **Rules And Regulations**. The Company and to the extent specifically delegated by the Company, the Claims Administrator, the Utilization Management Firm and the Review Panel, shall have the authority to make such rules and regulations and to take such actions as may be necessary to carry out the provisions of the Plan and will, subject to the provisions of the Plan, decide any questions arising in the administration, interpretation and application of the Plan, which decision shall be conclusive and binding on all parties. The Company may delegate any part of its authority and duties as it deems expedient and may withdraw such delegation at any time.

9.6 **Indemnification**. In the event and to the extent not insured against under any contract of insurance with an insurance company, the Company shall indemnify and hold harmless each "Indemnified Person," as defined below, against any and all claims, demands, suits, proceedings, losses, damages, interest, penalties, expenses (specifically including, but not limited to counsel fees to the extent approved by the Company or otherwise provided by law, court costs and other reasonable expenses of litigation), and liability of any kind, including amounts paid in settlement, with the approval of the Board of Directors, arising from any action or cause of action related to the Indemnified Person's act or acts or failure to act. Such indemnity shall apply regardless of whether such claims, demands, suits, proceedings, losses, damages, interest, penalties, expenses, and liabilities arise in whole or in part from (i) the negligence or other fault of the Indemnified Person, except when the same is judicially determined to be due to gross negligence, fraud, recklessness, willful or intentional misconduct of such Indemnified Person or (ii) from the imposition on such Indemnified Person of any penalties or excise taxes under ERISA or the Code. This paragraph shall not be deemed to supersede, limit or diminish any other indemnification arrangement covering an Indemnified Person. "Indemnified Person" shall mean each member of the Review Panel and each other Employee, officer or director who is allocated fiduciary responsibility hereunder.

9.7 **Fiduciaries**. The powers and duties of each fiduciary with respect to the Plan shall be limited to those specifically delegated to each of them under the terms of the Plan. None of the allocated responsibilities or any other responsibilities shall be shared by two or more fiduciaries unless such sharing shall be provided by a specific provision in the Plan. Whenever one fiduciary is required by the Plan to follow the directions of another fiduciary, the two fiduciaries shall not be deemed to have been assigned share responsibility; but the fiduciary giving the direction shall be solely responsible for such direction, and the responsibility of the fiduciary receiving such direction shall be to follow the same insofar as the same on its face is not improper under applicable law.

Any person or entity may serve in more than one fiduciary capacity with respect to the Plan. The Company or other fiduciary under the Plan may employ one or more persons to render advice with respect to any responsibility such fiduciary has under the Plan.

9.8 **Applicable Law**. The Plan will, unless preempted by federal law, be construed and enforced according to the laws of the State of Mississippi and all provisions of the Plan will, unless preempted by federal law, be administered according to the laws of the said state.

9.9 **Member Change of Address**. Members must provide the Plan Administrator with a correct address if they undergo a change of address.

ARTICLE X
CLAIMS PROCEDURES

10.1 **Claim Filing and Request for Services**.

(a) Neither Claims Administrator or Company will be liable under this Plan unless, within one year from the date the services are rendered, a claim is filed with the Claims Administrator in a form and manner that effectively provides notice to the Claims Administrator that the service has been rendered and a Covered Medical Expense incurred. A claim will be considered incurred on the date the service or supply is actually rendered or provided to the Member.

(b) A claim for a service that has been provided by a Participating Provider must be filed directly with the Claims Administrator by such Provider within one year from the date the service is rendered.

(c) Nonparticipating Providers may file the claim for a Covered Medical Expense if the Member asks them to do so. If they do not file the claim, it is the Member's responsibility to submit the claim to the Claims Administrator on a standard claim form that is appropriate for the services rendered. It is the responsibility of the Member to assure that any claim for a Covered Service that has been provided by Nonparticipating Provider is filed with the Claims Administrator within one year from the date the service is rendered.

(d) Claims Administrator will not be liable for issuing claims and appeals decisions as set forth herein where Company payments for administrative fees and/or claims funding is delinquent or where an agreement between the Claims Administrator and the Company for administration of claims has not been finalized. Once any delinquent fees or claims funding is brought current and/or any outstanding agreement between Claims Administrator and Company is finalized, the provisions related to claims and appeals decisions will apply to Members under this Plan.

10.2 **Individual Benefit Determination and Appeal Procedure**.

(a) Defined Terms (applicable only to Section 10.2):

(1) Designation of Authorized Representative: A Member may designate an Authorized Representative to act on the Member's behalf. A designated Authorized Representative may be any individual who is not otherwise included under the same coverage as the Member. A natural parent of a minor dependent Member and a provider of services for a Member may act on behalf of the Member without obtaining a formal designation. Any designation of an Authorized Representative must be submitted to the Claims Administrator on a form that will be provided by the Claims Administrator upon request of the Member. This Designation of Authorized Representative form must be signed by the Member whose claim is involved and submitted to CLAIMS REVIEW at the address

specified on the form. Once an Authorized Representative has been formally designated by a Member, all communications pertaining to the claim at issue will be directed to the Authorized Representative. Anyone acting as an Authorized Representative for a Member must adhere to all procedures and requirements contained herein which are otherwise the responsibility and obligation of the Member.

(2) Post-Service Claim: A claim that is submitted for medical services that have already been rendered to the Member. The Member will receive an Explanation of Benefit form reflecting the initial Benefit determination for claims that have been processed.

(b) Initial Benefit Determination Procedures.

(1) Following the procedures outlined in the Utilization Management section of the Plan, the Member's Provider or the Member (when utilizing a Nonparticipating Provider) will certify an Emergency Admission, request for Pre-Certification, Prior Authorization or Prior Approval of services where required.

(2) Once a claim or request for a payment of a Covered Medical Expense is received by the Claims Administrator, the Member or the Provider may be advised if additional information is needed to finalize the claim processing. If the claim relates to an Emergency Admission, the Member will be given notification of the proper procedures or additional information that is needed to complete the claim, within 24 hours of receipt of the claim. The Member will be given 48 hours to complete the claim. Claims Administrator has the right to deny any claim where additional information (*i.e.* medical records, etc.) is not received within the timeframes provided for making an initial benefit determination.

NOTE: If the Member disagrees with any pharmacy service and the Claims Administrator does not provide an Explanation of Benefits for the transaction, the Member must submit written notice of an initial claim to the Claims Administrator's Pharmacy Benefit Management Department.

(3) Time Lines for initial benefit determinations

(i) Certification of Emergency Admissions

(A) When the Member's Provider or the Member (only when utilizing a Nonparticipating Provider) requests Certification of an Emergency Admission in accordance with the Utilization Management section of the Plan, Claims Administrator will advise the Member's Provider of a decision as soon as possible taking into account the medical urgency, no later than 72 hours after the request for

Certification. However, if the Member or Provider is required to provide additional information in accordance with Section 10.2(b)(2), the decision will be rendered within 48 hours of the earlier of the following events: (1) receipt of the necessary information requested in accordance with Section 10.2(b)(2) or (2) expiration of the 48-hour period provided to submit the additional information requested in accordance with Section 10.2(b)(2). Claims Administrator will provide oral notice of approval to the Provider. If the request is denied, the Claims Administrator will provide the Member written notification of the decision within three days.

(ii) Notice of Initial Benefit Decision for Pre-Certification, Prior Authorization or Prior Approval of Services

(A) Only when the Member or the Member's Provider submits a request for services not yet rendered and the terms of the Utilization Management or Transplant sections of the Plan require Pre-Certification, Prior Authorization or Prior Approval, a notification of a determination will be made within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the request for services. The Claims Administrator has discretion (but is under no obligation) to extend the 15-day time period for reasons beyond the control of the Claims Administrator.

(B) If the request for Pre-Certification, Prior Authorization or Prior Approval of medical services is approved, Claims Administrator will advise the Member's Provider of the approval. If the request for Prior Authorization of pharmacy services is approved, Claims Administrator will advise the Member or the Provider of this decision. If the request for Pre-Certification, Prior Authorization or Prior Approval of either medical or pharmacy services is denied, Claims Administrator will provide the Member with written notification.

(iii) Notice of Initial Benefit Decision for Claims

When a claim is submitted for services that already have been rendered, a notification of a determination will be sent within a reasonable time period but not longer than 30 days from receipt of the claim. Claims Administrator has the discretion (but is under no obligation) to extend the 30-day time period for reasons beyond the control of the Claims Administrator.

(4) Appeal Procedures

(i) The Member or the Member's properly designated Authorized Representative will be entitled to request an appeal of an adverse benefit determination. An appeal must be filed within 180 days from the receipt of the notice of an initial benefit determination.

(ii) A request for an appeal must be submitted in writing to CLAIMS REVIEW at the address specified in the initial Benefit determination notification or the Explanation of Benefit form.

(iii) The Member's request for an appeal should state why the decision is incorrect. The Member will have the opportunity to submit written comments, documents, or other information in support of the appeal. Once a request for an appeal is received by Claims Administrator, the Member or the Provider may be advised if additional information is needed to finalize the decision. Claims Administrator has the right to deny any appeal where additional information (medical records, etc.) is not received within the timeframes provided for making a decision on an appeal.

(iv) Upon request and free of charge, the Member will have access to and be provided copies of relevant documents. The review of the initial benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

(v) The appeal will be conducted by a representative of the Claims Administrator who is neither the individual who made the initial benefit determination nor the subordinate of such individual. If the appeal involves a medical judgment question, the Claims Administrator will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved in the medical judgment.

(vi) A final decision on an appeal will be made within the time periods specified below:

(A) Appeal of an Emergency Admission

In the event the request for Certification of the Emergency Admission is denied, the Member's Provider may request an expedited review of the Certification. This request should be made by telephone, facsimile, or similarly rapid communication method. Utilizing the same communication method, Claims Administrator will notify

the Member's Provider as soon as possible, but in no less than 72 hours after the receipt of the expedited review of the Claims Administrator's approval or continued denial of the services. The Member will be notified of the continued denial of services.

(B) Appeal of Pre-Certification, Prior Authorization or Prior Approval of Services

When a Member requests an appeal of the Pre-Certification, Prior Authorization or Prior Approval of services, the Member will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 30 days from the date the request is received.

(C) Appeal of Claims

When the Member requests an appeal of a claim denial, the Member will be notified of the determination or status within a reasonable period of time but no later than 60 days from the date the request is received.

(5) Contents of notification for adverse decisions for Pre-Certification, Prior Authorization, Prior Approval of services, claims and appeals.

(i) The notice of initial benefit determination for adverse decisions for Pre-Certification, Prior Authorizations or Prior Approvals, claims and appeals will contain the following information:

(A) the specific reason or reasons for the adverse determination;

(B) a reference to the Claims Administrator's claims review procedures and a statement of the Member's rights pursuant to Section 502(a) of ERISA;

(C) state whether the denial is based on a medical necessity exclusion or limitation and advise that the Member will be provided with an explanation of the determination free of charge upon request.

(ii) In addition, the notification of an adverse decision for Pre-Certification, Prior Authorization, Prior Approval of services and appeals will disclose whether any internal rule, guideline or protocol was relied on in making the adverse determination and provide that a copy of such information will be made available free

of charge upon request. It will reference the specific plan provision on which the benefit determination is based.

(iii) Notifications for Pre-Certification, Prior Authorization or Prior Approvals will also indicate whether additional material or information is needed to perfect the request for services. Notifications for appeals will provide that the Member is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records and other information relevant to the claim for benefits.

(iv) The notice of initial Benefit determination for adverse claims will also indicate whether additional material or information is needed to perfect the claim.

10.3 **Legal Action**. The Member may not bring a lawsuit to recover benefits under this Plan until the Member has exhausted the administrative process described in this Article X. No action may be brought at all unless brought no later than three years following a final decision on the claim for benefits by Claims Administrator. The three-year statute of limitations on suits for all benefits shall apply in any forum where the Member may initiate such suit.

ARTICLE XI
GENERAL CONDITIONS

11.1 **Expense Of Administration**. Plan administrative expenses may be paid from Plan assets at the Plan Administrator's direction, in the event there are any such assets available. To the extent not paid by the Plan, the Company shall pay all administrative expenses of the Plan and may, at its sole discretion, require an Employer to reimburse the Company for some or all of the administrative expenses incurred in connection with such Employer, its Employees, and their Dependents.

11.2 **Benefits Not Assignable**. Except with respect to Medicaid assignments, as provided in ERISA §609(b), no benefits or rights shall exist under the Plan which are subject in any manner to voluntary or involuntary anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, transfer, assign, pledge, encumber or charge the same shall be null and void; nor shall any benefit or right under the Plan be in any manner liable for or subject to debts, contracts, liabilities, engagements, torts or other obligations of the person entitled to such benefit or right; nor shall any benefit or right under the Plan constitute an asset in case of the bankruptcy, receivership or divorce of any Member; and any such benefit or right under the Plan shall be payable only directly to the person entitled thereto; provided, however, a Member, when permitted under Section 11.3, may direct the payment of benefits under the Plan directly to the individual or entity whose charges gave rise to such benefits, and payment to such individual or entity shall satisfy all obligations of the Plan with respect to the amount paid.

11.3 **Direct Payment To Employee Or Dependent**. All benefits payable under this Plan and any amendment hereto are personal to the Member and are not assignable in whole or in part by the Member; but the Claims Administrator has the right to make payment for a Covered Medical Expense directly to a Participating Provider (instead of the Member) or to a parent, legal guardian, or personal representative in the case of a Member who is a minor or is incapacitated. In the case of a Nonparticipating Provider, the Claims Administrator will pay to the Member and only the Member those benefits called for herein, and the Claims Administrator will not recognize a Member's attempted assignment to or direction to pay another; provided, however, if a Nonparticipating Provider meets the Claims Administrator's criteria for status as a Participating Provider but has not yet been offered an opportunity to become a Participating Provider, the Claims Administrator will recognize a Member's attempted assignment to or direction to pay such Nonparticipating Provider.

11.4 **Conditions Of Employment Not Affected By Plan**. The establishment and maintenance of the Plan will not be construed as conferring any legal rights upon an Employee to the continuation of his employment with the Employer, nor will the Plan interfere with the right of the Employer to discipline, lay off or discharge any Employee or the right of the Employee to resign his employment or to decline coverage under the Plan. The adoption and maintenance of the Plan shall not be deemed to constitute a contract between the Employer and any Employee or to be a consideration for, inducement to, or condition of employment of any person.

11.5 **Written Communications Required**. Any notice, request, instruction, or other communication to be given or made hereunder shall be in writing and either personally delivered to the addressee or deposited in the United States mail fully postpaid and properly addressed to such addressee at the last address for notice shown on the Employer's records.

11.6 **Exhaustion Of Remedies**. No legal action for benefits under the Plan shall be brought unless and until the claimant: (a) has submitted a written claim in accordance with Section 10.1, (b) has been notified that the claim is denied (or has failed to receive a notice with respect to the claim within the period specified in Section 10.2), (c) has filed a written request for a review of the denial in accordance with Section 10.2, and (d) has been notified in writing that the Review Panel has affirmed the denial of the claim; provided that legal action may be brought after the Company and the Review Panel have failed to take any action on the claim within the time prescribed by Section 10.2.

11.7 **Examination**. The Company, Utilization Management Firm and/or Claims Administrator shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of a claim under the Plan when and so often as it may reasonably require during pendency of a claim.

11.8 **Overpayment**. If Member has been paid benefits under the Plan that are in excess of the benefits that should have been paid, the Company, Employer or Claims Administrator may cause the deduction of the amount of such excess or improper payment from any subsequent benefits payable to such Member or recover such amount by any other appropriate method that the Company, Employer or Claims Administrator, in its sole discretion, shall determine.

11.9 **Cancellation Of Health Care Benefits**. If the Employer is unable to ascertain the whereabouts of any person to whom benefits are payable under the Plan, and if, after one year from the date such payment is due, a notice of such payment due is mailed to the last known address of such person as shown on the records of the Employer, and within three months after such mailing such person has not filed with the Employer written claim therefor, the Employer shall pay any Provider(s) not previously paid by anyone for the services which generated such benefits. If there are no such Provider(s) or if benefits remain unpaid, then the Employer may direct that such payment be canceled and forfeited and, upon such cancellation, the Plan shall have no further liability therefor.

11.10 **No Waiver Or Estoppel**. No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or of any act, term or condition other than that specifically waived.

11.11 **Third Party Recovery.** A Member may incur Covered Medical Expenses due to injuries caused by the act or omission of another person or entity or the Member. As a result, the Member may have a claim against a Third Party and a Third Party may be responsible for

payment. "Third Party" is defined as anyone other than the Plan, the Employer or the Member, including but not limited to the person or the entity that caused the injury, his insurer, the Member's homeowners or uninsured motorist carrier, another employer, or a worker's compensation carrier. Accepting benefits under this Plan automatically assigns to the Plan any rights the Member may have to recover payments from any Third Party and provides the Plan with certain rights with respect to funds recovered from any Third Party, however recovered. The Plan shall have no obligation to provide benefits to a Member who does not cooperate with the Plan's efforts under this Section. The Plan's rights and the Members' responsibilities are further detailed as follows:

(a) To the extent that Covered Medical Expenses are paid by the Plan, the Plan shall be subrogated to all causes of action and all rights of recovery the applicable Member may have for the recovery of such payment(s) against any Third Party. The Plan shall have the right to intervene in any action that may be brought against a Third Party, or to bring a separate action against such Third Party in the name of the Plan or the Member. In the event of any recovery as a result of such an action, the Plan shall be entitled to retain such recovery, to the extent of benefits paid by the Plan. The remainder of any recovery shall be paid as the court directs.

(b) If the Plan does not, via Section 11.11(a), recover the Covered Medical Expenses paid by the Plan, but the Member recovers from a Third Party, the Member shall transfer to the Plan 100% of all amounts recovered in a judgment, settlement, or otherwise from any Third Party, to the extent of the benefits paid by the Plan. The Plan shall have a constructive trust or equitable lien on any amounts the Member, his attorney or other representative receive by judgment, settlement, or otherwise from any Third Party (up to the full amount of benefits paid by the Plan). The Member, his attorney or other representative shall be required to hold said amount in trust for the Plan and shall be a trustee of the Plan with respect to any such amount that is required to be transferred to the Plan under this Section. The Plan shall have the right to sue for an injunction: to enjoin the Member, his attorney or representative, or any recipient of such amounts, from dispersing the proceeds of the recovery; to order a transfer of title to the proceeds or any product of the proceeds; to obtain a security interest in the proceeds or any product of the proceeds; or to obtain any other relief allowed by law. If the Plan engages an attorney to recover from the Member, then the Plan shall be entitled to recover all court costs and attorney's fees incurred by the Plan, in addition to all benefits that it has paid (to the extent of the amount the Member recovers from a Third Party).

(c) If any amounts are recovered under this Section 11.11, the Plan shall be entitled to 100% of the recovery amount from the first dollar received, up to the amount of benefits paid by the Plan, even if the amount recovered is for, or is described as for, a partial or undifferentiated judgment or settlement, or for damages other than Covered Medical Expenses, or if the Member is a minor. The Plan's right to recover will apply whether or not the Third Party admits liability. The Plan's recovery amount shall not depend on whether the Member is "made whole" for, or

recovers the full amount of, the damage incurred, and shall not be reduced by attorneys fees or court costs.

(d) The Member or his representative will take such action, furnish such information and assistance, and execute such papers as the Plan Administrator or Claims Administrator requires in applying this Section, including completion of an accident questionnaire and the execution of a subrogation or other agreement, as a condition precedent to the Plan paying any future Covered Medical Expenses, and will take no action prejudicing the rights and interests of the Plan. If the Member pursues a claim or recovery for injury, or enters into settlement negotiations relating to such injury, the Member must notify the Plan Administrator immediately of such claim or negotiations. No waiver, release, settlement, or other document or action undertaken by a Member or his representative shall be binding on the Plan, which must approve all documents and actions that affect the Plan's rights. The Plan Administrator has the right to receive reports on all claims and negotiations affecting the Plan's rights under this Section. In the event the Member is a minor, the Plan Administrator may require court approval of applicable documents as a condition of the payment of benefits. Failure to obtain a subrogation agreement or accident questionnaire, or to obtain any applicable court approval, shall not be construed as a waiver of the Plan's rights under this Section.

(e) If a Member recovers from a Third Party, and if the Member or his representative fails to promptly remit funds that are due to the Plan under this Section, the Plan may deduct the amount of the recovery from other benefits that may be payable under the Plan. The Plan shall be entitled to interest or other earnings on amounts recoverable by the Plan under this Section.

(f) Nothing contained in this Section affects the Coordination of Benefits provisions in Article V.

11.12 **Care In A Veterans Administration Hospital**. In any case in which a veteran is furnished care or services by the Veterans Administration for a disability not connected to his military service, the United States shall have the right to recover or collect the reasonable cost for such care or services from the Plan to the extent the veteran would be eligible for benefits for such care or services from the Plan if the care or services had been furnished by a provider other than the Veterans Administration. The amount that the United States may recover shall be subject to all the limitations, exclusions, terms and conditions hereof, including but not limited to the Deductible Amount. The intent of this provision is to comply with PL 99-272, Section 19013.

11.13 **Care In A Military Hospital**. The United States shall have the right to collect from the Plan the reasonable cost of inpatient Hospital care incurred by the United States on behalf of a Member who is a military retiree or a military dependent, which care is rendered by a facility of the United States military, to the extent that such retiree or dependent would be eligible to receive reimbursement or indemnification from the Plan if the retiree or dependent were to incur such cost on his own behalf. The amount that the United States may recover shall be subject to all the limitations, exclusions, terms and conditions hereof, including but not

limited to the Deductible Amount. The intent of this provision is to comply with PL 99-272, Section 2001.

11.14 **Negligent Acts Of Providers**. None of the Claims Administrator, the Company, any Employer, the Utilization Management Firm or the Plan will be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, provider, nurse, technician or other person participating in or having to do with the care or treatment of a Member.

11.15 **Employee/Provider Relationship**.

(a) The choice of a provider is solely the Employee's.

(b) None of the Plan, the Utilization Management Firm, the Company, any Employer or the Claims Administrator makes, or has the authority under the Plan to make, any representation as to the abilities or quality of any Hospital, Physician, nurse, or other provider of medical services.

11.16 **Job-Related Injury Or Illness**. This Plan excludes benefits for any injury arising out of or in the course of employment or any sickness entitling the Member to benefits under any workers' compensation or employer liability law, or when the Member's employer accepts liability. In the event benefits are initially extended by the Plan and either a compensation carrier or employer makes any type settlement with the Member or with any person entitled to receive settlement when the Member dies, or the Member's injury or illness is found to be compensable under law, the Member must comply with the terms of Section 11.11 above.

11.17 **Conditions Precedent To Suit Against Company**. No suit or action in law or may be brought by a Member or on his behalf relating to the Plan unless, as a condition precedent, the Member has fully complied with all of the provisions of this Plan, including all of the procedures and requirements of Article X above for review of claims determinations, and unless and until the Review Panel has denied in writing his request for review of the claim determination.

11.18 **Release Of Information**. Each Member receiving care under this Plan authorizes and directs any provider to furnish to the Claims Administrator or Plan Administrator, at any time upon its request, all information, records, copies of records or testimony relating to attendance, diagnosis, examination or treatment, unless otherwise prohibited by applicable law or regulation. Such authorization and compliance therewith by each provider affected will be a condition precedent to rights to benefits to each Member hereunder, and no benefits will be provided in any case where such authorization is not given full effect. The Claims Administrator will utilize the information described in this paragraph for internal administration of this Plan, medical analysis, coordination of benefit provisions with other plans, subrogation of claims, or in the reviewing of a disputed claim.

As a part of the Plan's utilization management activities, information about a Member's utilization may be disclosed to a treating Physician or a dispensing pharmacy.

IN WITNESS WHEREOF, the Company has caused this instrument to be executed by its duly authorized officer effective as of January 1, 2003.

ATTEST:

By: _____
Ethel Truly
Secretary

Date: 3/19/03

MISSISSIPPI CHEMICAL CORPORATION

By: _____

Date: 3/7/03

DESIGNATIONS

The following entities have been designated by the Company to participate in the Plan:

MCC Employees Federal Credit Union

MCC Investments, Inc.

Mississippi Chemical Company, L.P.

Mississippi Chemical Management Company

MissChem Nitrogen, L.L.C.

Mississippi Chemical Corporation Group Medical Plan
Appendix A

Notwithstanding the provisions of Section 2.7 of the Plan, individuals meeting the conditions of this Appendix A are eligible to participate in the Plan, under the terms set forth below. Except as otherwise indicated below, the benefits provided are the same as benefits provided to all employees in the Plan. If the terms of the Plan change for active employees, they change for the individuals whose coverage is described in this Appendix A. Coverage commences and ends on the dates provided below.

I. Employees Who were Eligible for and Elected the June 1, 1985 Open Window

Eligibility:

At least 55 Years of Age and 10 Years of Service credit

Terms:

Medical Coverage Continued under the Plan For:

1. The Employee to age 65
2. The Employee's spouse (as of the Open Window) to age 65
3. Dependent children of the employee to age 19 (23 if a student)

This coverage will end when:

The Retired Employee:

1. reaches age 65
2. dies
3. becomes covered under another group plan (also resulting in the termination of coverage for the Retired Employee's Spouse and Dependents)

The Retiree's Spouse:

1. reaches age 65
2. dies
3. remarries (in the event of the Employee's death)
4. divorces (subject to COBRA)

The Dependent Child:

1. reaches age 19 (23 if student)
2. dies
3. marries

COBRA coverage runs concurrently with coverage under this Open Window.

II. Employees Who were Eligible for and Elected the February 1, 1988 Open Window

Eligibility: At least 55 Years of Age and 10 Years of Service credit

Terms:

Medical Coverage Continued under the Plan For:

1. The Employee to age 65
2. The Employee's spouse (as of the Open Window) to age 65
3. Dependent children of the employee to age 19 (23 if a student)

This coverage will end when:

The Retired Employee:

1. reaches age 65
2. dies
3. becomes covered under another group plan (also resulting in the termination of coverage for the Retired Employee's Spouse and Dependents)

The Retiree's Spouse:

1. reaches age 65
2. dies
3. remarries (in the event of the Employee's death)
4. divorces

The Dependent Child:

1. reaches age 19 (23 if student)
2. dies
3. marries

COBRA coverage runs concurrently with coverage under this Open Window.

III. Employees Who were Eligible for and Elected the August 1, 1999 Open Window

Eligibility:

1. Marketing Division (Mississippi Chemical Corp., Mississippi Chemical Management Company and Mississippi Chemical Company, L.P.);

2. Not already scheduled for Retirement;

3. At Least 55 Years of Age; and

4. Age Plus Years of Service must have totaled at least 85.

Terms:

Employees electing the Open Window are eligible for the Plan until the Employee attains age 65.

Spouse as of the Open Window is eligible for the Plan until the spouse attains age 65, for maximum of 10 years of coverage.

Qualified dependents are eligible for the Plan for a maximum of 10 years.

COBRA coverage runs concurrently with coverage under this Open Window.

Insurance will terminate if other employment provides medical insurance.

Current spouse coverage ceases in the event the couple divorces.

No additional coverage may be purchased for a new spouse of former employee.

IV. Employees Who were Eligible for and Elected the January 1, 2000 Open Window

Eligibility:

1. Exempt employees of Triad Nitrogen LLC ("TNLLC");
2. As of 1/1/2000, had to be at least 55 years of age;
3. Years of service had to be at least 25 years; and
4. Were in a current position with TNLLC that carries Pay Points of at least 500 Points.

Terms:

Employees electing the Open Window are eligible for the Plan until the employee attains age 65.

Spouse as of the Open Window is eligible for the Plan until the spouse attains age 65, for a maximum of 10 years of coverage.

Qualified dependents are eligible for the Plan for a maximum of 10 years.

COBRA coverage runs concurrently with coverage under this Open Window.

Insurance will terminate if other employment provides medical insurance.

Current spouse coverage ceases in the event the couple divorces.

No additional coverage may be purchased for a new spouse of former employee.

V. Employees Who were Eligible for and Elected the October 1, 2000 Open Window

Eligibility:

1. Nitrogen Companies and Headquarters Only;
2. As of 10/1/2000, had to be at least 59 years of age but not yet 65;
3. Age plus Years of service must have totaled at least 85; and
4. Not available to officers of the company.

Terms:

Two medical options: Normal COBRA continuation coverage or Early Retirement Option until the Employee reaches age 65. Early Retirement Option is an alternate benefit with a $1,000 annual deductible and an annual $5,000 out of pocket limit. Former Employees electing the Early Retirement Option are provided coverage for the Employee, spouse as of the Open Window, and any qualifying dependents until the Employee attains age 65 or death of former Employee.

Upon Medicare entitlement, death of the employee, the employee attaining age 65, or some other qualifying event, that day is the initial qualifying event date. The qualified dependent(s) will then be able to continue this Early Retirement Option under COBRA.

VI. Employees Who were Eligible for and Elected the December 10, 2002 Open Window

Eligibility:

1. Employee of MissChem Nitrogen, L.L.C., Mississippi Chemical Corp., Mississippi Chemical Management Co., or Miss Chem Company LP;
2. As of 2/1/2003, had to be at least 55 years of age;
3. Must be fully vested in the retirement plan as of 2/1/03.

Terms:

The Company offered three medical options, A, B and C, each of which represent COBRA continuation coverage options with different deductibles and out of pocket limits and provide coverage under the Plan for the Employee and his current spouse and dependents.

Former Employees electing coverage option C are provided coverage for the Employee, spouse as of the Open Window, and any qualifying dependents, from February 1, 2003 until the Employee attains age 65 or death of former Employee. Medical insurance ceases for the spouse after the former Employee reaches age 65 or death. COBRA coverage runs concurrently with coverage under this Open Window.

Mississippi Chemical Corporation Group Medical Plan
Appendix B

Individual Coverages

Notwithstanding the provisions of Section 2.7 of the Plan, the individuals described in this Appendix B are eligible to participate in the Plan, under the terms set forth below. Except as otherwise indicated below, the benefits provided are the same as benefits provided to all employees in the Plan. If the terms of the Plan changes for active employees, they change for the individuals whose coverage is described in this Appendix B. Coverage commences and ends on the dates provided below. COBRA coverage runs concurrently with coverage under this Appendix B.

John Crothers: December 31, 1994

Mr. Crothers and his wife as of December 31, 1994 are eligible for medical coverage under the Plan until Mr. Crothers reaches age 65 and until his wife reaches age 65.

J.D. Clark: April 1, 1996

J.D. Clark and his wife as of April 1, 1996 are eligible for medical coverage under the Plan until Mr. Clark reaches age 65 and until his wife reaches age 65, for a maximum of ten years.

R. B. (Tommy) Thompson: September 1, 1996

Mr. Thompson and wife as of September 1, 1986 are eligible for medical coverage under the Plan for beginning August 9, 1996, until Mr. Thompson reaches age 65 and until his wife reaches age 65.

Certain Individuals: February 1, 2003

Nine individuals are eligible to participate in the Plan under the same terms as those offered the December 10, 2002 Open Window described at Item VI of Appendix A. These individuals are:

George Attkisson
Charles Clayton
Wallace Cook
Chester Grisham
Hollis Martin
Duncan Roberts
Roy Lamar Self
Ephraim Smith
Ronald Wilkinson

Debtors:

John M. Flynt
Mississippi Chemical Corporation
P.O. Box 388
Yazoo City, MS 39194

James W. O'Mara Douglas C Noble
Phelps Dunbar LLP
Suite 500, SkyTel Centre North
200 South Lamar Street
Post Office Box 23066
Jackson, Mississippi 39225-3066

Alan J. Bogdanow
William D. Young
Vinson & Elkins L.L.P.
3700 Trammel Crow Center
2001 Ross Avenue
Dallas, TX 75201-2975

Peter S. Kaufman
Henry F. Owsley
Gordian Group, L.L.C.
499 Park Avenue, 5th Floor
New York, NY 10022

Bankruptcy Management Corporation
Attn: Tinamarie Feil
1330 E. Franklin Ave.
El Segundo, CA 90245

Harris Trust & Savings Bank:

James E. Spiotto
Chapman and Cutler
111 W. Monroe Street
Chicago, Illinois 60603

Stephen W. Rosenblatt
Butler, Snow, O'Mara, Stevens & Cannad.
Post Office Box 22567
Jackson, MS 39225-2567

FTI Consulting Inc.
Attn: Robert Paul
333 West Wacker Dr. Ste. 600
Chicago, IL 60606

Official Unsecured Creditors' Committee:

Anthony Princi
Thomas L. Kent
Orrick, Herrington & Sutcliffe LLP
666 Fifth Avenue
New York, New York 10103

Chanin Capital Partners
Attn: Mark Rubin
330 Madison Avenue, 11th Floor
New York, NY 10017

Harris, Geno & Dunbar
Attn: Craig Geno
P.O. Box 3919
Jackson, MS 39207-3919

Conseco Capital Management Corp.
Greg J. Sekata
11825 N. Pennsylvania Street
Carmel, IN 46032

Perry Capital LLC
Richard Paige
599 Lexington Ave.
New York, NY 10022

Integrity Life Insurance
Bernard M. Casey
420 East Fourth Street
Cincinnati, OH 45202

U.S. Trustee:

Ronald H. McAlpin
Assistant U.S. Trustee
Suite 706
100 W. Capitol Street
Jackson, Mississippi 39269

Bondholders/Shareholder:

Indenture Trustee:
BancorpSouth Bank
Attn: Lisa Neeld /Corporate Trust
Post Office Box 1605
Jackson, MS 39215

Stephen H. Leech, Jr.
Attorney at Law
P.O. Box 3623
Jackson, MS 39207

Governmental Agencies:

Internal Revenue Service
Anna Howell, IRS Agent
100 West Capitol St. Stop 15
Jackson, MS 39269

MS State Tax Commission
1577 Springridge Road
Raymond, MS 39154-9602

Taxation and Revenue Department
P.O. Box 25127
Santa Fe, NM 87504-5127

LA Dept. of Revenue
P.O. Box 3440
Baton Rouge, LA 70821-3440

U.S. Attorney
Dunn Lampton
188 East Capitol Street, Ste 500
Jackson, MS 39201

US SEC
3475 Lenox Road NE, Ste. 1000
Atlanta, GA 30326-1232

Parties Requesting Notice:

Spencer Gilbert
Wise Carter Law Firm
Post Office Box 651
Jackson, Mississippi 39205

Lawrence Bass
Holme Roberts & Owen
1700 Lincoln, Suite 4100
Denver, CO 80203

Arthur F. Jernigan, Jr.
W. Roberts Jones
Watson & Jernigan
Post Office Box 23546
Jackson, MS 39225-3546

Josef S. Athanas
Jim F. Spencer, Jr.
Latham & Watkins
Sears Tower Suite 5500
Chicago, IL 60606

Alan H. Katz, Esq.
639 Loyola Ave. 26th Floor
New Orleans, LA 70113

Clinton P. Hansen
Fagelhaber LLC
55 East Monroe St. 40th Floor
Chicago, IL 60603

T. Glover Roberts
Roberts & Grant, P.C.
Suite 700
3102 Oak Lawn Avenue
Dallas, TX 75219

David N. Usry
188 E. Capitol St. Ste. 500
Jackson, MS 39201

Edward E. Lawler, Jr.
McKay Simpson Lawler Franklin
& Foreman, PLLC
Post Office Box 2488
Ridgeland, MS 39158-2488

H.D. Brock
Whittington, Brock, Swayze & Dale
P.O. Box 941
Greenwood, MS 38935-0941

Fletcher C. Lewis
P.O. Box 410
McCrory, AR 72101

James H. Shenwick
Carnegie Hall Tower
152 West 57th Street
New York, NY 10019

Kay Bushman
Assistant Counsel
Defense Energy Support Center
8725 John J. Kingman Road
Ft. Belvoir, VA 22060

Brendan Collins, Attorney, Civil Div.
Department of Justice
P.O. Box 875
Ben Franklin Station
Washington, DC 20044-0875

Terri L. Gardner
Poyner & Spruill, LLP
P.O. Box 10096
Raleigh, NC 27605

John Harman
Martin Marietta Magnesia Specialities
195 Chesapeak Park Plaza, Ste. 200
Baltimore, MD 21220

Neil H. Herskowitz
Regen Capital I, Inc.
P.O. Box 626
Planetarium Station
New York, NY 10024-0540

Steve Van Hooser
Duke Energy Field Services, LP
5718 Westheimer, Suite 2000
Houston, TX 77057

Peter Couri
Durham Asset Management, LLC
680 Fifth Ave. 22nd Floor
New York, NY 10019

Joseph M. Krettek, Esq.
Pension Benefit Guaranty Corporation
Office of the General Counsel
1200 K Street, N.W.
Washington, D.C. 20005-4026