FORM 10-K

Annual report pursuant to section 13 and 15(d)

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FILER

STV GROUP INC
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SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549
FORM 10-K
Annual Report Pursuant to Section 13 or 15(d) of
The Securities Exchange Act of 1934

For the fiscal year ended	Commission File Number
September 30, 1996	0-3415

STV GROUP, INCORPORATED
(Exact name of registrant as specified in its charter)

Pennsylvania	23-1698231
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

205 West Welsh Drive, Douglassville, Pennsylvania 19518
(Address of principal executive offices) (Zip Code)

Registrant's telephone number, including area code: (610) 385-8200

Securities registered pursuant to Section 12(b) of the Act: None

Title of each class	Name of each exchange on which registered
Common Shares ($1.00 par)	NASDAQ

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months, (2) has been subject to such filing requirements for the past 90 days.

Yes _X_ No ___

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (ss.229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.[ ].

The aggregate market value of the voting stock held by non-affiliates of the registrant as of November 25, 1996 is $1,424,512. (1)

The number of shares outstanding of the registrant's classes of common stock as of November 25, 1996 is as follows:

Common Shares 1,821,246

DOCUMENTS INCORPORATED BY REFERENCE

Part I	Part II	Part III	Part IV
(None)	Annual Report to Shareholders for fiscal 1996	Proxy Statement and Annual Report to Shareholders for fiscal 1996	1984, 1987, 1989, 1990 1991, 1992, 1993, 1994 and 1995 Form 10-K; Registration Statement No. 2-88904

(1) The rules of the Securities and Exchange Commission require that the aggregate dollar amount of the voting stock set forth above equal the amount of common shares outstanding, reduced by the amount of common shares held by executive officers, directors and shareholders owning in excess of 10% of the Company's common shares, multiplied by the last traded price on November 25, 1996. The information provided shall in no way be construed as an evaluation by the Company of the market price of such common stock, nor shall it be construed as an admission that any officer, director or 10% shareholder in the Company may be deemed an affiliate of the Company and any such inference is hereby disclaimed. The information provided is included solely for record keeping purposes of the Securities Exchange Commission.

PART I

ITEM 1. BUSINESS

STV Group, Inc. provides engineering and architectural consulting and design services on a variety of projects for the federal government, local, state and foreign governments and private industry. The Company is also pursuing selected design/build projects. STV Group, Inc. consists of the following wholly-owned subsidiaries: STV Incorporated, STV Architects, Inc., STV Environmental, Inc., STV International, Inc., STV Surveying, Inc. and STV Construction Services. STV and its subsidiaries are hereinafter collectively referred to as the "Company".

The Company's projects frequently require the service of a firm with diverse capabilities. For example, a particular project may require electrical engineers, civil engineers, draftsmen and other professional personnel. Each of STV Group, Inc.'s subsidiaries customarily staffs a particular project with personnel from the respective firm's offices. Where appropriate, however, multifirm project teams are formed with qualified professionals drawn from the entire Company. Management believes that close cooperation among the STV Group, Inc. subsidiaries, under its management, assures proper control and support for all Company activities. As of September 30, 1996, the Company employed 982 people.

Services

The principal areas in which the Company provides services and the approximate percentage of the Company's revenue attributable to each service area are set forth below:*

	Year Ended September 30,		
	1996	1995	1994
Architectural Engineering	25%	27%	27%
Civil, Highway, Bridge, Airport and Port Engineering	33	35	36
Defense Systems Engineering	4	5	4
Industrial Process Engineering	1	2	2
Transportation Engineering	35	29	28
Other Engineering Services	2	2	3

* The Company does not record revenue data according to each service area. However, to provide an approximation of the revenue attributable to each service area, the Company has analyzed contract revenue in the fiscal year according to its principal service area. The aggregate revenue each year of these contracts is at least 75% of the consolidated revenue for these fiscal years.

Architectural Engineering

Architectural engineering generally involves consulting and design services, as well as construction inspection services, for the construction of commercial, industrial and governmental

buildings, medical and educational facilities, laboratories, recreational, religious and cultural centers, military installations, penal institutions, and public utility facilities. As part of its services, the Company has designed and developed systems for heating, ventilation, cooling, refrigeration, fire protection, lighting, power generation and distribution and communications. In addition, the Company has performed energy conservation audits and has recommended and designed programs, including computerized control programs for multi-building complexes, for the conservation of fuel and electrical energy.

Civil, Highway, Bridge, Airport and Port Engineering

This area of engineering generally involves consulting and design services for the construction of highways (including interchange ramps and secondary roads), bridges, airports and marine ports. Services performed by the Company have included site selection and development (including economic evaluations and feasibility reports), design and development of specifications, and construction inspection. As part of these services, the Company has designed lighting, toll and service facilities, drainage and erosion control systems, and has performed mapping and landscaping, hydraulic and hydrologic studies, soils engineering, traffic studies and surveys. In addition, the Company has designed and inspected the construction of airport terminals, runways, aircraft maintenance hangars, fuel systems, control towers and marine ports.

Defense Systems Engineering

Defense systems engineering involves consulting and design services for the development of equipment and special hardware for the Department of Defense. Services performed by the Company have included the design, development and testing for systems relating to naval aircraft, weapons systems, aircraft carriers, support ships, land-based operations and support missions. The Company has prepared analytical support studies for aircraft carriers, support ships, land-based operations and support missions, analytical support studies for aircraft catapults and arresting systems, jet blast deflectors, shipboard weapons, loading and transfer systems, ship-weapon compatibility, mobile weapon loaders, munition trailers, launch and recovery television systems, lighting and marking systems, parachutes, life rafts and personnel life-support systems. In addition, the Company has prepared operation and maintenance manuals, technical reports, specifications and other documents describing equipment and hardware. The Company has the capacity to provide all of the services necessary to prepare these publications, including layout, artwork composition, photography and reproduction.

Industrial Process Engineering

This area involves consulting and design services for the development of various manufacturing equipment and process systems. Services performed by the Company have included technical analyses, feasibility studies, plant layouts and machinery and construction inspection services. The Company has provided these services in connection with systems for the manufacture of paper, plastics, bulk chemicals, flooring, steel, rubber, telephone equipment, television sets, ammunition, foods and automotive production equipment. In addition, the Company has provided

services for various waste-to-energy engineering projects such as municipal and industrial incinerators designed to convert various forms of waste into marketable energy and for various environments, sanitary and water pollution control projects, including water supply systems, storm and sanitary sewage collection systems.

Transportation Engineering

Transportation engineering involves consulting and design services, as well as construction supervision services, for various transportation facilities, including the planning and design of track, terminals, stations, yards and shops for the railway industry. This area also involves evaluation and inspection of rolling stock for intercity rail lines, light rail, commuter line and urban mass transit systems and design and construction inspection of maintenance and storage facilities.

Design Build

This area involves the joint and simultaneous design and construction of a project under a single contract with an owner. Projects could be for complex transportation facilities, building design or rehab, and/or industrial projects. In order to perform these projects, the Company will join with a construction firm in order to provide the services to a client. The arrangement with a contractor could be as a subcontractor, a joint-venture partner, or as

the prime contractor. Depending upon the type of arrangement with the owner and the contractor, the Company may be responsible for ensuring the actual construction of a project for a guaranteed price.

In November, 1996 the Company entered into an agreement with Bombardier Corporation to provide the design and installation of three maintenance facilities for new trainsets to be purchased by Amtrak for its Northeast Corridor fleet.

Customers

The following table sets forth the percentage of contract revenues derived from each of the following customers for the periods indicated:

	Year Ended September 30,		
	1996	1995	1994
U.S. Government Contracts.....	14%	19%	22%
State and Local Government Contracts.....	56	50	49
Foreign Government Contracts.....	2	2	1
Private Contracts.....	28	29	28

In fiscal years 1996, 1995, and 1994 the Company's business activities in countries other than the United States accounted for approximately 4%, 4%, and 5% of total revenues, respectively. Due to the fact that virtually all of the Company's international business is funded through United States or international development agencies, management believes that there are no unusual risks attendant to obtaining payment for services rendered under its foreign contracts.

Contracts

In recent years, many of the Company's contracts have been awarded on a cost-plus, as opposed to a fixed-price, basis. Under cost-plus contracts, the Company is reimbursed for its allowable costs (direct labor plus overhead rate) and is paid a negotiated fixed fee. Under fixed-price contracts, the Company is paid an agreed-upon price for services rendered. Under fixed-price contacts, the Company bears any risk of increased or unexpected costs that may reduce its profit or cause it to sustain a loss. The majority (approximately 75%) of the Company's contracts are cost-plus contracts.

Government Contracts

Many of the government programs in which the Company participates as a contractor may extend for several years but may be funded on an annual basis. The Company's government contracts are subject to termination, reduction or modification as a result of changes in the government's requirements or budgetary restrictions. In addition, government contracts are subject to termination at the convenience of the government. If a contract were to be terminated for convenience, the Company would be reimbursed for its allowable costs to the date of termination and would be paid a proportionate amount of the stipulated profits or fees attributable to the work actually performed. To date, no government agency has terminated for convenience any significant contracts with the Company.

Under certain circumstances, the government can suspend or debar individuals or firms from obtaining future contracts with the government. While the Company has not experienced such a suspension or debarment and considers the possibility of any suspension or debarment to be remote, any such suspension or debarment would have a materially adverse effect upon the Company.

The books and records of the Company are subject to audits by a number

of federal, state and local government agencies, including the Defense Contract Audit Agency. Such audits could result in adjustments to contract costs and fees. To date, no material audit adjustments have been made in the Company's contracts, although no assurances can be given that future adjustments will not be required. All contract revenues are recorded in amounts which are expected to be realized upon final settlement and the Company does not anticipate material audit adjustments.

Accounts Receivable and Costs and Estimated Profits of Uncompleted Contracts in Excess of Related Billings

Accounts receivable and costs and estimated profits of uncompleted contracts in excess of related billings represented 87% and 83% of total assets as of September 30, 1996 and 1995, respectively. Accounts receivable are comprised of billed receivables while costs and estimated profits of uncompleted contracts in excess of related billings are essentially unbilled receivables. Unbilled receivables represent payment obligations for which invoices have not or cannot be presented until a later period. The reasons for which invoices are not presented may include normal invoice preparation lag, lack of billable documents to be supplied by the client, and excess of actual direct and indirect costs over amounts currently billable under cost reimbursement contracts to the extent they are expected to be billed and collected. The financing of receivables requires bank borrowings and the payment of associated interest expense. Interest expense is a business expense not permitted as a reimbursable item of cost under any government contracts.

Backlog

Backlog represents the value of existing contracts less the portion of such contracts included in revenues on the basis of percentage-of-completion. The Company's backlog for services as of September 30, 1996 and 1995 was approximately $130,000,000 and $129,000,000, respectively. The Company's backlog includes anticipated pass through cost such as reimbursement for travel, purchase of supplies and sub-contracts. Over the last three years, pass through costs, as a percent of total revenues, have been 24.2% in 1996, 22.2 in 1995, and 26.5% in 1994.

A majority of the Company's customer orders or contract awards and additions to contracts previously awarded are received or occur at random during the year and may have varying periods of performance. The comparison of backlog amounts on the same date in successive years is not necessarily indicative of trends in the Company's business or future revenues.

The major component of the Company's operating costs are payroll and payroll-related costs. Since the Company's business is dependent upon the reputation and experience of its personnel and adequate staffing, a reasonable backlog is important for the scheduling of operations and for the maintenance of a fully staffed level of operation.

Competition

The Company has numerous competitors in all areas in which it does business. Some of its competitors are large, diversified firms having substantially greater financial resources and larger technical staffs than the Company. It is not possible to predict the extent of competition which the Company will encounter in the future because of changing customer requirements in terms of types of projects and technological developments. It has been the Company's experience that the principal competitive factors for the type of service business in which the Company engages are a firm's demonstrated ability to perform certain types of projects, the client's own previous experience with the competing firms, a firm's size and financial condition, and the cost of the particular proposal.

It is Management's belief that the diversified scope of the services offered by the Company is a positive competitive factor. Among other things, the wide range of expertise which the Company possesses permits it to remain competitive in obtaining federal government contracts despite shifts in federal spending emphasis. Management believes that the national and international scope of the Company is a positive factor in attracting and retaining clients which have the need for engineering services in different regions of the country and the world.

Marketing

Marketing activities are conducted by key operating and executive personnel, including specifically assigned sales personnel, as well as through professional personnel who maintain existing and develop new client relationships. The Company's ability to compete successfully in the industry is largely dependent on aggressive marketing, the development of information regarding client requirements, the submission of responsive cost-effective proposals and the successful completion of contracts. Information concerning private and governmental requirements is obtained during the course of contract performance, from formal and informal briefings, from participation in activities of professional organizations, and from literature published by the government and other organizations.

Personnel

As of September 30, 1996, the Company had 982 employees, of whom 864 were engaged in engineering and architectural services, 87 were engaged in administration and 31 in marketing.

Because of the nature of services provided, many employees are professional or technical personnel having specialized training and skills, including engineers, architects, analysts, management specialists, technical writers and skilled technicians. Although many of the Company's personnel are highly specialized in certain areas the Company is not currently experiencing any material difficulty in obtaining the personnel it requires to perform under its contracts. Management believes that the future growth and success of the Company will depend, in part, upon its continued ability to retain and attract highly qualified personnel. The Company believes its employee relations to be good.

Environmental Compliance

The Company's facilities are subject to federal, state and local authorities environmental control regulations. The Company believes it is in compliance with these numerous regulations and that it is not exposed to any material liability as it relates to contamination of the environment. To date, compliance with these environmental regulations has not had a material effect on the Company's earnings nor has it required the Company to expend significant capital expenditures.

Executive Officers of the Registrant

Name	Age	Position with STV Group, Inc. Business Experience During the Past 5 Years
Michael Haratunian (1)	63	Chairman of the Board and Chief Executive Officer of STV Group, Inc.
Dominick M. Servedio (2)	56	Director, President and Chief Operating Officer of STV Group, Inc. and President and Chief Operating Officer of STV Incorporated

Frank E. Lyon, Jr. (3)	68	Senior Vice President of STV Incorporated
W. A. Sanders II (4)	49	Senior Vice President of STV Incorporated
Peter W. Knipe (5)	47	Secretary/Treasurer of STV Group, Inc.

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(1) Mr. Haratunian has been associated with the Company continuously since 1972 in various capacities and was appointed President of Seelye, Stevenson, Value & Knecht, Inc. in 1977 and Director and Executive Vice-President of Engineering of STV Group, Inc. in 1981 and assumed the Presidency of STV Group, Inc. in 1988. He was appointed Chief Executive Officer in 1991 and Chairman of the Board in 1993. Mr. Haratunian is a registered professional engineer.

(2) Mr. Servedio joined the Company is 1977 as Vice President of Seelye, Stevenson, Value & Knecht, Inc. and was appointed Executive Vice President in 1982. He was appointed President of Seelye, Stevenson, Value & Knecht, Inc. and Executive Vice President of STV Group, Inc. in 1988. Mr. Servedio was elected President of STV Group, Inc. in 1993. Mr. Servedio is a registered professional engineer.

(3) Mr. Lyon was the President and Chairman of the Board of Lyon Associates, Inc. for more than five years prior to the acquisition of certain of its assets by a subsidiary of the Company in 1983. Mr. Lyon currently is President of the Company's Lyon Associates, Inc. subsidiary. Mr. Lyon is a registered professional engineer.

(4) Mr. Sanders has been associated with the Company continuously since 1968 in various capacities and was appointed Executive Vice President of Sanders & Thomas in 1991. Mr. Sanders is a registered professional engineer.

(5) Mr. Knipe joined the Company in 1979, was appointed Controller in 1983 and was elected Treasurer in 1987 and Secretary in 1993. In addition to his position with the Company, he serves as a director and officer of certain subsidiaries of the Company.

ITEM 2. PROPERTIES

The Company's executive offices and a principal engineering office are located in a modern 58,000 square foot building leased by the Company in Douglassville, Pennsylvania, pursuant to a lease which expires in October 2011.

The Company leases office facilities in a number of other locations both in the United States and overseas, at which it performs engineering and architectural consulting and design services, including a facility of approximately 55,000 square feet in New York, New York, pursuant to a 15 year lease which expires in December, 2006.

The Company believes that its facilities are adequate to meet the current and foreseeable needs of the Company. The Company does not expect to experience any difficulty in securing additional space should that become necessary.

ITEM 3. LEGAL PROCEEDINGS

The Company is the subject of various claims, legal actions and complaints arising in the ordinary course of business. In most cases, the Company is one of several named defendants or third-party defendants. In the opinion of management, most of these matters are without merit or are of such a nature or involve such amounts that an unfavorable disposition would not have a material adverse effect on the financial condition of the Company.

For policy years beginning March 4, 1993, the Company's professional liability insurance arrangement provides for an annual aggregate $5,000,000 of coverage with a $250,000 deductible per occurrence on a claims made basis. For the policy year beginning March 4, 1992, the Company's professional liability insurance arrangement provided for an aggregate $5,000,000 of coverage. There

was a $500,000 deductible and a requirement to indemnify the insurer for an additional aggregate $1,000,000. The Company had a similar arrangement for professional liability coverage for the period October 1, 1986, to March 3, 1992, providing an aggregate $5,000,000 of professional liability coverage. The Company has recognized the indemnity obligation by charges of $4,500,000 to operations in prior years and the posting of a $1,000,000 letter of credit. In addition to the professional liability coverage, the Company has general liability insurance in excess of $10,000,000 per occurrence and in the aggregate.

During 1992, the Company and its insurers settled a personal injury lawsuit for $5,400,000, of which $2,700,000 was paid by the Company's professional liability insurer from the funded indemnity and $2,700,000 by the general liability insurer. There remains a declaratory judgement action pending as to whether insurance coverage was to be provided under the previous general liability policy or professional liability policy then in effect. In this proceeding, the court has required that the limits of the Company's insured coverage be reserved to pay this claim if the insurer is found liable. The Company and its professional liability insurer believe that this matter should be covered under its general liability policy in which case the $2,700,000 would be repaid to the professional liability insurer to replenish the indemnity.

In addition, in 1992 the Company's former professional liability insurer was found liable for approximately $4,000,000 due to a previous arbitration proceeding allegedly relating to an asset acquisition. The judgement was reversed on appeal in 1994. If the Company's professional liability insurer is found ultimately liable under both of these actions, the Company may be required to indemnify the professional liability insurer to the extent of the policy limit of $5,000,000 as described above. Such payments would constitute a charge to operations in the year the determination is made. The Company and the Company's professional liability insurer continue to deny liability and intend to vigorously pursue defenses available to them.

The Company is also involved in various other litigation arising out of the ordinary course of business, which may require the payment of additional amounts. The Company's management believes that the final resolution of the above legal matters will not have a material adverse effect on the Company's financial statements.

If the outcome of all of the aforementioned litigation is adverse to the Company and the Company is required to pay additional amounts, it could have a material adverse effect on the earnings and financial condition of the Company in the year such determination is made; however, management believes that the final resolution of these legal matters will not have a material adverse effect on the Company's financial condition.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS.

Not applicable.

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON EQUITY AND RELATED STOCKHOLDER MATTERS.

The information contained under the caption "Common Stock Market Prices" from the Company's Annual Report to Shareholders for the fiscal year ended September 30, 1996, is incorporated herein by reference.

ITEM 6. SELECTED FINANCIAL DATA

The information contained under the caption "Financial Highlights for the Fiscal Year Ended September 30," 1992 through 1996 in the Company's Annual Report to Shareholders for the fiscal year ended September 30, 1996 is incorporated herein by reference.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATION.

Results of Operation

The Company's contracts have been awarded on a cost-plus or fixed-price basis. See Part I, Item 1, "BUSINESS - Contracts". As a service business, the Company's profitability is directly affected by the degree to which its professional staff is fully utilized on existing contracts.

Fiscal Year 1996 Compared to Fiscal Year 1995

Total revenues for the fiscal year ended September 30, 1996, increased 5.4 percent to $94,073,000. This is up from a .3 percent decrease in fiscal 1995 and up from a 2.4 percent increase in fiscal 1994. The increase in total revenues in fiscal 1996 was mostly due to a 15.0 percent increase in subcontract and procurement mainly in the transportation area. Revenues from U.S. government contracts decreased 21.5 percent in fiscal 1996 as compared to fiscal 1995 and 13 percent as compared to fiscal 1994. This decrease is attributable to the government's spending reduction, particularly in overseas infrastructure projects. Operating revenues (total revenues excluding pass-through costs) increased 2.7 percent to $71,271,000 compared to a 5.6 percent increase to $69,397,000 in fiscal 1995 and a 4.9 percent increase in fiscal 1994. We continue to see an increased demand for facilities and transportation engineering. United States defense work has decreased slightly, but there is continued demand for services in other areas of the U.S. government.

Pass-through costs, expressed as a percentage of total revenue, increased to 24.2 percent in fiscal 1996 compared to 22.2 percent in fiscal 1995 compared to 26.5 percent in fiscal 1994. Costs will vary from year to year depending on the need for specialty subconsultants and governmental subcontract requirements.

Cost of services, expressed as a percentage of operating revenues, was 89.2 percent in fiscal 1996, which is a decrease from the 89.3 percent in fiscal 1995, but is comparable to 89.2 percent in fiscal 1994. In fiscal 1996, costs increased from $61,942,000 in fiscal 1995 to $63,557,000. This increase is due primarily to increased labor expenses as a result of increased workload commensurate with operating revenue increase.

General and administrative expense, expressed as a percentage of operating revenues, decreased to 6.9 percent in fiscal 1996 from 7.1 in 1995 and 1994. Total general and administrative costs also decreased .8 percent in fiscal 1996 from $4,952,000 to $4,912,000.

Interest, expressed as a percentage of operating revenues, was 2.1 percent in fiscal 1996 and 2.2 percent in fiscal 1995 and 1994. Interest rates decreased in fiscal 1996, and bank loans were lower due to a more efficient use of cash.

The Company had a pre-tax profit of $1,301,000. Income tax expense was 54 percent of pre-tax income compared to 58 percent in fiscal 1995 and 45 percent in fiscal 1994. The variance in the rate is due to reduction in non-deductible expenses as a percent of pre-tax income.

In the fourth quarter, the Company had a pre-tax profit of $483,000 as compared to $286,000 in fiscal 1995 and $144,000 in fiscal 1994. The increase in pre-tax profit from fiscal 1995 is due to a decrease in employee-related costs and interest expense.

Fiscal Year 1995 Compared to Fiscal Year 1994

Total revenues for the fiscal year ended September 30, 1995 decreased, 0.3% to $89,232,000. This is down from a 2.4% increase in fiscal 1994 and a 15.3% increase in fiscal 1993. The reduction in total revenues in fiscal 1995 was the result of a 16.4% reduction in subcontract and procurement mainly in the transportation area. Revenues from U. S. Government contracts decreased 13% in fiscal 1995 as compared to fiscal 1994 and 15.8% as compared to fiscal 1993. This decrease is attributable to the Government's spending reduction, particularly in overseas infrastructure projects. Operating revenues (total revenues excluding pass-through costs) increased 5.6% to $69,397,000 compared to a 4.9% increase in fiscal 1994 and a 13.5% increase in fiscal 1993. While there was a reduction in the international region, we continue to see an increased demand for facilities and transportation engineering. United States defense work has decreased slightly but there is continued demand for services in other areas of the U. S. Government.

Pass-through costs, expressed as a percentage of total revenue, decreased to 22.2% in fiscal 1995 compared to 26.5% in fiscal 1994 and 28.2% in fiscal 1993. Costs will vary from year to year depending on the need for specialty subconsultants and governmental subcontract requirements.

Cost of services, expressed as a percentage of operating revenues, was 89.3% in fiscal 1995, which is comparable to the 89.2% in fiscal 1994, but is an increase from the 88.0% in fiscal 1993. In fiscal 1995, costs increased from $58,614,000 in fiscal 1994 to $61,942,000. This increase is due to increased international marketing efforts and increased labor and labor-related expenses due to

increased workload. The increase in fiscal 1994 was due in part to a transfer of certain costs from general and administrative expense to cost of services. Without this transfer, cost of services expressed as a percentage of revenue was comparable to fiscal 1993 at 87.7%. Total costs in fiscal 1994 (excluding the transfer of $1.0 million) increased to $57,614,000 from $55,173,000. This increase was due to increased post retirement benefit costs, increased international marketing efforts and increased labor and labor-related expenses due to an increased workload.

General and administrative expense, expressed as a percentage of operating revenues, was 7.1% in fiscal 1995 and 1994 and decreased from 8.3% in fiscal 1993. Total general and administrative costs increased 6.3% in fiscal 1995 from $4,657,000 to $4,952,000. This increase is due mainly to an increase in legal fees. The decrease in fiscal 1994 was due to the above mentioned reclassification of costs from general and administrative expense to cost of services.

Interest, expressed as a percentage of operating revenues, was 2.2% in fiscal 1995 and 1994 and decreased from 2.3% in fiscal 1993. While interest rates increased in fiscal 1995, the average amount of the bank loan outstanding decreased by 7% as compared to fiscal 1994.

The company had a pre-tax profit of $949,000. Income tax expense was 58% of pre-tax income compared to 45% in fiscal 1994 and 46% in fiscal 1993. The variance in the rate is due to an increase in non-deductible expenses and the recognition of income in the various states in which we do business and their tax rates.

In the fourth quarter the Company had a pre-tax profit of $286,000 as compared to $144,000 in fiscal 1994 and $152,000 in fiscal 1993.

Fiscal Year 1994 Compared to Fiscal Year 1993

Total revenues for the fiscal year ended September 30, 1994 increased 2.4% to $89,465,000. This is down from a 15.3% increase in fiscal 1993 and a 6.4% increase in fiscal 1992. The increased revenues in fiscal 1994 were the result of increased demand for transportation engineering services. In fiscal 1993, U. S. government contracts accounted for 47 percent of the total increase in revenues as compared to fiscal 1992, while revenues for U. S. government contracts were comparable in fiscal 1994 versus fiscal 1993. The balance of the

fiscal 1993 increase was also due to increased demand for transportation engineering services. Operating revenues (total revenues excluding pass-through costs) increased 4.9% to $65,746,000 compared to a 13.5% increase in fiscal 1993 and a 1.6% decrease in fiscal 1992. The increase in operating revenues reflects continued demand for transportation engineering services as well as the results of increased marketing effort. While there have been decreases in the U.S. Government spending for defense, there has been significant demand for services in other departments of the U. S. government as well as demand by non U. S. government clients for transportation and infrastructure.

Pass-through costs, expressed as a percentage of total revenue, decreased to 26.5% in fiscal 1994 compared to 28.2% in fiscal 1993 and 27.1% in fiscal 1992. Costs will vary from year to year depending on the need for specialty subconsultants and governmental subcontract requirements.

Cost of services, expressed as a percentage of operating revenues, increased to 89.2% in fiscal 1994 from 88.0% in fiscal 1993 and decreased from 89.6% in fiscal 1992. The increase in fiscal 1994 is due in part to a transfer of certain costs from general and administrative expense to cost of services. Without this transfer, cost of services expressed as a percentage of revenue would be comparable to fiscal 1993 at 87.7%. Total costs (excluding the transfer of $1.0 million) increased from $55,173,000 to $57,614,000. This increase is due to increased post retirement benefit costs, increased international marketing efforts and increased labor and labor related expenses due to an increased workload. The decrease in fiscal 1993 from fiscal 1992 was due to an increase in revenue and the Company's cost containment strategy.

General & administrative expense, expressed as a percentage of operating revenues, decreased to 7.1% in fiscal 1994 from 8.3% in fiscal 1993 and 8.9% in fiscal 1992. This reduction was due to the above mentioned reclassification of costs from general and administrative expense to cost of services and without this reclassification, would have been comparable to previous years at 8.6%.

Interest, expressed as a percentage of operating revenues, decreased to 2.2% in fiscal 1994 from 2.3% in fiscal 1993 and 2.5% in fiscal 1992. This decrease was the result of the increase in revenues.

The company had a pre-income tax profit of $1,028,000 due to the increase in revenues. Income tax expense was 45% of pre-tax income compared to 46% in fiscal 1993 and an income tax benefit of 37% in fiscal 1992. Included in the 1994 tax rate was a favorable adjustment of $45,000 due to the adoption of FASB 109. The variance in the rate is primarily due to the recognition of income in the various states in which we do business and their tax rates.

In the fourth quarter the Company had a pre-tax profit of $144,000. This profit was impacted by higher than anticipated legal expenses.

Liquidity, Capital Resources and Financing Agreements.

Cash provided in operating activities was $4,268,000 in fiscal 1996 compared to cash provided in operating activities of $1,109,000 in fiscal 1995. This increase was due mainly to an increase in billings in excess of related costs and an increase in accounts payable and other current liabilities. Working capital increased $501,000 to $8,721,000 in fiscal 1996 compared to a $1,036,000 increase in 1995 and a $554,000 increase in 1994. Investing activities slowed to $357,000 for the continued purchase of computer hardware and software compared to $951,000 in 1995. Financing activities consisted of a $3,803,000 net reduction in short-term borrowing due to the previously mentioned increase in billings in excess and accounts payable and other current liabilities.

Capital resources available to the Company include an existing line of credit for working capital. The current line is a maximum of $16.5 million based on accounts receivable and work-in-progress, of which approximately $5,900,000 is currently available. An agreement is being negotiated whereby the line of credit may be reduced. The line of credit is also a demand note and requires the Company to maintain certain financial covenants. To date, the Company has maintained these

covenants and believes that its working capital and existing or reduced line of credit are adequate to meet current fiscal year requirements. If the Company should fail to meet these covenants or should the bank demand payment on the note, there would be a material adverse financial impact. The Company is not aware of any reason for the bank to demand payment and does not expect that it would do so in the future. The Company is planning to continue its program of purchasing computer-assisted design and drafting equipment.

In the long term the Company relies on the ability to generate sufficient cash flows from operating activities to fund investing and financing requirements. If demand for services should increase sharply, additional sources of financing may be required.

The Company is currently involved in two lawsuits, Skinner and American Continental Properties. If the outcome of these lawsuits is adverse, the Company may be required to pay substantial deductibles or indemnification. The Company believes that it will be able to finance any adverse finding through the use of an income tax carryback of the resulting loss in combination with the line of credit and existing resources. The Company is vigorously pursuing its defenses, and management believes the final resolution of these legal matters will not have a material adverse effect on the Company's financial statements.

Impact of Inflation

Because the Company's business is essentially the supplying to customers of the expertise of its employees, there are certain factors which significantly reduce the impact of inflation. One such factor is that the Company has a comparatively small investment in property and equipment as a percentage of total assets. In addition, a substantial percentage of the Company's contracts are under cost reimbursement contract provisions or fixed-price contracts which include inflation assumptions when bid upon.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA.

The report of the independent auditors and consolidated financial statements included in the Company's Annual Report to Shareholders for the year ended September 30, 1996, are included in Part IV, Item 14 of this Report.

ITEM 9. CHANGE IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE.

None.

PART III

ITEM 10. DIRECTORS AND EXECUTIVE OFFICERS OF THE REGISTRANT

The information contained under the caption "Election of Directors" in the company's 1996 Proxy Statement is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION.

The information contained under the caption "Executive Compensation" in the Company's 1996 Proxy Statement is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT.

The information contained under the caption "Security Ownership" in the Company's 1996 Proxy Statement is incorporated herein by reference.

ITEM 13. CERTAIN TRANSACTIONS AND RELATED TRANSACTIONS.

The information contained under the caption "Certain Transactions" in the Company's 1996 Proxy Statement is incorporated herein by reference.

PART IV

ITEM 14. EXHIBITS, FINANCIAL STATEMENTS, AND REPORTS ON FORM 8-K.

(A) The following documents are filed as part of this report;

(1) Financial Statements:

Report of Independent Auditors

Consolidated Balance Sheets - September 30, 1996 and 1995

Consolidated Statements of Income - Years ended September 30, 1996, 1995 and 1994

Consolidated Statements of Stockholders' Equity Years ended September 30, 1996, 1995 and 1994

Consolidated Statements of Cash Flows - Years ended September 30, 1996, 1995 and 1994

Notes to Consolidated Financial Statements - September 30, 1996

(2) Financial Statements schedules required by Item 8.

All schedules for which provision is made in the applicable accounting regulations of the Securities and Exchange Commission are not required under the related instructions or are inapplicable, and therefore have been omitted.

(B) Reports on Form 8-K.

There were no reports on Form 8-K for the fiscal year ended September 30, 1996.

(C) Exhibits filed pursuant to Item 601 of Regulation S-K:

****** 3.1 Amended and restated Articles of Incorporation of the Company.

****** 3.2 By-Laws of the Company, as amended.

*** 3.3 Amendment to Section 1.04 of the By-Laws of the Company.

* 4.0 Specimen Common Stock Certificate of the Company.

* 10.2 Loan Agreement, undated, between the Company and Richard L. Holland, relating to the purchase of 48,779 shares of Common Stock.

*** 10.3 Asset Acquisition Agreement, dated September 22, 1987, between STV/WAI, Inc. and Michael Lynn Assoc., P.C. relating to the acquisition by STV/Michael Lynn Associates, Inc. of certain assets of Michael Lynn Assoc., P.C.

* 10.4 Lease, dated October 3, 1980, between the Company and Montco Investors Realty Company, relating to the Company's executive and engineering offices in Pottstown, Pennsylvania

* 10.5 Lease, dated August 30, 1983, between the Company and Montco Investors Realty Company, relating to the addition to the Company's offices in Pottstown, Pennsylvania and granting the Company an option to extend its lease for such facility for two additional five-year periods.

* 10.6 Lease, dated November 22, 1983, accompanying Workletter, dated October 12, 1983, and letters (2) dated November 22, 1983 between the Company and 225 Fourth Company, providing for the renovation and use of office space at 225 Park Avenue South, New York, New York.

* 10.7 STV Engineers, Inc. Employee Stock Ownership Plan, dated January 7, 1982, and STV Engineers Employee Stock Ownership Plant Trust Agreement, dated January 7, 1982, and Amendment No. 1 thereto, dated May 14, 1982.

* 10.8 STV Revised Pension Plan.

* 10.9 STV, Inc. Money Purchase Pension Plan.

10.10 Officers' and Directors' Liability Policy.

*** 10.11 Employment Agreement of Richard L. Holland

**** 10.12 Stipulation of Amendment to Employee Stock Ownership Plan effective October 1, 1984.

*** 10.13 Loan Agreement, dated February 28, 1986, between the Company and First Pennsylvania Bank, N.A., relating to the Company's $13,000,000 line of credit.

*** 10.14 Amendment, dated November 26, 1986, to the Loan Agreement between the company and First Pennsylvania Bank, N.A., increasing the limit of standby letters of credit in the Agreement to $3,500,000.

*** 10.15 STV Engineers, Inc. 1985 Stock Option Plan.

*** 10.16 Lease, dated January 27, 1986, and Amendments thereto, between Company and 225 Fourth Company providing for the use of office space at 233 Park Avenue, New York, New York.

*** 10.17 Amendment, dated May 28, 1987, between the Company and First Pennsylvania Bank, N.A., decreasing the interest rate for short term borrowings and the creation of a $1,500,000 term loan.

*** 10.18 Amendment, dated November 12, 1987, increasing the line of credit to $17,000,000.

***** 10.22 Amendment, dated June 1, 1990 between the Company and First Pennsylvania Bank, NA increasing the interest rate for short term borrowings.

****** 10.26 Amendment dated September 30, 1991, between the company and CoreStates Bank, N.A., decreasing the maximum amount of the line of credit and increasing the charge for issuing letters of credit.

******* 10.27 Lease extension dated March 13, 1992 between the Company and 225 Fourth Company relating to an extension of seven years, four months for use of office space at 225 Park Avenue South, New York, New York.

******* 10.28 Agreement effective January 1, 1992 relating to ACEC medical and life insurance.

******* 10.29 Agreement dated August 29, 1991 relating to U. S. Healthcare medical insurance.

********* 10.31 Employment Agreement of Dominick M. Servedio.

********* 10.32 Employment Agreement of Michael Haratunian.

********** 10.33 Amendment to the STV Group Incorporated Employee Stock Ownership Plan

10.34 Lease, dated August 21, 1995, and Addendums thereto, between the Company and Dame Enterprises, relating to the Company's executive and engineering offices in Douglassville, Pennsylvania.

10.35 Agreement effective July 1, 1996 with Corporate Health Insurance Company providing Group Health Insurance - Custom Plan.

10.36 Agreement effective December 1, 1996 with U. S. Healthcare providing medical insurance.

11 Statement Re: Computation of Per Share Earnings.

13.1 "Common Stock Market Prices" from Company's Annual Report to Shareholders.

13.2 "Financial Highlights for the Fiscal Year Ended September 30," 1992 through 1996 from Company's Annual Report to Shareholders.

21.1 Subsidiaries of the Company from Company's Annual Report to Shareholders.

* Incorporated by reference from the Annual Report and Form 10-K for the year ended September 30, 1984.

** Incorporated by reference from Registration Statement No. 2-88904.

*** Incorporated by reference from Form 10-K and the Annual Report for the year ended September 30, 1987.

**** Incorporated by reference from Form 10-K and the Annual Report for the year ended September 30, 1989.

***** Incorporated by reference from Form 10-K and the Annual Report for the year ended September 30, 1990.

****** Incorporated by reference from Form 10-K and the Annual Report for the year ended September 30, 1991.

******* Incorporated by reference from Form 10-K and the Annual Report for the year ended September 30, 1992.

******** Incorporated by reference from Form 10-K and the Annual Report for the year ended September 30, 1993.

********* Incorporated by reference from Form 10-K and the Annual Report for the year ended September 30, 1994.

********** Incorporated by reference from Form 10-K and the Annual Report for the year ended September 30, 1995.

SIGNATURES

Pursuant to the requirements of Section 13 of 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Date: December 30, 1996

STV GROUP, INCORPORATED

(Registrant)

By: /s/ Michael Haratunian

MICHAEL HARATUNIAN,
Chairman of the Board, Chief Executive Officer and Director
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

SIGNATURE	CAPACITY	DATE
/s/ Michael Haratunian --- MICHAEL HARATUNIAN	Chairman of the Board, Chief Executive Officer and Director (Principal Executive Officer)	December 30, 1996
/s/ Dominick M. Servedio --- DOMINICK M. SERVEDIO	President, Chief Operating Officer and Director	December 30, 1996
/s/ Peter W. Knipe --- PETER W. KNIPE	Secretary/Treasurer (Principal Accounting and Financial Officer)	December 30, 1996
/s/ Richard L. Holland --- RICHARD L. HOLLAND	Director	December 30, 1996
/s/ Harry Prystowsky --- HARRY PRYSTOWSKY	Director	December 30, 1996
/s/ Ray M. Monti --- RAY M. MONTI	Director	December 30, 1996
/s/ Maurice L. Meier --- MAURICE L. MEIER	Director	December 30, 1996
/s/ William J. Doyle --- WILLIAM J. DOYLE	Director	December 30, 1996

FINANCIAL STATEMENTS

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REPORT OF INDEPENDENT AUDITORS

Stockholders and Board of Directors
STV Group, Incorporated

We have audited the accompanying consolidated balance sheets of STV Group, Incorporated and Subsidiaries as of September 30, 1996 and 1995, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended September 30, 1996. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of STV Group, Incorporated and Subsidiaries as of September 30, 1996 and 1995, and the consolidated results of their operations and their cash flows for each of the three years in the period ended September 30, 1996, in conformity with generally accepted accounting principles.

/s/ ERNST & YOUNG LLP

Reading, Pennsylvania

November 14, 1996

CONSOLIDATED BALANCE SHEETS
STV Group and Subsidiaries.

<TABLE>
<CAPTION>

	September 30	
	1996	1995
<S>	<C>	<C>
Assets		

Current Assets:		
Cash	$ 28,000	$ 668,000
Accounts receivable	20,504,000	21,758,000
Costs and estimated profits of uncompleted contracts in excess of related billings	14,290,000	12,976,000
Deferred tax benefit	180,000	165,000
Income taxes recoverable	0	486,000
Prepaid expenses and other current assets	1,577,000	1,888,000
Total Current Assets	36,579,000	37,941,000
Property and equipment, net	1,314,000	1,883,000
Deferred tax benefit	1,369,000	1,026,000
Other assets	733,000	776,000
Total Assets	$39,995,000	$41,626,000
Liabilities and Stockholders' Equity		
Current Liabilities:		
Note payable	$ 9,448,000	$13,251,000
Current maturity of long-term debt	1,000,000	1,340,000
Accounts payable	5,603,000	5,254,000
Billings on uncompleted contracts in excess of related costs and estimated profits	4,318,000	3,344,000
Accrued payroll and related expenses	5,775,000	5,217,000
Accrued expenses	1,522,000	1,315,000
Income tax payable	192,000	0
Total Current Liabilities	27,858,000	29,721,000
Long-Term Debt	1,795,000	2,021,000
Other liabilities	0	12,000
Total Liabilities	29,653,000	31,754,000
Commitments and contingencies		
Stockholders' Equity:		
Preferred stock, authorized 2,000,000 shares, no par, no shares issued or outstanding	0	0
Convertible preferred stock, cumulative, par $1, authorized 2,000,000 shares, issuable in series, $1.50 series, no shares issued or outstanding	0	0
Common stock, par $1, authorized 6,000,000 shares	1,921,000	1,921,000
Capital in excess of par	3,003,000	3,003,000
Retained earnings	5,814,000	5,219,000
	10,738,000	10,143,000
Less: Treasury stock	271,000	271,000
Loans receivable from officers	125,000	0
Total Stockholders' Equity	10,342,000	9,872,000
Total Liabilities and Stockholders' Equity	$39,995,000	$41,626,000

</TABLE>

See notes to consolidated financial statements.

CONSOLIDATED STATEMENTS OF INCOME
STV Group and Subsidiaries

<TABLE>
<CAPTION>

	For the Year Ended September 30		
	1996	1995	1994
<S>	<C>	<C>	<C>
Total revenues	$ 94,073,000	$ 89,232,000	$ 89,465,000
Subcontract and procurement costs	22,802,000	19,835,000	23,719,000
Operating revenue	$ 71,271,000	$ 69,397,000	$ 65,746,000

Costs and expenses:			
Costs of services	$ 63,557,000	$ 61,942,000	$ 58,614,000
General and administrative	4,912,000	4,952,000	4,659,000
Interest	1,501,000	1,554,000	1,445,000
	$ 69,970,000	$ 68,448,000	$ 64,718,000
Income before income taxes	$ 1,301,000	$ 949,000	$ 1,028,000
Income tax expense	(706,000)	(555,000)	(465,000)
Net income	$ 595,000	$ 394,000	$ 563,000
Earnings per common share	$ .32	$ .22	$ .32

</TABLE>

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
STV Group and Subsidiaries

<TABLE>
<CAPTION>

	Common Stock				Treasury Stock	
	Number of shares	Amount	Capital in excess of par	Retained earnings	Number of shares	Amount
<S>	<C>	<C>	<C>	<C>	<C>	<C>
Balance September 30, 1993	1,842,972	$1,843,000	$2,681,000	$4,262,000	99,726	$ 271,000
Net income for the year				563,000		
Balance September 30, 1994	1,842,972	$1,843,000	$2,681,000	$4,825,000	99,726	$ 271,000
Net income for the year				394,000		
Issuance of stock	78,000	78,000	322,000			
Balance September 30, 1995	1,920,972	$1,921,000	$3,003,000	$5,219,000	99,726	$ 271,000
Net income for the year				595,000		
Balance September 30, 1996	1,920,972	$1,921,000	$3,003,000	$5,814,000	99,726	$ 271,000

</TABLE>

See notes to consolidated financial statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS
STV Group and Subsidiaries

<TABLE>
<CAPTION>

	For the Year Ended September 30		
	1996	1995	1994
<S>	<C>	<C>	<C>
Operating Activities			
Net income	$ 595,000	$ 394,000	$ 563,000
Adjustments to reconcile net income to net cash provided by (used in) operating activities			
Depreciation	997,000	1,015,000	836,000
Deferred income taxes	(358,000)	(165,000)	(225,000)
Stock contribution to Employee Stock Ownership Program (ESOP)	--	400,000	--
Interest in Joint Venture	--	--	2,000
Changes in operating assets and			

liabilities			
Accounts receivable	1,254,000	2,655,000	(3,254,000)
Costs and estimated profits of uncompleted contracts in excess of related billings and other current assets	(1,003,000)	(1,000)	(149,000)
Accounts payable and other current liabilities	1,131,000	(2,533,000)	1,523,000
Billings on uncompleted contracts in excess of related costs and estimated profits	974,000	(456,000)	390,000
Current income taxes	678,000	(200,000)	130,000
Net cash provided by (used in) operating activities	$ 4,268,000	$ 1,109,000	$ (184,000)
Investing Activities			
Purchase of property and equipment	$ (338,000)	$ (727,000)	$ (827,000)
Purchase of software	(19,000)	(224,000)	(46,000)
(Increase) decrease in other assets	(40,000)	9,000	(23,000)
Loans receivable from officers	(125,000)	--	--
Net cash used in investing activities	$ (522,000)	$ (942,000)	$ (896,000)
Financing Activities			
Proceeds from line of credit and long term borrowings	$ 85,797,000	$ 84,412,000	$ 79,889,000
Principal payments on line of credit and long term borrowings	(90,183,000)	(84,551,000)	(78,987,000)
Net cash (used in) provided by financing activities	$ (4,386,000)	$ (139,000)	$ 902,000
(Decrease) increase in cash	(640,000)	28,000	(178,000)
Cash at beginning of year	668,000	640,000	818,000
Cash at end of year	$ 28,000	$ 668,000	$ 640,000

</TABLE>

See notes to consolidated financial statements.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
STV Group and Subsidiaries.

1. Significant Accounting Policies

Basis of Presentation

The Company and its subsidiaries consider themselves in a single line of business: consulting engineering, architectural, surveying and related services. The Company's clients consist primarily of various governmental agencies, with an increasing presence in the private sector in geographic regions throughout the United States.

Certain amounts in the 1994 and 1995 financial statements have been reclassified to conform to their 1996 presentation.

Principles of Consolidation

The consolidated financial statements include the accounts of the Company, its subsidiaries, and the 50 percent interest in an architectural joint venture. All significant intercompany transactions and balances have been eliminated.

Use of Estimates

The preparation of financial statements in conformity with generally accepted

accounting principles requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Revenue Recognition

The Company uses the percentage-of-completion method of accounting for contract revenues. Progress toward completion is measured on a contract-by-contract basis using direct labor costs incurred to date as compared with estimated total labor costs at completion. The asset, "Cost and estimated profits of uncompleted contracts in excess of related billings," represents revenues recognized in excess of amounts billed. The liability, "Billings on uncompleted contracts in excess of related costs and estimated profits," represents billings in excess of revenues recognized. Significant changes in contract terms affecting the results of operations are recorded and recognized in the period in which the revisions are determined.

Fair Value of Financial Instruments

The Company's financial instruments consist primarily of cash and cash equivalents, trade receivables, investments in U.S. treasury bills, trade payables, and debt instruments. The book value of cash and cash equivalents, trade receivables, U.S. treasury bills, and trade payables are considered to be representative of their respective fair values. The carrying value of the Company's long-term debt is comparable to fair value based on current rates and terms, with the exception of the deferred compensa

tion plan liability with interest imputed at 16 percent (See Note 11.) The fair value of this liability discounted at 8 percent is estimated to be $1,382,000.

Depreciation

Depreciation is primarily on the straight-line method over the estimated useful lives of the assets. Depreciation of assets recorded under capital leases is included in depreciation expense. For income tax purposes, accelerated depreciation methods are used by certain subsidiaries and deferred income taxes are provided, when applicable.

New Accounting Standards

In March 1995, the Financial Accounting Standards Board issued Statement of Financial Accounting Standards (SFAS) No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of," which requires impairment losses to be recorded on long-lived assets used in operations when indicators of impairment are present and the undiscounted cash flows estimated to be generated by those assets are less than the assets' carrying amount. The Company will adopt SFAS 121 in the first quarter of fiscal year 1997 and, based upon the circumstances, does not believe the effect of adoption will be material.

SFAS No. 123, "Accounting for Stock-Based Compensation," is effective for fiscal years beginning after December 15, 1995. SFAS 123 provides companies with a choice to follow the provisions of SFAS 123 in determining stock-based compensation expense or to continue with the provisions of APB 25, "Accounting for Stock Issued to Employees." The Company expects to continue to follow APB 25 in respect to its Stock Option Plan and will provide disclosures as required by SFAS 123 in the September 30, 1997, notes to the financial statements.

2. Costs and Estimated Profits of Uncompleted Contracts in Excess of Related Billings

Costs and estimated profits of uncompleted contracts at September 30, 1996, and 1995, respectively, are as follows:

	1996	1995
Costs and estimated earnings on uncompleted contracts	$328,090,000	$294,418,000
Less billings to date	318,118,000	284,786,000
	$ 9,972,000	$ 9,632,000

Costs and estimated profits of uncompleted contracts are included in the accompanying balance sheet under the following captions:

	1996	1995
Costs and estimated profits of uncompleted contracts in excess of related billings	$14,290,000	$12,976,000
Billings on uncompleted contracts in excess of related costs and estimated profits	4,318,000	3,344,000
	$ 9,972,000	$ 9,632,000

Included in accounts receivable are retainages related to uncompleted contracts in the amount of $3,230,000 in 1996 and $3,245,000 in 1995. The collection of retainages generally coincides with final project acceptance.

3. Property and Equipment

Property and equipment, at cost, are as follows:

	1996	1995
Land	$ 54,000	$ 54,000
Equipment	5,895,000	5,616,000
Leased equipment	930,000	1,227,000
Furniture and fixtures	2,673,000	2,334,000
Leased furniture and fixtures	233,000	271,000
Leasehold improvements	2,516,000	2,566,000
	$12,301,000	$12,068,000
Less: Accumulated depreciation and amortization	10,987,000	10,185,000
	$ 1,314,000	$ 1,883,000

4. Note Payable

The note payable on demand with the Company's bank is with interest at 1-1/2 percent above the prime rate and is secured by substantially all assets. The weighted average interest rate was 9.9 percent and 10.2 percent in fiscal 1996 and 1995, respectively. The bank also provides letters of credit which incur a charge of 2-1/2 percent of the face value. Currently, $1,140,000 letters of credit are outstanding. The face value of the letters of credit and note payable cannot exceed a maximum of $16,500,000 based on the accounts receivable and contracts in progress.

An agreement with this bank contains restrictive covenants regarding additional debt and stockholders' equity. The restrictions include maintaining a minimum tangible net worth, a maximum total debt to tangible net worth ratio, and a minimum working capital amount.

5. Income Taxes

The Company uses the liability method of accounting for income taxes required by Statement of Financial Accounting Standards (SFAS) No. 109, "Accounting for Income Taxes."

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amount of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Significant components of the Company's deferred tax assets and liabilities as of September 30, 1996, are as follows:

Deferred tax assets:	
Vacation accruals	$ 574,000
Depreciation	88,000
Deferred compensation	662,000
Litigation	284,000
Postemployment benefits	18,000
Postretirement medical benefits	314,000
Total deferred tax assets	1,940,000
Deferred tax liabilities:	
Retainage	391,000
Total deferred tax liabilities	391,000
Net deferred tax assets	$1,549,000

Significant components of the provision (benefit) for income taxes are as follows:

	1996	1995	1994
Current:			
Federal	$ 734,000	$ 520,000	$ 600,000
State	330,000	200,000	90,000
Total current	$ 1,064,000	$ 720,000	$ 690,000
Deferred:			
Federal	$ (239,000)	$ (100,000)	$ (172,000)
State	(119,000)	(65,000)	(53,000)
Total deferred	$ (358,000)	$ (165,000)	$ (225,000)
Income tax expense	$ 706,000	$ 555,000	$ 465,000

A reconciliation of federal income taxes at the statutory rate to the Company's income tax provision follows:

	1996	1995	1994
Federal income tax rate	34.0%	34.0%	34.0%
Non-deductible expenses and other	9.2	14.6	7.0
State taxes, net of federal tax effect	10.8	9.4	4.0

54.0% 58.0% 45.0%

The Company made income tax payments of $488,000, $1,014,000, and $881,000 in 1996, 1995, and 1994, respectively. The Company received income tax refunds of $51,000 in 1996, $92,000 in 1995, and $225,000 in 1994.

6. Amounts per Common Share

Earnings per common share is based on the weighted-average number of shares outstanding during the periods presented after giving effect to the potential dilutive effect, if any, of the exercise of stock options. Earnings per common share are based upon 1,873,000 shares in 1996, 1,832,000 shares in 1995, and 1,754,000 shares in 1994.

7. Commitments and Contingencies

For policy years beginning March 4, 1993, the Company's professional liability insurance arrangement provides for an annual aggregate $5,000,000 of coverage with a $250,000 deductible per occurrence

on a claims made basis. For the policy year beginning March 4, 1992, the Company's professional liability insurance arrangement provides for an aggregate $5,000,000 of coverage. There was a $500,000 deductible and a requirement to indemnify the insurer for an additional aggregate $1,000,000. The Company had a similar arrangement for professional liability coverage for the period October 1, 1986, to March 3, 1992, providing an aggregate $5,000,000 of professional liability coverage. The Company has recognized the indemnity obligation by charges of $4,500,000 to operations in prior years and the posting of a $1,000,000 letter of credit. In addition to the professional liability coverage, the Company has general liability insurance in excess of $10,000,000 per occurrence and in the aggregate.

During 1992, the Company and its insurers settled a personal injury lawsuit for $5,400,000, of which $2,700,000 was paid by the Company's professional liability insurer from the funded indemnity and $2,700,000 by the general liability insurer. There remains a declaratory judgement action pending as to whether insurance coverage was to be provided under the previous general liability policy or professional liability policy then in effect. In this proceeding, the court has required that the limits of the Company's insured coverage be reserved to pay this claim if the insurer is found liable. The Company and its professional liability insurer believe that this matter should be covered under its general liability policy in which case the $2,700,000 would be repaid to the professional liability insurer to replenish the indemnity.

In addition, in 1992 the Company's former professional liability insurer was found liable for approximately $4,000,000 due to a previous arbitration proceeding allegedly relating to an asset acquisition. The judgement was reversed on appeal in 1994. If the Company's professional liability insurer is found ultimately liable under both of these actions, the Company may be required to indemnify the professional liability insurer to the extent of the policy limit of $5,000,000 as described above. Such payments would constitute a charge to operations in the year the determination is made. The Company and the Company's professional liability insurer continue to deny liability and intend to vigorously pursue defenses available to them.

The Company is also involved in various other litigation arising out of the ordinary course of business, which may require the payment of additional amounts. The Company's management believes that the final resolution of the above legal matters will not have a material adverse effect on the Company's financial statements.

The Company has noncancellable lease agreements for the use of office space and equipment. These agreements expire on varying dates and in some instances contain renewal options. In addition to the base rental costs, occupancy lease

agreements generally provide for rent escalations resulting from increased assessments for real estate taxes and other charges. Future minimum lease payments under noncancellable leases (excluding automobile leases) with remaining terms of more than one year are due as follows:

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (CONTINUED)
STV Group and Subsidiaries

	Capital Leases	Operating Leases
1997	$ 555,000	$ 2,987,000
1998	$ 228,000	$ 2,453,000
1999	$ --	$ 2,375,000
2000	$ --	$ 1,920,000
2001	$ --	$ 1,771,000
Thereafter	$ --	$10,741,000
Total minimum lease payments	$ 783,000	$22,247,000
Less amount representing interest	$ 56,000	
Present value of net minimum lease payments	$ 727,000	

Rental expense under operating leases amounted to $2,892,000, $2,705,000, and $2,713,000 in 1996, 1995, and 1994, respectively.

8. Stock Plans

On October 1, 1981, the Company initiated an Employee Stock Ownership Plan (ESOP) which covers substantially all of its employees. Contributions to the plan are based on a percentage of eligible salaries. The total retirement expense for the years 1996, 1995, and 1994 was $1,002,000, $989,000, and $918,000, respectively. The liability is funded through either the issuance of shares of Company stock (at fair market value on date of issuance) or a cash payment for future stock purchases. The Company has funded the 1996 contribution with cash payments throughout 1996. At September 30, 1996, 1,240,000 shares of Company stock are held by the ESOP and are included in the earnings per share computation.

The Company adopted the 1985 Stock Option Plan which reserves 300,000 shares of its common stock for grants of options to officers and key employees. The plan requires that option prices be at least equal to the fair market value of the common stock at the date of grant. Options to purchase 190,000 shares at $4.12 to $5.12 per share have been granted.

A new Stock Option Plan was approved in fiscal 1996. Under this plan, 500,000 shares of common stock are reserved for issuance upon the exercise of the options granted. No options under the plan have been granted.

On October 20, 1995, certain Company officers borrowed $125,000 from the Company to purchase 25,000 shares of common stock from an outside director of the Company. The five-year term loan, secured by a stock pledge agreement, is payable at the term with interest at the Company bank borrowing rate currently at 1-1/2 percent above prime rate. These loans have been recorded as a reduction to stockholders' equity.

9. Postretirement Benefit Plan

The Company sponsors a defined benefit health care plan that provides postretirement medical benefits to all current and retired officers and their spouses upon attaining age 65, or age 55 with 10 years of service. The plan is contributory, with retiree contributions adjusted annually, and contains other

cost-sharing features such as deductibles and coinsurance. The accounting for the plan anticipates future cost-sharing changes to the written plan that are consistent with the Company's expressed intent to increase the retiree contribution rate annually for the expected general inflation rate for that year.

The following table presents the plan's status reconciled with amounts recognized in the Company's balance sheets:

	1996	1995
Accumulated postretirement benefit obligation:		
Retirees	$ (305,000)	$ (728,000)
Fully eligible active plan participants	(489,000)	(1,071,000)
Other active plan participants	(375,000)	(790,000)
Accumulated postretirement benefit obligation	$(1,169,000)	$(2,589,000)
Unrecognized net gain	(536,000)	(250,000)
Unrecognized transition obligation	951,000	2,220,000
Accrued postretirement benefit cost	$ (754,000)	$ (619,000)

Net periodic postretirement benefit costs include the following components:

	1996	1995	1994
Service cost	$ 43,000	$ 67,000	$ 70,000
Interest cost	119,000	185,000	187,000
Amortization of transition obligation over 20 years	84,000	124,000	124,000
Unrecognized (gain) loss	(49,000)	--	--
Net periodic postretirement benefit cost	$ 197,000	$ 376,000	$ 381,000

Effective December 1,1995, STV switched from an indemnity to a combination indemnity and managed care program. The cost assumptions associated with a managed care plan are less than with an indemnity program. The weighted-average annual assumed rate of increase in the per capita cost of covered benefits (i.e., health care cost trend rate) is 11.5 percent for 1996 (12 percent in 1995, 12.5 percent in 1994) and is assumed to decrease gradually to 6 percent in 2008 and remain at that level thereafter. The health care cost trend rate assumption has a significant effect on the amounts reported. For example, increasing the assumed health care cost trend rates by one percentage point in each year would increase the accumulated post retirement benefit obligation as of September 30, 1996, 1995 and 1994 by $133,000, $330,000 and $334,000, respectively, and the aggregate of the service and interest cost components of net periodic postretirement benefit cost for 1996 and 1995 by $20,000 and $34,000, respectively.

The weighted-average discount rate used in determining the accumulated postretirement benefit obligation was 7.75 percent at September 30, 1996 and 1995.

10. Major Customers

The percentage of total revenues derived from contracts with the United States government for fiscal years 1996, 1995 and 1994 were 14 percent, 19 percent and 22 percent, respectively.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (CONTINUED)
STV Group and Subsidiaries

11. Long-Term Debt

Long-term debt consists of the following:

<TABLE>
<CAPTION>

<S>	1996 <C>	1995 <C>
Capital leases with various maturities, the latest to September 1998, rates ranging from 8 percent to 11 percent, and monthly installments ranging from $974 to $15,897	$ 727,000	$1,305,000
Deferred compensation liability payable in fixed monthly installments of $12,000 through September 2006 with interest imputed at 16 percent	689,000	715,000
Executive deferred compensation liability for certain executives with annual interest at 1 percent above prime rate as of November 1 payable upon the termination of employment or approval of the Board of Directors	558,000	499,000
Deferred compensation liability payable in fixed monthly installments of $6,000 through October 1996 with interest imputed at 20 percent	6,000	65,000
Supplemental executive retirement agreements for two current executives payable in monthly installments upon retirement with interest imputed at 7 percent. (1)	360,000	193,000
Other	455,000	584,000
	2,795,000	3,361,000
Less: Current portion	1,000,000	1,340,000
	$1,795,000	$2,021,000

</TABLE>

(1) These agreements for two current executives provide for future cash payments of $122,000 and $226,000 annually, based on salary at retirement commencing September 2003 and September 2005, respectively. If maximum Company performance goals are achieved, these amounts would be increased 20 percent starting in September 2003, or at a prorated rate based on the levels of performance achieved.

Interest paid during 1996, 1995, and 1994 amounted to $1,472,000, $1,517,000, and $1,423,000, respectively.

The company incurred capital lease obligations of $ 0 in 1996, $804,000 in 1995, and $613,000 in 1994 to acquire equipment.

Annual maturities of long-term debt are as follows:

Year ending September 30	
1997	$1,000,000
1998	$ 254,000
1999	$ 42,000
2000	$ 49,000
2001	$ 57,000
Thereafter	$1,393,000

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (CONTINUED)
STV Group and Subsidiaries

12. Quarterly Results (unaudited)

(All dollar amounts omit 000 except per share data.)

	Quarter				Year
	First	Second	Third	Fourth	
Revenue from services:					
1996	$ 22,983	$ 23,502	$ 24,949	$ 22,639	$ 94,073
1995	$ 22,817	$ 21,092	$ 23,187	$ 22,136	$ 89,232
Operating revenue:					
1996	$ 18,004	$ 17,788	$ 17,982	$ 17,497	$ 71,271
1995	$ 17,353	$ 17,519	$ 17,358	$ 17,167	$ 69,397
Gross profit:					
1996	$ 1,883	$ 1,781	$ 1,979	$ 2,071	$ 7,714
1995	$ 1,885	$ 1,871	$ 1,835	$ 1,864	$ 7,455
Net income:					
1996	$ 103	$ 71	$ 159	$ 262	$ 595
1995	$ 102	$ 95	$ 79	$ 118	$ 394
Earnings per share:					
1996	$ .06	$ .04	$ .08	$ .14	$ .32
1995	$ .05	$ .05	$ .05	$ .07	$ .22

In the fourth quarter of 1996, STV made revised estimates to record the actual results of certain expenses. The impact of these adjustments on fourth quarter earnings was an increase of $.05 per share.

EXHIBITS

Index

Exhibit 10.10 - Officers' and Directors' Liability Policy

Exhibit 10.34 - Lease, dated August 21, 1995, and Addendums thereto, between the Company and Dame Enterprises, relating to the Company's executive and engineering offices in Douglassville, Pennsylvania.

Exhibit 10.35 - Agreement effective July 1, 1996 with corporate Health Insurance Company providing Group Health Insurance - Custom Plan.

Exhibit 10.36 - Agreement effective December 1, 1996 with U. S. Healthcare providing medical insurance.

Exhibit 11 - Statement Re: Computation of Per Share Earnings

Exhibit 13.1 - "Common Stock Market Prices" from Company's Annual Report to Shareholders

Exhibit 13.2 - "Financial Highlights for the Fiscal Year Ended September 30," 1991 through 1995 from Company's Annual Report to Shareholders

Exhibit 21.1 - Subsidiaries of the Company from Company's Annual Report to Shareholders

Exhibit 10.10

POLICY NUMBER:
483-12-48
RENEWAL OF:
444-97-15

[GRAPHIC OMITTED]

American International Companies

Directors, Officers and Corporate Liability Insurance Policy

[ ] AIU Insurance Company
[ ] Illinois National Insurance Company
[ ] American International South Insurance Company
[X] National Union Fire Insurance Company of Pitts., PA
[ ] Birmingham Fire Insurance Company of Penns.
[ ] National Union Fire Insurance Company of Louisiana
[ ] Granite State Insurance Company
[ ] New Hampshire Insurance Company

(each of the above being a capital stock company)

NOTICE: EXCEPT TO SUCH EXTENT AS MAY OTHERWISE BE PROVIDED HEREIN, THE COVERAGE OF THIS POLICY IS GENERALLY LIMITED TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD AND REPORTED IN WRITING TO THE INSURER PURSUANT TO THE TERMS HEREIN. PLEASE READ THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR INSURANCE AGENT OR BROKER.

NOTICE: THE LIMIT OF LIABILITY AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS SHALL BE REDUCED BY AMOUNTS INCURRED FOR LEGAL DEFENSE. AMOUNTS INCURRED FOR LEGAL DEFENSE SHALL BE APPLIED AGAINST THE RETENTION AMOUNT.

NOTICE: THE INSURER DOES NOT ASSUME ANY DUTY TO DEFEND; HOWEVER, THE INSURER MUST ADVANCE DEFENSE COSTS PAYMENTS PURSUANT TO THE TERMS HEREIN PRIOR TO THE FINAL DISPOSITION OF A CLAIM.

DECLARATIONS

ITEM 1. NAMED CORPORATION: STV GROUP, INC.

MAILING ADDRESS: 11 ROBINSON STREET
Pottstown, PA 19464

STATE OF INCORPORATION OF THE NAMED CORPORATION:
Pennsylvania

ITEM 2. SUBSIDIARY COVERAGE: any past, present or future Subsidiary of the Named Corporation

ITEM 3. POLICY PERIOD: From: May 05, 1996 To: May 05, 1997
(12:01 A.M. standard time at the address stated in Item 1.)

ITEM 4. LIMIT OF LIABILITY: $6, 000, 000
aggregate for Coverages A and B combined (including Defense Costs)

ITEM 5. RETENTION:
SECURITIES CLAIMS:

Judgments & Settlements (all coverages)	None
Defense Costs (non-lndemnifiable Loss)	None
Defense Costs (Coverage B(i) and Indemnifiable Loss)	$125.000 for Loss arising from Claims alleging the same Wrongful Act or related Wrongful Acts (waivable under Clause 6 in certain circumstances)

OTHER CLAIMS:

Judgments, Settlements and Defense Costs (non-Indemnifiable Loss)	None
Judgments, Settlements and Defense Costs (Indemnifiable Loss)	$ 125,000 for Loss arising from Claims alleging the same Wrongful Act or related Wrongful Acts

ITEM 6. CONTINUITY DATES:
A. Coverages A and B(ii): October 26, 1983
B. Coverage B(i): May 05, 1996
C. Coverages A and B:
Outside Entity Coverage (Per Outside Entity)
See Endorsement #62790

ITEM 7. PREMIUM: $ 95.000

ITEM 8. NAME AND ADDRESS OF INSURER ("Insurer"):

(This policy is issued only by the insurance company indicated below.)

National Union Fire Insurance Company of Pittsburgh, Pa.
70 Pine Street
New York. NY 10270

IN WITNESS WHEREOF, the Insurer has caused this policy to be signed on the Declarations Page by its President, a Secretary and a duly authorized representative of the Insurer.

/s/ Elizabeth M. Tuck
SECRETARY PRESIDENT

AUTHORIZED REPRESENTATIVE

COUNTERSIGNATURE DATE COUNTERSIGNED AT

ROEHRS & COMPANY
INC
PO BOX 100
EXTON PA 19341

American International Companies
DIRECTORS, OFFICERS AND CORPORATE LIABILITY INSURANCE POLICY

In consideration of the payment of the premium, and in reliance upon the statements made to the Insurer by application forming a part hereof and its attachments and the material incorporated therein, the insurance company designated in Item 8 of the Declarations, herein called the "Insurer"-, agrees as follows:

1. INSURING AGREEMENTS

COVERAGE A: DIRECTORS AND OFFICERS INSURANCE

This policy shall pay the Loss of each and every Director or Officer of the Company arising from a Claim first made against the Directors or Officers during the Policy Period or the Discovery Period (if applicable) and reported to the Insurer pursuant to the terms of this policy for any actual or alleged Wrongful Act in their respective capacities as Directors or Officers of the Company, except when and to the extent that the Company has indemnified the

Directors or Officers. The Insurer shall, in accordance with and subject to Clause 8, advance Defense Costs of such Claim prior to its final disposition.

COVERAGE B: CORPORATE LIABILITY INSURANCE

This policy shall pay the Loss of the Company arising from a:

(i) Securities Claim first made against the Company, or

(ii) Claim first made against the Directors or Officers,

during the Policy Period or the Discovery Period (if applicable) and reported to the Insurer pursuant to the terms of this policy for any actual or alleged Wrongful Act, but, in the case of (ii) above, only when and to the extent that the Company has indemnified the Directors or Officers for such Loss pursuant to law, common or statutory, or contract, or the Charter or By-laws of the Company duly effective under such law which determines and defines such rights of indemnity. The Insurer shall, in accordance with and subject to Clause 8, advance Defense Costs of such Claim prior to its final disposition.

2. DEFINITIONS

(a) "Claim". means:

(1) a written demand for monetary or non-monetary relief; or

(2) a civil, criminal, or administrative proceeding for monetary or non-monetary relief which is commenced by:

(i) service of a complaint or similar pleading; or
(ii) return of an indictment (in the case of a criminal proceeding); or
(iii) receipt or filing of a notice of charges.

The term "Claim" shall include a Securities Claim; provided, however, that with respect to Coverage B(i) only, Claim or Securities Claim shall not mean a criminal or administrative proceeding against the Company.

(b) "Company" means the Named Corporation designated in Item 1 of the Declarations and any Subsidiary thereof.

(c) "Continuity Date" means the date set forth in:

(1) Item 6A of the Declarations with respect to Coverages A and B (ii); or

(2) Item 6B of the Declarations with respect to Coverage B(i); or

(3) Item 6C of the Declarations with respect to Coverages A and B for a Claim against an Insured arising out of such Insured serving as a director, officer, trustee or governor of an Outside Entity.

(d) "Defense Costs" means reasonable and necessary fees, costs and expenses consented to by the Insurer (including premiums for any appeal bond, attachment bond or similar bond, but without any obligation to apply for or furnish any such bond) resulting solely from the investigation, adjustment, defense and appeal of a Claim against the Insureds, but excluding salaries of Officers or employees of the Company.

(e) "Director(s) or Officer(s)" or "Insured(s)" means:

(1) with respect to Coverages A and B (ii), any past, present or future duly elected or appointed directors or officers of the Company. In the event the Named Corporation or a Subsidiary thereof operates outside the United States, then the terms "Director(s) or Officer(s)" or "Insured(s)" also mean those titles, positions or capacities in such foreign Named Corporation or Subsidiary which is equivalent to the position of Director(s) or Officer(s) in a corporation incorporated within the United States. Coverage will automatically apply to all new Directors and Officers after the inception date of this policy;

(2) with respect to Coverage B(i) only, the Company.

(f) "Listed Event. means any of the following events:

(1) any event for which the Company has reported or is required to report on Form 8-K filed with the Securities and Exchange Commission pursuant to the Securities Exchange Act of 1934; or

(2) any restatement or correction of a Company financial statement contained in any document filed with the Securities and Exchange Commission; or

(3) any statement or disclosure made by or on the behalf of the Company relating to a prior forecast, estimate or projection of the Company's earnings or sales made by or on behalf of the Company, which statement or disclosure represents a greater than 15% change from such prior forecast, estimate or projection.

(g) "Loss. means damages, judgments, settlements and Defense Costs; however,

Loss shall not include civil or criminal fines or penalties imposed by law, punitive or exemplary damages, the multiplied portion of multiplied damages, taxes, any amount for which the Insureds are not financially liable or which are without legal recourse to the Insureds, or matters which may be deemed uninsurable under the law pursuant to which this policy shall be construed.

Further, with respect to Coverage B only, Loss shall not include damages, judgments or settlements arising out of a Claim alleging that the Company paid an inadequate or unfair price or consideration for the purchase of its own securities or the securities of a Subsidiary.

Notwithstanding the foregoing, with respect to Coverage B(i) only and subject to the other terms, conditions and exclusions of the policy, Loss shall include punitive damages (if insurable by law) imposed upon the Company.

(h) "No Liability" means with respect to a Securities Claim made against the Insured(s): (1) a final judgment of no liability obtained prior to trial, in favor of all Insureds, by reason of a motion to dismiss or a motion for summary judgment, after the exhaustion of all appeals; or (2) a final judgment of no liability obtained after trial, in favor of all Insureds, after exhaustion of all appeals. In no event shall the term "No Liability" apply to a Securities Claim made against an Insured for which a settlement has occurred.

(i) "Outside Entity" means:

(1) a not-for-profit organization under section 501(c)(3) of the Internal Revenue Code of 1986 (as amended); or

(2) any other corporation, partnership, joint venture or other organization listed by endorsement to this policy.

(j) "Policy Period" means the period of time from the inception date shown in Item 3 of the Declarations to the earlier of the expiration date shown in Item 3 of the Declarations or the effective date of cancellation of this policy; however, to the extent that coverage under this policy replaces coverage in other policies terminating at noon standard time on the inception date of such coverage hereunder, then such coverage as is provided by this policy shall not become effective until such other coverage has terminated.

(k) "Securities Claim" means a Claim made against an Insured which alleges a

violation of the Securities Act of 1933 or the Securities Exchange Act of 1934, rules or regulations promulgated thereunder, the securities laws of any state, or any foreign jurisdiction, and which alleges a Wrongful Act in connection with the claimant's purchase or sale of, or the offer to purchase or sell to the claimant, any securities of the Company, whether on the open market or arising from a public or private offering of securities by the Company.

(l) "Subsidiary" means:

(1) any corporation of which the Named Corporation owns on or before the inception of the Policy Period more than 50% of the issued and outstanding voting stock either directly, or indirectly through one or more of its Subsidiaries; -;

(2) automatically any corporation whose assets total less than 10% of the total consolidated assets of the Company as of the inception date of this policy, which corporation becomes a Subsidiary during the Policy Period. The Named Corporation shall provide the Insurer with full particulars of the new Subsidiary before the end of the Policy Period;

(3) any corporation which becomes a Subsidiary during the Policy Period (other than a corporation described in paragraph (2) above) but only upon the condition that within 90 days of its becoming a Subsidiary the Named Corporation shall have provided the Insurer with full particulars of the new Subsidiary and agreed to any additional premium and/or amendment of the provisions of this policy required by the Insurer relating to such new Subsidiary. Further, coverage as shall be afforded to the new Subsidiary is conditioned upon the Named Corporation paying when due any additional premium required by the Insurer relating to such new Subsidiary.

A corporation becomes a Subsidiary when the Named Corporation owns more than 50% of the issued and outstanding voting stock, either directly, or indirectly through one or more of its Subsidiaries. A corporation ceases to be a Subsidiary when the Named Corporation ceases to own more than 50% of the issued and outstanding voting stock either directly, or indirectly through one or more of its Subsidiaries.

In all events, coverage as is afforded under this policy with respect to any Claim made against a Subsidiary or any Director or Officer thereof shall only apply for Wrongful Acts committed or allegedly committed after the effective time that such Subsidiary became a Subsidiary and prior to

the time that such Subsidiary ceased to be a Subsidiary

(m) "Wrongful Act" means:

(1) with respect to individual Directors or Officers, any breach of duty, neglect, error, misstatement, misleading statement, omission or act by the Directors or Officers of the Company in their respective capacities as such, or any matter claimed against them solely by reason of their status as Directors or Officers of the Company, or any matter claimed against them arising out of their serving as a director, officer, trustee or governor of an Outside Entity in such capacities, but only if such service is at the specific written request or direction of the Company,

(2) with respect to the Company, any breach of duty, neglect, error, misstatement, misleading statement, omission or act by the Company, but solely as respects a Securities Claim.

3. EXTENSIONS

Subject otherwise to the terms hereof, this policy shall cover Loss arising from any Claims made against the estates, heirs, or legal representatives of deceased Directors or Officers, and the legal representatives of Directors or Officers in the event of incompetency, insolvency or bankruptcy, who were Directors or Officers at the time the Wrongful Acts upon which such Claims are based were committed.

Subject otherwise to the terms hereof, this policy shall cover Loss arising from all Claims made against the lawful spouse (whether such status is derived by reason of statutory law, common law or otherwise of any applicable jurisdiction in the world) of an individual Director or Officer for all Claims arising solely out of his or her status as the spouse of an individual Director or Officer, including a Claim that seeks damages recoverable from marital community property, property Jointly held by the individual Director or Officer and the spouse, or property transferred from the individual Director or Officer to the spouse; provided, however, that this extension shall not afford coverage for any Claim for any actual or alleged Wrongful Act of the spouse, but shall apply only to Claims arising out of any actual or alleged Wrongful Acts of an individual Director or Officer, subject to the policy's terms, conditions and exclusions.

4. EXCLUSIONS

The Insurer shall not be liable to make any payment for Loss in connection

with a Claim made against an Insured:

(a) arising out of, based upon or attributable to the gaining in fact of any profit or advantage to which an Insured was not legally entitled;

(b) arising out of, based upon or attributable to: (1) profits in fact made from the purchase or sale by an Insured of securities of the Company within the meaning of Section 16(b) of the Securities Exchange Act of 1934 and amendments thereto or similar provisions of any state statutory law; or (2) payments to an Insured of any remuneration without the previous approval of the stockholders of the Company, which payment without such previous approval shall be held to have been illegal;

(c) arising out of, based upon or attributable to the committing in fact of any criminal or deliberate- fraudulent act; ;

[The Wrongful Act of a Director or Officer shall not be imputed to any other Director or Officer for the purpose of determining the applicability of the foregoing exclusions 4(a) through 4(c)]

(d) alleging, arising out of, based upon or attributable to the facts alleged, or to the same or related Wrongful Acts alleged or contained, in any claim which has been reported, or in any circumstances of which notice has been given, under any policy of which this policy is a renewal or replacement or which it may succeed in time;

(e) alleging, arising out of, based upon or attributable to any pending or prior litigation as of the Continuity Date, or alleging or derived from the same or essentially the same facts as alleged in such pending or prior litigation;

(f) alleging, arising out of, based upon or attributable to a Listed Event that occurs no later than 90 days subsequent to the Continuity Date; provided, however, that this exclusion shall only apply with respect to coverage which would have otherwise been afforded under Coverage B(i) of the policy;

(g) with respect to serving as a director, officer, trustee or governor of an Outside Entity, for any Wrongful Act occurring prior to the Continuity Date if the Insured knew or could have reasonably foreseen that such Wrongful Act could lead to a Claim under this policy;

(h) alleging, arising out of, based upon or attributable to any actual or alleged act or omission of the Directors or Officers serving in their capacities as directors, officers, trustees or governors of any other entity other than the Company or an Outside Entity, or by reason of

their status as directors, officers, trustees or governors of such other entity;

(i) which is brought by any Insured or by the Company; or which is brought by any security holder of the Company, whether directly or derivatively, unless such security holder's Claim is instigated and continued totally independent of, and totally without the solicitation of, or assistance of, or active participation of, or intervention of, any Insured or the Company; provided, however, this exclusion shall not apply to a wrongful termination of employment Claim brought by a former employee other than a former employee who is or was a Director of the Company;

(j) for any Wrongful Act arising out of the Insured serving as a director, officer, trustee or governor of an Outside Entity if such Claim is brought by the Outside Entity or by any director, officer, trustee or governor thereof; or which is brought by any security holder of the Outside Entity, whether directly or derivatively, unless such security holder's Claim is instigated and continued totally independent of, and totally without the solicitation of, or assistance of, or active participation of, or intervention of, the Outside Entity, any director, officer, trustee or governor thereof, any Insured or the Company;

(k) for bodily injury, sickness, disease, death or emotional distress of any person, or damage to or destruction of any tangible property, including the loss of use thereof, or for injury from libel or slander or defamation or disparagement, or for injury from a violation of a person's right of privacy;

(l) alleging, arising out of, based upon, attributable to, or in any way involving, directly or indirectly:

(1) the actual, alleged or threatened discharge, dispersal, release or escape of pollutants; or

(2) any direction or request to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize pollutants,

including but not limited to a Claim alleging damage to the Company or its securities holders.

Pollutants include (but are not limited to) any solid, liquid, gaseous

or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes (but is not limited to) materials to be recycled, reconditioned or reclaimed;

(m) for violation(s) of any of the responsibilities, obligations or duties imposed upon fiduciaries by the Employee Retirement Income Security Act of 1974, or amendments thereto or any similar provisions of state statutory law or common law.

5. LIMIT OF LIABILITY - (FOR ALL LOSS - INCLUDING DEFENSE COSTS)

The Limit of Liability stated in Item 4 of the Declarations is the limit of the Insurer's liability for all Loss, under Coverage A and Coverage B combined, arising out of all Claims first made against the Insureds during the Policy Period and the Discovery Period (if applicable); however, the Limit of Liability for the Discovery Period shall be part of, and not in addition to, the Limit of Liability for the Policy Period. Further, any Claim which is made subsequent to the Policy Period or Discovery Period (if applicable) which pursuant to Clause 7(b) or 7(c) is considered made during the Policy Period or Discovery Period shall also be subject to the one aggregate Limit of Liability stated in Item 4 of the Declarations.

Defense Costs are not payable by the Insurer in addition to the Limit of Liability. Defense Costs are part of Loss and as such are subject to the Limit of Liability for Loss.

6. RETENTION CLAUSE

The Insurer shall only be liable for the amount of Loss arising from a Claim which is in excess of the Retention amount stated in Item 5 of the Declarations, such Retention amount to be borne by the Company and/or the Insureds and shall remain uninsured, with regard to all Loss under: (i) Coverage A or B(ii) for which the Company has indemnified or is permitted or required to indemnity the Director(s) or Officer(s) (-Indemnifiable Loss-); or (ii) Coverage B(i). A single Retention amount shall apply to Loss arising from all Claims alleging the same Wrongful Act or related Wrongful Acts.

Notwithstanding the foregoing, solely with respect to a Securities Claim under this policy, the Retention shall only apply to Defense Costs; provided, however, no Retention shall apply for a Securities Claim even as respects Defense Costs in the event of a determination of No Liability of all Insureds, and the Insurer shall thereupon reimburse such Defense Costs paid by the Insured.

7. NOTICE/CLAIM REPORTING PROVISIONS

Notice hereunder shall be given in writing to the Insurer named in Item 8 of the Declarations at the address indicated in Item 8 of the Declarations. It mailed, the date of mailing shall constitute the date that such notice was given and proof of mailing shall be sufficient proof of notice.

(a) The Company or the Insureds shall, as a condition precedent to the obligations of the Insurer under this policy, give written notice to the Insurer of any Claim made against an Insured as soon as practicable and either:

(1) any time during the Policy Period or during the Discovery Period (if applicable); or

(2) within 30 days after the end of the Policy Period or the Discovery Period (if applicable), as long as such Claim is reported no later than 30 days after the date such Claim was first made against an Insured.

(b) If written notice of a Claim has been given to the Insurer pursuant to Clause 7(a) above, then any Claim which is subsequently made against the Insureds and reported to the Insurer alleging, arising out of, based upon or attributable to the facts alleged in the Claim for which such notice has been given, or alleging any Wrongful Act which is the same as or related to any Wrongful Act alleged in the Claim of which such notice has been given, shall be considered made at the time such notice was given.

(c) If during the Policy Period or during the Discovery Period (if applicable) the Company or the Insureds shall become aware of any circumstances which may reasonably be expected to give rise to a Claim being made against the Insureds and shall give written notice to the Insurer of the circumstances and the reasons for anticipating such a Claim, with full particulars as to dates, persons, and entities involved, then any Claim which is subsequently made against the Insureds and reported to the Insurer alleging, arising out of, based upon or attributable to such circumstances or alleging any Wrongful Act which is the same as or related to any Wrongful Act alleged or contained in such circumstances, shall be considered made at the time such notice of such circumstances was given.

8. DEFENSE COSTS, SETTLEMENTS, JUDGMENTS (INCLUDING THE ADVANCEMENT OF DEFENSE

COSTS)

Under both Coverage A and Coverage B of this policy, except as hereinafter stated, the Insurer shall advance, at the written request of the Insured, Defense Costs prior to the final disposition of a Claim. Such advanced payments by the Insurer shall be repaid to the Insurer by the Insureds or the Company severally according to their respective interests, in the event and to the extent that the Insureds or the Company shall not be entitled under the terms and conditions of this policy to payment of such Loss.

The Insurer does not, however, under this policy, assume any duty to defend. The Insureds shall defend and contest any Claim made against them. The Insureds shall not admit or assume any liability, enter into any settlement agreement, stipulate to any judgment, or incur any Defense Costs without the prior written consent of the Insurer. Only those settlements, stipulated judgments and Defense Costs which have been consented to by the Insurer shall be recoverable as Loss under the terms of this policy. The Insurer's consent shall not be unreasonably withheld, provided that the Insurer shall be entitled to effectively associate in the defense and the negotiation of any settlement of any Claim.

The Insurer shall have the right to effectively associate with the Company and the Insureds in the defense of any Claim that appears reasonably likely to involve the Insurer, including but not limited to negotiating a settlement. The Company and the Insureds shall give the Insurer full cooperation and such information as it may reasonably require.

The Insurer may make any settlement of any Claim it deems expedient with respect to any Insured subject to such Insured's written consent. If any Insured withholds consent to such settlement, the Insurer's liability for all Loss on account of such Claim shall not exceed the amount for which the Insurer could have settled such Claim plus Defense Costs incurred as of the date such settlement was proposed in writing by the Insurer.

The Company is not covered in any respect under Coverage A; the Company is covered, subject to the policy's terms and conditions, only with respect to its indemnification of its Directors or Officers under Coverage B(ii) as respects a Claim against such Directors and Officers, and subject to the policy's terms and conditions, under Coverage B(i) for a Securities Claim made against the Company. Accordingly, the Insurer has no obligation under this policy for Defense Costs incurred by, judgments against or settlements by the Company arising out of a Claim made against the Company other than a covered Securities Claim, or any obligation to pay Loss arising out of any legal liability that the Company has to the claimant except as respects a covered Securities Claim against the Company.

With respect to (i) Defense Costs jointly incurred by, (ii) any joint settlement made by, and/or (iii) any adjudicated judgment of joint and several liability against the Company and any Director or Officer, in connection with any Claim other than a Securities Claim, the Company and the Director(s) or Officer(s) and the Insurer agree to use their best efforts to determine a fair and proper allocation of the amounts as between the Company and the Director(s) or Officers(s) and the Insurer, taking into account the relative legal and financial exposures of and the relative benefits obtained by the Directors and Officers and the Company. In the event that a determination as to the amount of Defense Costs to be advanced under the policy cannot be agreed to, then the Insurer shall advance such Defense Costs which the Insurer states to be fair and proper until a different amount shall be agreed upon or determined pursuant to the provisions of this policy and applicable law.

9. PRE-AUTHORIZED SECURITIES DEFENSE ATTORNEYS

Only with respect to a Securities Claim:

Affixed as Appendix A hereto and made a part of this policy is a list of Panel Counsel law firms ("Panel Counsel Firms"). The list provides the Insured a choice of law firms from which a selection of legal counsel shall be made to conduct the defense of any Securities Claim made against them.

The Insureds shall select a Panel Counsel Firm to defend a Securities Claim made against the Insureds in the jurisdiction in which the Securities Claim is brought. In the event a Securities Claim is brought in a jurisdiction not included on the list, the Insureds shall select a Panel Counsel Firm in the listed jurisdiction which is the nearest geographical jurisdiction to either where the Securities Claim is brought or where the corporate headquarters of the Named Corporation is located. In such instance the Insureds also may, with the consent of the Insurer, which consent shall not be unreasonably withheld, select a non-Panel Counsel Firm in the jurisdiction in which the Securities Claim is brought to function as "local counsel" on the Securities Claim to assist the Panel Counsel Firm which will function as mead counsel. in conducting the defense of the Securities Claim.

With the express prior written consent of the Insurer, an Insured may select a Panel Counsel Firm different from that selected by other Insured defendants if such selection is required due to an actual conflict of interest or is otherwise reasonably justifiable.

The list of Panel Counsel Firms may be amended from time to time by the Insurer. However, no change shall be made to the specific list attached to this policy during the Policy Period without the consent of the Named Corporation. At the request of the Insured, the Insurer may in its discretion add to the attached list of Panel Counsel Firms for the purposes

of defending a Securities Claim made against the Insured in any specified jurisdiction (including a jurisdiction not originally included in the Panel Counsel list) a Panel Counsel Firm not originally listed for such jurisdiction. The Insurer may in its discretion waive, in part or in whole, the provisions of this clause as respects a particular Securities Claim.

10. DISCOVERY CLAUSE

Except as indicated below, if the Insurer or the Named Corporation shall cancel or refuse to renew this policy, the Named Corporation shall have the right, upon payment of an additional premium of 75% of the "full annual premium", to a period of one year following the effective date of such cancellation or nonrenewal (herein referred to as the "Discovery Period") in which to give to the Insurer written notice of Claims first made against the Insureds during said one year period for any Wrongful Act occurring prior to the end of the Policy Period and otherwise covered by this policy. As used herein, "full annual premium" means the premium level in effect immediately prior to the end of the Policy Period. The rights contained in this paragraph shall terminate, however, unless written notice of such election together with the additional premium due is received by the Insurer within 30 days of the effective date of cancellation or nonrenewal.

In the event of a Transaction, as defined in Clause 12, the Named Corporation shall have the right, within 30 days before the end of the Policy Period, to request an offer from the Insurer of a Discovery Period (with respect to Wrongful Acts occurring prior to the effective time of the Transaction) for a period of no less than three years or for such longer or shorter period as the Named Corporation may request. The Insurer shall offer such Discovery Period pursuant to such terms, conditions and premium as the Insurer may reasonably decide. In the event of a Transaction, the right to a Discovery Period shall not otherwise exist except as indicated in this paragraph.

The additional premium for the Discovery Period shall be fully earned at the inception of the Discovery Period. The Discovery Period is not cancelable. This clause and the rights contained herein shall not apply to any cancellation resulting from non-payment of premium.

11. CANCELLATION CLAUSE

This policy may be canceled by the Named Corporation at any time only by mailing written prior notice to the Insurer or by surrender of this policy to the Insurer or its authorized agent. This policy may also be canceled by

or on behalf of the Insurer by delivering to the Named Corporation or by mailing to the Named Corporation, by registered, certified, or other first class mail, at the Named Corporation's address as shown in Item 1 of the Declarations, written notice stating when, not less than 60 days thereafter, the cancellation shall be effective. The mailing of such notice as aforesaid shall be sufficient proof of notice. The Policy Period terminates at the date and hour specified in such notice, or at the date and time of surrender.

If this policy shall be canceled by the Named Corporation, the Insurer shall retain the customary short rate proportion of the premium herein.

If this policy shall be canceled by the Insurer, the Insurer shall retain the pro rata proportion of the premium herein.

Payment or tender of any unearned premium by the Insurer shall not be a condition precedent to the effectiveness of cancellation, but such payment shall be made as soon as practicable.

If the period of limitation relating to the giving of notice is prohibited or made void by any law controlling the construction thereof, such period shall be deemed to be amended so as to be equal to the minimum period of limitation permitted by such law.

12. CHANGE IN CONTROL OF NAMED CORPORATION

If during the Policy Period:

a. the Named Corporation shall consolidate with or merge into, or sell all or substantially all of its assets to any other person or entity or group of persons and/or entities acting in concert; or

b. any person or entity or group of persons and/or entities acting in concert shall acquire an amount of the outstanding securities representing more than 50% of the voting power for the election of Directors of the Named Corporation, or acquires the voting rights of such an amount of such securities;

(either of the above events herein referred to as the "Transaction")

then this policy shall continue in full force and effect as to Wrongful Acts occurring prior to the effective time of the Transaction, but there

shall be no coverage afforded by any provision of this policy for any actual or alleged Wrongful Act occurring after the effective time of the Transaction. This policy may not be canceled after the effective time of the Transaction and the entire premium for this policy shall be deemed earned as of such time. The Named Corporation shall also have the right to an offer by the Insurer of a Discovery Period described in Clause 10 of the policy.

The Named Corporation shall give the Insurer written notice of the Transaction as soon as practicable, but not later than 30 days after the effective date of the Transaction.

13. SUBROGATION

In the event of any payment under this policy, the Insurer shall be subrogated to the extent of such payment to all the Company's and the Insureds' rights of recovery thereof, and the Company and the Insureds shall execute all papers required and shall do everything that may be necessary to secure such rights including the execution of such documents necessary to enable the Insurer to effectively bring suit in the name of the Company and/or the Insureds. In no event, however, shall the Insurer exercise its rights of subrogation against an Insured under this policy unless such Insured has been convicted of a criminal act, or been judicially determined to have committed a deliberate fraudulent act, or obtained any profit or advantage to which such Insured was not legally entitled.

14. OTHER INSURANCE AND INDEMNIFICATION

Such insurance as is provided by this policy shall apply only as excess over any other valid and collectible insurance.

In the event of a Claim against a Director or Officer arising out of his or her serving as director, officer, trustee or governor of an Outside Entity, coverage as is afforded by this policy shall be specifically excess of indemnification provided by such Outside Entity and any insurance provided to such Outside Entity with respect to its directors, officers, trustees or governors. Further, in the event such other Outside Entity insurance is provided by the Insurer or any member company of American International Group, Inc. ("AIG"-) (or would be provided but for the application of the retention amount, exhaustion of the limit of liability or failure to submit a notice of a Claim) then the maximum aggregate Limit of Liability for all Losses combined covered by virtue of this policy as respects any such Claim

shall be reduced by the limit of liability (as set forth on the declarations page) of the other AIG insurance provided to such Outside Entity.

15. NOTICE AND AUTHORITY

It is agreed that the Named Corporation shall act on behalf of its Subsidiaries and all Insureds with respect to the giving notice of Claim or giving and receiving notice of cancellation, the payment of premiums and the receiving of any return premiums that may become due under this policy, the receipt and acceptance of any endorsements issued to form a part of this policy and the exercising or declining to exercise any right to a Discovery Period.

16. ASSIGNMENT

This policy and any and all rights hereunder are not assignable without the written consent of the Insurer.

17. ARBITRATION

It is hereby understood and agreed that all disputes or differences which may arise under or in connection with this policy, whether arising before or after termination of this policy, including any determination of the amount of Loss, shall be submitted to the American Arbitration Association under and in accordance with its then prevailing commercial arbitration rules. The arbitrators shall be chosen in the manner and within the time frames provided by such rules. If permitted under such rules the arbitrators shall be three disinterested individuals having knowledge of the legal, corporate management or insurance issues relevant to the matters in dispute.

Any party may commence such arbitration proceeding in either New York, New York; Atlanta, Georgia; Chicago, Illinois; or Denver, Colorado. The arbitrators shall give due consideration to the general principles of Delaware law in the construction and interpretation of the provisions of this policy; provided, however, that the terms, conditions, provisions and exclusions of this policy are to be construed in an evenhanded fashion as between the parties, including without limitation, where the language of this policy is alleged to be ambiguous or otherwise unclear, the issue shall be resolved in the manner most consistent with the relevant terms, conditions, provisions or exclusions of the policy (without regard to the authorship of the language, the doctrine of reasonable expectation of the

parties and without any presumption or arbitrary interpretation or construction in favor of either party or parties, and in accordance with the intent of the parties.)

The written decision of the arbitrators shall be provided to both parties and shall be binding on them. The arbitrators' award shall not include attorney fees or other costs.

Each party shall bear equally the expenses of the arbitration.

18. ACTION AGAINST INSURER

Except as provided in Clause 17 of the policy, no action shall lie against the Insurer unless, as a condition precedent thereto, there shall have been full compliance with all of the terms of this policy, nor until the amount of the Insureds' obligation to pay shall have been finally determined either by judgment against the Insureds after actual trial or by written agreement of the Insureds, the claimant and the Insurer.

Any person or organization or the legal representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recover under this policy to the extent of the insurance afforded by this policy. No person or organization shall have any right under this policy to join the Insurer as a party to any action against the Insureds or the Company to determine the Insureds' liability, nor shall the Insurer be impleaded by the Insureds or the Company or their legal representatives. Bankruptcy or insolvency of the Company or the Insureds or of their estates shall not relieve the Insurer of any of its obligations hereunder.

19. HEADINGS

The descriptions in the headings of this policy are solely for convenience, and form no part of the terms and conditions of coverage.

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APPENDIX A

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APPENDIX A (continued)

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ENDORSEMENT # 1

This endorsement, effective 12:01 AM May 05, 1996 forms a part of policy number 483-12-48
issued to STV GROUP, INC.

by National Union Fire Insurance Company of Pittsburgh, Pa.

NUCLEAR ENERGY LIABILITY EXCLUSIONS ENDORSEMENT
(BROAD FORM)

In consideration of the premium charged, it is hereby understood and agreed that the Insurer shall not be liable to make any payment for Loss in connection with any Claim made against any Insured(s):

A. alleging, arising out of, based upon, attributable to, or in any way involving, directly or indirectly the hazardous properties of nuclear material, including but not limited to:

(1) nuclear material located at any nuclear facility owned by, or operated by or on behalf of, the Company, or discharged or dispersed therefrom; or

(2) nuclear material contained in spent fuel or waste which was or is at any time possessed, handled, used, processed, stored, transported or disposed of by or on behalf of the Company; or

(3) the furnishing by an Insured or the Company of services, materials, parts or equipment in connection with the planning, construction, maintenance, operation or use of any nuclear facility; or

(4) claims for damages to the Company or its shareholders which alleges, arises from, is based upon, is attributed to or in any way involves, directly or indirectly, the hazardous properties of nuclear material.

B. (1) which is insured under a nuclear energy liability policy issued by Nuclear Energy Liability Insurance Association, Mutual Atomic Energy Liability underwriters, or Nuclear Insurance Association of Canada, or

would be insured under any such policy but for its termination or exhaustion of its Limit of Liability; or,

(2) with respect to which (a) any person or organization is required to maintain financial protection pursuant to the Atomic Energy Act of 1954, or any law amendatory thereof, or (b) the Insured is, or had this policy not been issued would be entitled to indemnity from the United States of America, or any agency thereof, under any agreement entered into the United States of America, or any agency thereof, with any person or organization.

ENDORSEMENT # 1 (Continued)

As used in this endorsement:

"hazardous properties" include radioactive, toxic or explosive properties;

"nuclear material" means source material, special nuclear material or byproduct material;

"source material", "special nuclear material", and "byproduct material" have the meanings given them in the Atomic Energy Act of 1954 or in any law amendatory thereof;

"spent fuel" means any fuel element or fuel component, solid or liquid, which has been used or exposed to radiation in a nuclear reactor;

"waste" means any waste material (1) containing byproduct material and (2) resulting from the operation by any person or organization of any nuclear facility included within the definition of nuclear facility under paragraph (a) or (b) thereof;

"nuclear facility" means--

(a) any nuclear reactor,

(b) any equipment or device designed or used for (1) separating the isotopes of uranium or plutonium, (2) processing or utilizing spent fuel, or (3) handling, processing or packaging waste,

(c) any equipment or device used for the processing, fabricating or alloying of special nuclear material if at any time the total amount of such material in the custody of the insured at the premises where such equipment or device is located consists of or contains more than 25 grams of plutonium or uranium 233 or any combination thereof, or more than 250 grams of uranium 235,

(d) any structure, basin, excavation, premises or place prepared or used for the storage or disposal of waste, and includes the site on which any of the foregoing is located, all operations conducted on such site and all-premises used for such operations;

"nuclear reactor" means any apparatus designed or used to sustain nuclear fission in a self-supporting chain reaction or to contain a critical mass of fissionable material.

All-other terms, conditions and exclusions remain unchanged.

/s/
AUTHORIZED REPRESENTATIVE

ENDORSEMENT # 2

This endorsement, effective 12:01 AM May 05, 1996 forms a part of policy number 483-12-48
issued to STV GROUP, INC.

by National Union Fire Insurance Company of Pittsburgh, Pa.

CAPTIVE INSURANCE COMPANY

In consideration of the premium charged, it is hereby understood and agreed that the Insurer shall not be liable to make any payments for Loss in connection with any Claim made against any Insured(s) alleging, arising out of, based upon, attributable to the ownership, management, maintenance and/or control by the Company of any captive insurance company or entity including but not limited to Claims alleging the insolvency or bankruptcy of the Named Corporation as a result of such ownership, operation, management and control.

All other terms, conditions and exclusions remain unchanged.

/s/
AUTHORIZED REPRESENTATIVE

ENDORSEMENT # 3

This endorsement, effective 12:01 AM May 05, 1996 forms a part of
policy number 483-12-48
issued to STV GROUP, INC.

by National Union Fire Insurance Company of Pittsburgh, Pa.

COMMISSIONS EXCLUSION

In consideration of the premium charged, it is hereby understood and agreed that the Insurer shall not be liable to make any payment for Loss in connection with any Claim made against any Insured(s) alleging, arising out of, based upon, attributable to:

(i) Payments, commissions, gratuities, benefits or any other favors to or for the benefit of any full or part-time domestic or foreign government or armed services officials, agents, representatives, employees or any members of their family or any entity with which they are affiliated; or

(ii) Payments, commissions, gratuities, benefits or any other favors to or for the benefit of any full or part-time officials, directors, agents, partners, representatives, principal shareholders, or owners or employees, or affiliates (as that term is defined in The Securities Exchange Act of 1934, including any of their officers, directors, agents, owners, partners, representatives, principal shareholders or employees) of any customers of the company or any members of their family or any entity with which they are affiliated; or

(iii) Political contributions, whether domestic or foreign.

All other forms, conditions and exclusions remain unchanged.

/s/
AUTHORIZED REPRESENTATIVE

ENDORSEMENT # 4

This endorsement, effective 12:01 AM May 05, 1996 forms a part of
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by National Union fire insurance Company of Pittsburgh, Pa.

PENNSYLVANIA AMENDATORY ENDORSEMENT
TAIL COVERAGE CLAUSE

In consideration of the premium charged, it is hereby understood and agreed that the first paragraph of the clause which is referred to in the policy as the "Extended Reporting Clause" or "Discovery Clause. is deleted in its entirety and replaced by the following;

I. DEFINITIONS

The following definitions apply for purposes of this endorsement:

1) "Termination of Coverage" means:

a) cancellation of this policy: or

b) non-renewal of the policy.

2) "Authorized Insured" means the "Named Insured", the "First Named Insured", "Named Corporation", "Named Sponsor", or "Named Organization" first named in item 1 of the Declarations page of this policy.

3) "Full Annual Premium" means the premium level in effect immediately prior to termination of coverage.

4) "Insurer" means the insurance company which issued the policy to which this endorsement is attached.

II. TAIL COVERAGE CLAUSE

Upon Termination of Coverage by the Insurer or the Insured, the Authorized Insured shall have the right to purchase Tail Coverage. The premium for the Tail Coverage shall be 40% of the Full Annual Premium.

Tail Coverage shall be effective for a period of one (1) year following the effective date of Termination of Coverage. If purchased, the Authorized Insured can give written notice to the Insurer of claims first made against an Insured during said one year period for a Wrongful act occurring prior to such Termination of Coverage and otherwise covered by the policy.

The right of the Authorized Insured to buy Tail Coverage will terminate unless the Insurer within sixty (60) days from the effective date of Termination of Coverage receives written acceptance of the Tail Coverage from the Authorized Insured together with payment from the Authorized Insured of an amount equal to: (a) the premium for the Tail Coverage plus (b) any premium for the Policy Period which is owed and not yet paid.

The premium for the Tail Coverage shall be fully earned by the Insurer at

the inception of the Tail. The Tail Coverage shall not be cancelable.

The Limit of Liability for the Tail Coverage shall be part of and not in addition to the Limit Of Liability for the policy period.

The offer by the Insurer of renewal terms, conditions, limits of liability and/or premiums different from those of the expiring policy shall not constitute a refusal to renew.

All other terms, conditions and exclusions remain unchanged.

/s/
AUTHORIZED REPRESENTATIVE

ENDORSEMENT # 5

This endorsement, effective 12:01 AM May 05, 1996 forms a part of
policy number 483-12-48
issued to STV GROUP, INC.

by National Union Fire Insurance Company of Pittsburgh, Pa.

PENNSYLVANIA
AMENDATORY ENDORSEMENT

Wherever used in this endorsement: 1) "we", "us", "our", and "Insurer" mean the insurance company which issued this policy; and 2) "you", "your", "named Insured", "First Named Insured", and "Insured" mean the Named Corporation, Named Organization, Named Sponsor, Named Insured, or Insured stated in the declarations page; and 3) "Other Insured(s). means all other persons or entities afforded coverage under the policy.

CANCELLATION/NONRENEWAL

The cancellation provision of this policy is amended as follows:

Cancelling a policy midterm is prohibited except if:

1. A condition material to insurability has changed substantially;

2. Decrease or loss of reinsurance has occurred;

3. Material misrepresentation by the Insured or Other Insured(s);

4. Policy was obtained through fraud;

5. The Insured has failed to pay a premium when due;

6. The Insured has requested cancellation;

7. Material failure to comply with terms;

8. Other reasons that the commissioner may approve.

Notice Requirements for Midterm Cancellation and Nonrenewal

Notice shall be mailed by registered or first class mail by the Insurer directly to the named Insured. Written notice will be forwarded directly to the named Insured at least sixty (60) days in advance of the termination date unless one or more of the following exists:

1) The Insured have made a material misrepresentation which affects the insurability of the risk, in which case the prescribed written notice of cancellation shall be forwarded directly to the named Insured at least fifteen (15) days in advance of the effective date of termination.

ENDORSEMENT # 5 (continued)

2) The Insured has failed to pay a premium when due, whether the premium is payable directly to the Insurer or its agents or indirectly under a premium finance plan or extension of credit, in which case the prescribed written notice of cancellation shall be forwarded directly to the Named Insured at least fifteen (15) days in advance of the effective date of termination.

3) The policy was cancelled by the named Insured, in which case written notice of cancellation shall not be required and coverage shall be terminated on the data requested by the Insured. Nothing in these three sections shall restrict the Insurer's right to rescind an insurance policy ab initio upon discovery that the policy was obtained through fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by the Insurer.

The notice shall be clearly labeled "Notice of Cancellation" or "Notice of Nonrenewal". A midterm cancellation or nonrenewal notice shall state the specific reasons for the cancellation or nonrenewal. The reasons shall identify the condition or loss experience which caused the midterm cancellation or nonrenewal. The notice shall provide sufficient information or data for the Insured to correct the deficiency.

A midterm cancellation or nonrenewal notice shall state that, at the Insured's

request, the Insurer shall provide loss information to the Insured for at least three years or the period of time during which the Insurer has provided coverage to the Insured, whichever is less. Loss information on the Insured shall consist of the following:

1) Information on closed claims, including date and description or occurrence, and any amount of payments, if any;

2) Information on open claims, including date and description of occurrence, amount of payment, if any, and amount of reserves, if any;

3) Information on notices of occurrence, including date and description of occurrence and amount or reserves, if any.

The Insured's written request for loss information must be made within ten (10) days of the Insured's receipt of the midterm cancellation or nonrenewal notice. The Insurer shall have thirty (30) days from the date of receipt of the Insured's written request to provide the requested information.

Notice of Increase in Premium

The Insurer shall provide not less than sixty (60) days notice of intent to increase the Insured's renewal premium with thirty (30) days notice of an estimate of the renewal premium. The notice of renewal premium increase will be mailed or delivered to the Insured's last known address. If notice is mailed, it will be by registered or first class mail.

Return of Unearned Premium

Cancellation Initiated by Insurer -- Unearned premium must be returned to the Insured not later than ten (10) business days after the effective date of termination. i

ENDORSEMENT # 5 (continued)

Cancellation Initiated by Insured -- Unearned premium must be returned to the Insured not later than thirty (30) days after the effective date of termination.

All other terms, conditions and exclusions shall remain the same.

/s/
AUTHORIZED REPRESENTATIVE

ENDORSEMENT # 6

This endorsement, effective 12:01 AM May 05, 1996 forms a part of
policy number 483-12-48
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by National Union Fire Insurance Company of Pittsburgh, Pa.

OUTSIDE ENTITY ENDORSEMENT
(2x)

In consideration of the premium charged, It is hereby understood and agreed that the following entities shall be deemed an "Outside Entity", but only as respects the Outside Entity's respective Continuity Date below:

OUTSIDE ENTITY	CONTINUITY DATE
1) A not-for-profit organization under section 501(c) (3) of the Internal Revenue Code of 1986 (as amended).	May 05, 1996

ALL OTHER TERMS, CONDITIONS AND EXCLUSIONS REMAIN UNCHANGED

/s/
AUTHORIZED REPRESENTATIVE

ENDORSEMENT # 7

This endorsement, effective 12:01 A.M.. May 5, 1996 forms a part of
policy number 483-12-48
issued to STV GROUP, INC.
by National Union Fire Insurance Company of Pittsburgh, PA.

In consideration of the premium charged, it is hereby understood and agreed that Clause 4, EXCLUSIONS (d), of the policy is deleted in its entirety and replaced by the following:

(d) alleging, arising out of, based upon or attributable to any pending or prior litigation as of May 5. 1992. Or alleging or derived from the same or essentially the same facts as alleged in such pending or prior litigation.

It is further understood and agreed that the Limit of Liability $1,000,000

excess of $3,000,000. exclusion 4(h) is amended to indicate that the Insurer shall not be liable to make any payment for Loss in connection with any claim or claims made against the Directors and Officers alleging, arising out of, based upon or attributable to any pending or prior litigation as of August 19, 1992 or alleging or derived from the same facts as alleged in such pending or prior litigation.

It is further understood and agreed that the Limit of Liability $2,000,000 excess of $4,000,000, exclusion 4(h) is amended to indicate that the Insurer shall not be liable to make any payment for Loss in connection with any claim or claims made against the Directors and Officers alleging, arising out of, based upon or attributable to any pending or prior litigation as of May 5, 1994 or alleging or derived from the same facts as alleged in such pending or prior litigation.

/s/
Authorized Representative

ENDORSEMENT # 8

This endorsement, effective 12:01 AM May 05, 1996 forms a part of
policy number 483-12-48
issued to STV GROUP, INC.

by National Union Fire Insurance Company of Pittsburgh, Pa.

EMPLOYMENT PRACTICES ENDORSEMENT

COVERAGE

In consideration of the premium charged, it is hereby understood and agreed that the coverage as is afforded by this policy is extended to Employment Practice Claims against an individual "Insured" (defined below) (whether such claims are brought by (i) a past, present or prospective employee or employees, whether directly or by class action; or (ii) by the Equal Employment Opportunity Commission ("EEOC") or any other state or federal governmental authority regulating employment practices; or (iii) by any other person or entity), subject to both the terms, conditions and exclusions of this endorsement and the policy.

DEFINITIONS

It is further understood and agreed that for the purposes of this endorsement only, the following definitions shall apply:

(1) "Employment Practices Claims. shall mean any Claim relating to a past, present or prospective employee of the Company for, or arising out of the following: (i) any actual or alleged wrongful dismissal, discharge

or termination (either actual or constructive), of employment; (ii) employment related misrepresentation; (iii) wrongful failure to employ or promote; (iv) wrongful deprivation of career opportunity; (v) wrongful discipline; (vi) failure to grant tenure or negligent employee evaluation; or (vii) failure to provide adequate employee policies and procedure; or (viii) sexual or workplace harassment of any kind, (including the alleged creation of a harassing workplace environment); or (ix) unlawful discrimination, (including sexual or workplace harassment or creation of a harassing workplace environment) whether direct, indirect, or unintentional.

Employment Practices Claims shall include Claims brought under state, local or federal law (whether common or statutory) and shall include, but not be limited to, allegations of violations of the following federal laws (as amended), including regulations promulgated thereunder:

1. Family and Medical Leave Act of 1993 ;

2. Americans with Disabilities Act of 1992 (ADA),

3. Civil Rights Act of 1991,

ENDORSEMENT # 8 (continued)

4. Age Discrimination in Employment Act of 1967 (ADEA), including the Older Workers Benefit Protection Act of 1990.

5. Title VII of the Civil Rights Law of 1964, as amended, including the Pregnancy Discrimination Act of 1978,

6. Civil Rights Act of 1866, Section 1981, and

7. Fifth and Fourteenth Amendments of the U.S. Constitution.

(2) The term "Insured" shall include, for the purposes of Employment Practices Claims only, any past, present or future duly elected individual Director or Officer or any past, present of future employee of the Company whether such individual is in a supervisory, co-worker or subordinate position or otherwise. Coverage shall automatically apply to all new employees after the inception date of the policy.

EXCLUSIONS

It is further understood and agreed that solely for the additional coverage hereby granted for Employment Practices Claims exclusions (i) and (k) are amended as follows:

(1) Exclusion (i) is amended by deleting the phrase, "wrongful termination of employment claims", and substituting the phrase, "Employment Practice Claims" (as defined in this endorsement) and by deleting the word "former employee" and substituting the word "employee" to read as follows:

(i) which are brought by any Insured or the Company; or which are brought by any security holder of the Company, whether directly or derivatively, unless such security holder's Claim(s) is instigated and continued totally independent of, and totally without the solicitation of, or assistance of, or active participation of, or intervention of, any Insured or the Company; provided, however, this exclusion shall not apply to Employment Practice Claims brought by an employee other than an employee who is or was a Director of the Company.

(2) Exclusion (k) is amended by deleting the phrase, "emotional distress", and by deleting the phrase, "or for injury from libel or slander or defamation or disparagement or for injury from a violation of a person's right of privacy", to read as follows:

(k) for bodily injury, sickness, disease or death of any person, or damage to or destruction of any tangible property, including the loss of use thereof.

It is further understood and agreed that only as respects any additional coverage granted by virtue of this endorsement, the following exclusions shall apply: '

(1) The Insurer shall not be liable for any Loss in connection with any Claim or Claims made against an Insured alleging, arising out of, based upon or attributable to any pending or prior litigation as of May 05, 1996 , or alleging or derived from the same or essentially the same facts as alleged in such pending or prior litigation.

(2) The Insurer shall not be liable for any Loss in connection with any Claim or Claims made against an Insured for any alleged Wrongful Act committed prior to May 05, 1996 if any Insured(s), as of such date, knew or could have reasonably foreseen that such Wrongful Act could

lead to a Claim.

ALL OTHER TERMS, CONDITIONS, AND EXCLUSIONS OF THE POLICY REMAIN UNCHANGED.

/s/
AUTHORIZED REPRESENTATIVE

ENDORSEMENT # 9

This endorsement, effective 12:01 AM May 05, 1996 forms a part of
policy number 483-12-48
issued to STV GROUP, INC.

by National Union Fire Insurance Company, of Pittsburgh, Pa.

SEC Exclusion Relating to Secondary Public Offerings of Securities
(With 30 day reporting provision)

In consideration of premium charged, it is hereby understood and agreed that the Insurer shall not be liable to make any payment for Loss in connection with any claim or claims made against the Directors and Officers (including but not limited to claims brought by any governmental or regulatory entity or any security holder, whether directly, derivatively or by class action, or by any other claimant) whether under federal, state or foreign, statutory, regulatory or common law, if such claim alleges, arises out of, is based upon or is attributable to the purchase or sale, or offer or solicitation of an offer to purchase or sell, any security of the Company in a public offering of securities (hereinafter an OFFERING OF SECURITIES).

This exclusion shall apply, but not be limited to, any such claim which alleges, arises out of, is based upon or is attributable to any claim arising out of any alleged misrepresentations or non-disclosures in any written or oral statement, including but not limited to any Registration Statement, prospectus, offering circular, private placement memorandum or other document or statement relating to the OFFERING OF SECURITIES, as well as any failure to file any document required to be filed with the Securities and Exchange Commission.

Notwithstanding the above, this endorsement shall not apply to the OFFERING OF SECURITIES described below:

REGISTRATION STATEMENT NO. DATE

Notwithstanding the foregoing, however, this exclusion shall not apply in the event that within thirty days prior to the effective time of an OFFERING OF SECURITIES not scheduled or described above, the Company gives written notice

thereof together with all particulars and underwriting information relating thereto; the Insurer agrees, in its discretion, to grant coverage subject to such terms, conditions and additional premium as it may require; and the Company accepts such terms, conditions and additional premium. Such coverage is also subject to the Company paying when due such additional premium.

ALL OTHER TERMS AND CONDITIONS REMAIN UNCHANGED.

/s/
Authorized Representative

ENDORSEMENT # 10

This endorsement, effective 12:01 AM May 05, 1996 forms a part of
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issued to STV GROUP, INC.

by National Union Fire Insurance Company of Pittsburgh, Pa.

ARCHITECT OR ENGINEER E&O EXCLUSION

In consideration of the premium charged, it is hereby understood and agreed that the Insurer shall not be liable to make any payment for Loss in connection with any Claim made against an Insured(s) alleging, arising out of, based upon or attributable to the performance of or failure to perform services as an architect or engineer, or any act, error or omission related thereto.

ALL OTHER TERMS, CONDITIONS AND EXCLUSIONS REMAIN UNCHANGED.

/s/
AUTHORIZED REPRESENTATIVE

Exhibit 10.34

LEASE

THIS AGREEMENT made the 21st day of August, 1995, by and between DAME ENTERPRISES, a Pennsylvania partnership (hereinafter called "Landlord") of one part, and STV GROUP, INCORPORATED, a Pennsylvania Corporation with its principal place of business located at 11 Robinson Street, Pottstown, PA 19464 (hereinafter called "Tenant") of the other part.

RECITALS:

WHEREAS, Landlord desires to acquire title to a certain parcel of real estate located generally at Route 422, Old Airport Road, Amity Township, Berks County, Pennsylvania (the "Property"); and

WHEREAS, the Tenant desires to lease the Property from the Landlord, have the Landlord erect an office building thereon that is constructed to specifications acceptable to Tenant, and conduct its business in said office building.

NOW, THEREFORE, in consideration of the mutual covenants set forth herein, and intending to be legally bound hereby, the parties agree as follows:

1. Description Of Property, Duration Of Lease And Rental - Landlord does hereby demise and let unto Tenant all that certain premises consisting of approximately six (6) acres as shown on the plan attached as Exhibit "A", (the "Premises"), together with the use of driveways, sidewalks and parking areas for the term of fifteen (15) years beginning on the latter of July 1, 1996 or seven (7) days after the date of issuance by the proper municipal authorities of a certificate of occupancy for the Building (hereinafter defined) (the "Commencement Date") and ending on the last day of the calendar month next succeeding 15 years from the Commencement Date (the "Termination Date"). The annual net rental (the "Base Rent") payable in equal monthly installments in advance during the said term of this Lease shall be:

A. Year one (1) of the lease term: $544,980.00
B. Years two (2) through five (5) of the lease term: $544,980.00 per year
C. Years six (6) through ten (10) of the lease term: $559,992.00 per year
D. Years eleven (11)through fifteen (15) of the lease term: $575,880.00 per year

Monthly rent payments shall be made on the same day of each month, the first installment to be paid on the Commencement Date and monthly on the same day of each month thereafter. The monthly rent payments to be made by the Tenant shall be:

A. Year one (1) of the lease term (provided, however, that the tenant shall not be required to pay any rent during the first, fourth, eighth and twelfth months of the first year of the lease): $45,415.00 each
B. Years two (2) through five (5) of the lease term: $45,415.00 each
C. Years six (6) through ten (10) of the lease term: $46,660.00 each
D. Years eleven (11) through fifteen (15) of the lease term: $47,990.00 each

The foregoing notwithstanding, the Tenant shall not be required to pay Base Rent during the first, fourth, eighth and twelfth months of the first year of the lease term. The term of this Lease shall end on the Termination Date without the necessity of notice from either party to the other.

2. Construction of Improvements -

A. The Landlord shall construct on the Premises a multi-story office building, containing approximately Fifty-Eight Thousand (58,000) square feet, substantially in accordance with the preliminary plans and specifications attached hereto and made a part hereof as Exhibit "B" (the "Building") including all necessary and required site work. The Landlord shall complete final plans and specifications for the Building with due diligence upon the execution of this Lease Agreement. Upon completion of the final plans for the Building, together with any modifications or amendments thereto, the plans shall be approved by the Landlord and the Tenant. Upon approval of the final plans and specifications by the Landlord and the Tenant and after all appropriate municipal approvals have been received by Tenant, the Landlord shall commence construction of the Building on the Premises in accordance with the final plans and specifications and shall proceed diligently to complete the same.

B. In the event that Tenant requests any modifications or changes to be made to the Building during or after construction of the same has begun or is completed, as the case may be, or the final plans for the Building, after the same shall have been approved by the Landlord and the Tenant as provided in subparagraph A, above, in either event Landlord shall have the option of approving said change or modification and Tenant shall first have the option of securing financing for said change or modification and paying the Landlord for the same and absent the ability or desire of tenant to secure financing then Landlord shall first reasonably attempt to secure financing thus allowing Tenant to pay for any and all of the added costs of such changes and modifications, including, without limitation, design costs, architectural fees, engineering fees, bank financing charges and attorney fees for the Landlord's lender's legal counsel, as additional rent in equal monthly installments amortized over the remaining term of the Lease at an annual capitalization rate equal to the annual interest rate charged to the Landlord by its lender to finance the cost of making such changes and modifications (said interest rate to be set forth in a commitment letter issued to the Landlord) plus one and one half percent (1.5%). By way of example only, if the Tenant submits a written request for changes to the Building at the end of the fifth year of this Lease, the cost of making said changes to the Building at the end of the fifth year of this Lease, the cost of making said changes is One Hundred Thousand Dollars

($100,000.00) and the interest rate charged to the Landlord to finance the changes and modifications requested by the Tenant is six and one half (6.5%), then Landlord shall require the Tenant to pay for such costs as additional rent in consecutive equal monthly payments of One Thousand Two Hundred Thirteen Dollars and Twenty-Eight Cents ($1,213.28). If after reasonable efforts the Landlord is unable to secure financing for the change or modification, the Landlord shall then require Tenant to pay any and all costs necessary to effect such changes and modifications, including, without limitation, design costs, architectural fees and engineering fees, at the time the Landlord is charged for the same by the contractor overseeing the construction of the Building. Tenant's request for a change or modification in the approved final plans for the Building or for a change or modification of the Building's existing structure shall be submitted in writing to the Landlord for its approval.

C. Tenant's taking possession of the Building shall be conclusive evidence, as against the Tenant, that, at the time such possession was so taken, the work to be performed by the Landlord in constructing the Building was substantially completed. Within ten (10) days after the Commencement Date or the date on which the Tenant takes possession of the Building, whichever shall first occur, a representative of the Landlord and a representative of the Tenant shall survey the Building for the purpose of determining those items, if any, of the work to be performed by the Landlord in the Building that remain to be completed, which items they shall reduce to an itemized agreed "punch" list, and the Landlord agrees to complete the items on said punch list within thirty days thereafter or within such other time as the parties may agree in writing. In the event that the Landlord does not complete items on the "punch" list within thirty days or such other time as agreed upon by the parties, the Tenant shall have the right to employ a third party of its choosing to complete the items on the "punch" list and deduct the cost of doing so from the monthly rent payments due to the Landlord hereunder. Notwithstanding the said punch list, the Tenant shall be obligated to the conditions of this Lease and the payment of rent as of the Commencement Date.

D. If the completion of construction of the Building shall be delayed due to any act or omission of the Tenant or its agents, employees or contractors, the Building shall be deemed ready for occupancy on the date when it would have been ready but for such delay. Such delay shall include, without limitation:

1. Delay in the submission of Tenant's plans or specifications or the giving of any authorizations or approvals required for the preparations for or execution of the Landlord's work;

2. Delay due to changes made by or on behalf of the Tenant to the preliminary or final plans for the Building;

3. Delay due to postponement of any of Landlord's work at the Tenant's request; or

4. Delay due to any other interference with the Landlord's work in the Building by the Tenant and/or its agents, servants or employees.

In the event that Landlord determines that there has been an act or omission of the Tenant or it's agents, employees or contractors that causes completion of construction of the building to be delayed, Landlord, or it's agent, shall notify the Tenant in writing. Such notice shall describe with reasonable specificity the cause and nature of the delay being attributed to the Tenant and it's agents, employees or contractors.

3. Security Deposit -

A. Concurrent with the commencement of the Lease term, the Tenant has deposited with the Landlord Forty Five Thousand Four Hundred Fifteen Dollars ($45,415.00) as security for Tenant's performance of all its obligations hereunder. Alternatively, Tenant may present Landlord with an irrevocable letter of credit that may be drawn upon by Landlord in an amount equal to the aforementioned security deposit (the "Letter of Credit"). Landlord shall return such sum or said Letter of Credit, as the case may be, to Tenant after the expiration of the lease term if Tenant has performed all of such obligations. Prior to the time that Tenant is entitled to the return of the security deposit, and if Tenant elects not to present Landlord with the Letter of Credit, Landlord shall maintain such security deposit in a separate interest bearing account. Interest on said account shall inure to the benefit of Tenant, less a service fee equal to one percent (1%) of the principal of the security deposit to be retained by the Landlord. The net interest on the account shall be paid to Tenant annually or at such time as the Tenant is entitled to a return of the principal of the security deposit, whichever occurs first.

B. If Tenant defaults in the performance of any of its obligations hereunder, including, but not limited to, the payment of rent and additional rent, the Landlord may use, apply, or retain all or any part of such security deposit for the payment of any unpaid rent and additional rent, or for any other amount which the Landlord may be required to spend by reason of the Tenant's default, including any damages or deficiency in the reletting of the Premises, regardless of whether the accrual of such damages or deficiency occurs before or after an eviction or a summary reentry or other reentry by the Landlord.

C. Tenant shall not assign or encumber the security deposit

or attempt to revoke the Letter of Credit without Landlord's written consent, and any assignment, encumbrance or revocation without such consent shall not bind the Landlord. Regardless of any assignment of this Lease by the Tenant, the Landlord may return the security deposit to the original Tenant, in the absence of evidence satisfactory to the Landlord of an assignment of the right to receive such security deposit or any part of the balance thereof.

D. If there is a bona fide sale, subject to this Lease, the Landlord may transfer the security deposit to the purchaser for the benefit of the Tenant. In such case, the Landlord

shall be considered released by the Tenant from all liability for the return of the security deposit, and the Tenant shall look to the new landlord solely for the return of the security deposit. The preceding shall apply to every transfer or assignment made of the security deposit to a new landlord.

4. Intent of Parties to Create A "Net Lease" - It is the intention of the Landlord and the Tenant that the rent aforementioned shall be net to the Landlord in each year and month during the term of this Lease, that all costs, expenses and obligations of every kind relating to the Premises which may arise or become due during the term of this Lease, except those specifically made the Landlord's responsibility herein, shall be paid by the Tenant, and that the Landlord shall be indemnified by the Tenant against such costs, expense and obligations. Except as provided for in this Lease, the net rent shall be paid to the Landlord without notice or demand without abatement, deduction or set-off.

5. Use Of Premises - The Premises shall be used as an office building or for such other lawful business mutually agreed upon by the parties which agreement shall not be unreasonably withheld. Tenant shall not use the Premises for any unlawful purpose and shall not suffer any article to be brought, or act to be done on the Premises which would increase the fire hazard to the Building or the Premises or would increase any insurance rates above the rates applicable to the above-mentioned type of business, or that would make the Building or the Premises uninsurable for their prescribed uses.

6. Payment Of Taxes, Etc. - The Tenant shall promptly pay all real estate taxes, taxes on rents, assessments, water and sewer charges, and other governmental levies against the Premises, and also any occupancy tax and tax on rents, all of which are herein called "impositions". The phrase "tax on rents" shall mean any tax levied, assessed, or imposed in connection with the receipt of rent under this Lease for the use and occupancy of the Premises, in lieu of, in whole or in part, or in addition to, any real estate or personal property tax upon the Premises. The Tenant may pay any imposition in installments, if payment may be so made without penalty. All impositions for the tax year in which the Lease shall commence or terminate shall be apportioned between the Tenant and the Landlord, except that any imposition which the Tenant has elected to pay installments shall be paid in full by the Tenant at least sixty (60) days prior

to the expiration of the Lease term.

A. The Tenant shall furnish to the Landlord official receipts or other satisfactory proof of payment, within a reasonable time after demand by the Landlord.

B. The Tenant may contest the amount or validity of any imposition by appropriate proceedings. However, the Tenant shall promptly pay such impositions unless (1) such proceedings shall operate to prevent or stay the collection of the imposition so contested and (2) the Tenant shall have deposited with the Landlord the amount so contested and unpaid, together with a sum sufficient to cover all charges that may be assessed against the Premises in

such proceedings. Upon the termination of such proceedings, the Tenant shall deliver to the Landlord proof of the imposition as finally determined, and thereupon the Landlord shall, out of the sums so deposited with it by the Tenant, pay such imposition, and shall refund the balance to the Tenant. If the sums deposited with the Landlord shall be insufficient to pay the full amount of such imposition and other charges, the Tenant shall forthwith pay any deficiency. If, at any time during such proceedings the Landlord shall deem the amount deposited with it insufficient, the Tenant shall, upon demand, deposit with the Landlord such additional sums as the Landlord may reasonably request. The Landlord, at the Tenant s sole expense, shall join in any such contestation proceedings if any law shall so require. Any sums deposited hereunder with the Landlord shall be held in a trust account.

C. All sums (other than the Base Rent) which may be due and payable or are to be deposited by the Landlord under this Lease shall be payable on demand and shall be deemed to be additional rent hereunder.

D. The Landlord appoints the Tenant the attorney-in-fact of the Landlord for the purpose of making all payments to be made by the Tenant pursuant to any of the provisions of this Lease to persons other than the Landlord. In case any person to whom any sum is directly payable by Tenant under any of the provisions of this Lease shall refuse to accept payment of such sum from the Tenant, the Tenant shall thereupon give written notice of such fact to the Landlord and shall pay such sum directly to the Landlord, who shall thereupon pay such sum to such person.

7. Additional Rent - All taxes, charges, costs, and expenses which the Tenant is required to pay hereunder, together with all interest and penalties that may accrue thereon in the event of the Tenant's failure to pay such amounts, and all damages, costs, and expenses which the Landlord may incur by reason of any default of the Tenant or failure on the Tenant's part to comply with the terms of this Lease, shall be deemed to be additional rent and, in the event of non-payment by the Tenant, the Landlord shall have all the rights and remedies with respect thereto as the Landlord has for the non-payment of the

basic rent.

8. Place For Payment Of Rent - All rents and charges shall be payable without prior notice or demand at the office of Landlord at 2201 Ridgewood Road, Suite 400, Wyomissing, Pennsylvania 19610, Attn: Mervin A. Heller, Jr., Esquire, or at such other place as Landlord may from time to time designate by notice in writing.

9. Acceptance Of Premises By Tenant - Provided the Landlord shall construct the Building in accordance with the final plans and specifications therefor referred to in Paragraph 2, the Tenant shall accept the Premises in its existing condition. All warranties obtained from contractors, sub-contractors, suppliers or manufacturers pertaining to the Building or any equipment installed in the Building as called for in the final plans and specifications shall be assigned by the Landlord to the Tenant at the time Tenant takes occupancy of the Building unless

specifically prohibited by the terms of such warranties. In addition to the foregoing, Landlord shall specifically assign to the Tenant any and all rights pursuant to Section 13.2.2 of its construction contract with Advanced Building Systems, Inc., the contractor for the Premises which shall remain in full and effect regardless of any limitations expressed herein or hereafter. The following are the provisions of 13.~.2 of its construction contract: "13.2.2 If, within one year after the Date of Substantial Completion of the Work or designated portion thereof or within one year after acceptance by the Owner of designated equipment or within such longer period of time as may be prescribed by law or by the terms of any applicable special warranty required by the Contract Documents, any of the Work is found to be defective or not in accordance with the Contract Documents, the Contractor shall correct it promptly after receipt of a written notice from the Owner to do so unless the Owner has previously given the Contractor a written acceptance of such condition. This obligation shall survive termination of the Contract. The Owner shall give such notice promptly after discovery of the condition." Landlord agrees to provide a certified copy of the construction contract sufficient to confirm the aforesaid warranty is part of the construction contract. No representation, statement or warranty, express or implied, has been made by or on behalf of the Landlord as to such condition, or as to the use that may be made of the Premises and/or the Building. In no event shall the Landlord be liable for any defect in the Premises or the Building or for any limitation on the use of either or both. Tenant's taking possession of the Building shall be conclusive evidence, as against the Tenant, that, at the time such possession was so taken, the Tenant accepted the Building and Premises in their then existing condition and without relying upon any representation, statement or warranty, express or implied, made by or on behalf of the Landlord.

10. Duty Of Tenant To Maintain Premises -

A. The Tenant shall not cause or permit any waste, damage or injury to the Premises and shall surrender the Premises to the Landlord at the end of the lease term in the same condition as the Premises existed at the inception of this Lease, reasonable wear and tear excepted. The Tenant, at its sole expense, shall keep the Premises as now or hereafter constituted with all improvements made thereto (including, without limitation, the Building) and the adjoining sidewalks, curbs, walls, parking areas, landscaping, and access roads clean and in good condition (reasonable wear and tear excepted) and shall make any and all repairs, replacements and renewals, whether ordinary or extraordinary, seen or unforeseen necessary to maintain the Premises. The foregoing notwithstanding, the Landlord, at its sole cost and expense, shall make all structural repairs to the Building not necessitated by the negligent or willful misconduct of the Tenant or its agents, employees, licensees or invitees. For purposes of this Lease, the term "structural repairs" shall mean repairs to the roof, exterior walls, foundation, and interior load bearing walls of the Building. Structural repairs shall not include repairs to the HVAC System (hereinafter defined) or the electrical, plumbing and sewer systems in the building. All repairs, replacements and renewals made by the Tenant shall be at least equal in quality of materials and workmanship to that originally existing in the Building. The Landlord shall in no event be required to make any repair, alteration or improvement to the Premises, unless specifically

required to do so pursuant to the terms of the Lease. Any equipment and materials replaced by Tenant shall belong to the Landlord and all proceeds from the disposition thereof may be retained by the Landlord. The Tenant shall indemnify the Landlord against all costs, expenses, liabilities, losses damages, suits, fines, penalties, claims and demands, including reasonable counsel fees, because of Tenant's failure to comply with the foregoing, and the Tenant shall not call upon the Landlord for any disbursement or outlay whatsoever in connection therewith, and hereby expressly releases and discharges Landlord from any liability therefor.

B. Tenant shall engage, at its sole cost and expense, a maintenance firm to service the heating, ventilating and air conditioning system (the "HVAC System") servicing the Building. Said maintenance firm shall service the HVAC System on a quarterly basis, and such service shall include, without limitation, adjustment and replacement of all belts, and inspection, replacement and necessary servicing of all filters, condensers, chiller coils and compressors. The Tenant shall provide Landlord with a copy of such maintenance contract prior to the Commencement Date and, thereafter, Tenant shall provide Landlord with evidence that the maintenance contract has been renewed on or before each anniversary of the Commencement Date. If Tenant fails to obtain or renew such maintenance contract at any time during the term of this Lease, the

Landlord may, but shall not be obligated to, provide for maintenance of the HVAC System and the Tenant shall pay the Landlord on demand the cost therefor as additional rent.

11. Compliance With Municipal Authorities - Except for those items which are required as a prerequisite of the issuance of the Occupancy Permit, the Tenant, at its sole expense, shall comply with all orders, and regulations of Federal, state, county and municipal authorities, and with any direction of any public officer, pursuant to law, which shall impose any duty upon the Landlord or the Tenant with respect to the Premises. The Tenant, at its sole expense, shall obtain all licenses or permits which may be required for the making of repairs, alterations, improvements, or additions and the Landlord, when necessary, will join with the Tenant in applying for all such permits or licenses. The foregoing notwithstanding, the Landlord shall be responsible for obtaining the initial building permits and all other certificates and governmental approvals required for construction of the Building, all at the Landlord's sole cost and expense.

12. Zoning; Permits; Signs - Anything herein elsewhere contained to the contrary notwithstanding, this Lease and all the terms, covenants, and conditions hereof are in all respects subject and subordinate to all zoning restrictions affecting the Premises, and the building in which the Premises is located, and the Tenant agrees to be bound by such restrictions. The Landlord further does not warrant that any license or licenses, permit or permits, which may be required for the business to be conducted by the Tenant on the Premises will be granted, or, if granted, will be continued in effect or renewed, and any failure to obtain such license or licenses, permit or permits, or any revocation thereof or failure to renew the same, shall not release the

Tenant from the terms of this Lease. Tenant shall comply with the Laws of the Township of Amity, Berks County, Pennsylvania for said signs.

13. Land Use and Development Approval - The Landlord and Tenant each acknowledge that this Lease is being executed prior to the Landlord's acquisition of the Premises whereon the Building shall be erected. The Landlord and Tenant further acknowledge that the Landlord's obligations hereunder are specifically conditioned on the Landlord's acquiring good and marketable title to the Premises and obtaining all land use and development approvals necessary to allow the Landlord to construct the Building in accordance with the plans therefor, whether preliminary or final on or before December 15, 1995 (the "Lease Termination Date"). In the event that the Landlord is not able to acquire good and marketable title to the Premises or is unable to obtain any and all land use and development approvals necessary to allow the Landlord to construct

the Building in accordance with the plans therefor, whether preliminary or final, prior to the Lease Termination Date, this Lease shall immediately become null and void and neither party shall have any obligation to the other under the terms of this Lease and any security deposit and rent paid by the Tenant to the Landlord shall be returned immediately with interest at a rate equal to that earned by Landlord prior to termination and return of the security deposit. Notwithstanding anything heretofore stated, if the building being constructed is not ready for occupancy, through no fault of the Tenant, on or before November 13, 1996, the terms of this Lease, at the option of the Tenant, shall become null and void.

14. Subordination and Attornment - This Lease shall be subject and subordinate at all times to the lien of any mortgages and/or rents and/or other encumbrances now or hereafter placed on the land and buildings demised or of which the Premises form a part without the necessity of any further instrument or act on the part of the Tenant to effectuate such subordination, but the Tenant covenants and agrees to execute and deliver upon demand such further instrument or instruments evidencing such subordination of this Lease to the lien of any such mortgage or mortgages and/or ground rent and/or other encumbrances as shall be desired by any mortgagee or proposed mortgagee or by any other such person. Upon the Tenant's written request, the Landlord shall use good faith efforts to obtain from any such mortgagee a written Subordination, Nondisturbance and Attornment Agreement providing that the rights of the Tenant shall remain in full force and effect during the term of this Lease so long as Tenant shall continue to recognize and perform all of the covenants and conditions of this Lease required to be performed by the Tenant as herein provided.

15. Assignment of Leases and Rents - Tenant hereby consents to the Landlord's executing one or more assignments of leases and rents as may be required by any lender providing financing for the Landlord's acquisition of the Premises and construction of the Building. If a lender notifies the Tenant in writing that, pursuant to the terms of its assignment agreement, all future payments and performance under this Lease are to be made to and for the benefit of such lender, the Tenant shall comply with such notice notwithstanding any default whatsoever on the part of the Landlord.

16. Tenant's Right To Make Alterations - Upon commencement of the lease term, the Tenant shall have the right to make changes or alterations to the Premises, subject to the following conditions:

A. No change or alteration shall at any time be made which shall impair the structural soundness or diminish the value of the Building or

the Premises, as the case may be.

B. No change or alteration shall be made involving an expenditure in excess of Five Thousand Dollars ($5,000.00) without the prior written consent of the Landlord.

C. Before commencing any material change or material alteration to or of the Building, the Landlord and Tenant shall procure the written consent of the holder of any mortgage covering the Premises to which this Lease is subordinated.

D. No change or alteration shall be undertaken until the Tenant shall have procured and paid for all required municipal and other governmental permits and authorizations of the various municipal departments and governmental subdivisions having jurisdiction.

E. Tenant shall submit to Landlord for Landlord's written approval (said approval not to be unreasonably withheld) any and all plans and architectural drawings for the proposed change or alteration. In addition, all changes or alterations to the Building or the Premises shall be performed by such contractors as shall be approved by the Landlord which such approval shall not be unreasonably withheld. In no event shall Landlord have any responsibility or liability with regard to any change or alteration made by, or at the request or direction of, the Tenant.

F. All work done in connection with any change or alteration shall be done in a good and workmanlike manner and in compliance with the building and zoning laws, and with all other laws, ordinances, orders, rules, regulations, and requirements of all federal, state and municipal governments, and the appropriate departments, commissions, boards, and officers thereof, and in accordance with the orders, rules and regulations of the Board of Fire Underwriters or any other body now or hereafter constituted exercising similar functions, and the Tenant shall procure certificates of occupancy and other certificates if required by law.

G. At all times when any change or alteration is in progress, there shall be maintained, at the Tenant's expense, workmen's compensation insurance in accordance with laws covering all persons employed in connection with the change or alteration, and general liability insurance for the mutual benefit of the Tenant and the Landlord expressly covering the additional hazards due to the change or alteration. Tenant shall provide Landlord with any and all reasonable documentation the Landlord may require to establish that said workman's compensation insurance and general liability insurance is in force at the time any change or alteration to the Building is made.

H. Any improvement to the Premises or any part thereof and any replacement of fixtures during the term of this Lease shall at once become the absolute property of the Landlord without payment of any kind therefor. Landlord shall have the right to require Tenant to remove any and all such improvements or fixtures upon termination of this Lease and restore the Building to its original condition, reasonable wear and tear excepted, all at Tenant's sole cost and expense.

I. Tenant shall have no right or power to do any act or make any contract which may create or be the basis for any lien, mortgage or other encumbrance upon the estate of the Landlord in the Premises or the Building, or any part of either. All changes, alterations, repairs, materials and labor shall be done at Tenant's sole expense, and Tenant shall be solely and wholly responsible to contractors, laborers and materialmen's furnishing labor and materials to the Tenant in connection with the Premises and/or the Building. To that end Tenant shall file a waiver of mechanics' and materialmen's liens prior to commencing any repair, change or alteration to the Premises or the Building so as to place all laborers and materialmen and contractors on notice that they must look solely to the Tenant for the payment of any bills and charges for work done and materials furnished to or at the Premises and/or the Building.

17. Utilities To Be Furnished By Tenant - The Landlord shall, as part of its, work in constructing the Building, provide adequate utility service to the Premises as set forth in the plans and specifications for the Building mutually agreed upon by Landlord and Tenant. The cost of all utilities consumed on the Premises, including, without limitation, water, steam, heat, gas, electricity and sewer services shall be paid for by Tenant. Tenant further agrees to maintain a temperature in the Building of no less than fifty degrees Fahrenheit at all times during the term of this Lease.

18. Indemnification By Tenant - Tenant agrees to be responsible for and to relieve and hereby relieves the Landlord from all liability by reason of any injury or damage to any person or property in or on the Premises, whether belonging to the Tenant or any other person caused by any fire, breakage or leakage in any part or portion of the Premises, or from water, rain or snow that may leak into, issue or flow from any part of the Building or the Premises from the drains, pipes, or plumbing work of the same, or from any place or quarter, to the extent such breakage, leakage, injury or damage shall be caused by or result from the negligence of the Tenant or its servants, agents or invitees. Tenant also agrees to be responsible for, and to relieve and hereby relieves Landlord from, all liability by reason of any damage or injury to any person or thing which may arise from or be due to the use, misuse or abuse of all or any of the appurtenances of any kind whatsoever which may exist or hereafter be erected or constructed on the Premises, or from any kind of injury which may arise from any other cause whatsoever on said Premises to the extent such use, misuse, abuse, injury or damage shall be caused by or result from the negligence or willful misconduct of the Tenant or its servants, agents or invitees.

If the Landlord pays a sum of money for property damage or personal injury resulting from the Tenant's failure to observe or perform this covenant, then the sum so paid by the Landlord, together with all costs, damages and reasonable attorney's fees, shall be considered additional rent, due in the month succeeding such payment and collectible at such time.

19. Environmental Indemnification -

A. Tenant shall, to the fullest extent allowable by law, be responsible for and indemnify, defend and hold harmless Landlord from any liability and costs associated with any liability, including, without limitation, reasonable attorney's fees, arising out of or incident to the presence of any hazardous substances, hazardous wastes or other environmental contamination as defined under the Storage Tank and Spill Prevention Act or any other applicable federal. state or local environmental law, whether asserted by private or public entities, which liability arises from the actions of Tenant, its employees, agents, invitees, sublessees and permitted assigns subsequent to the execution of this Lease and during Tenant's or its permitted subtenants' or assignees' occupancy of the Premises. In no event shall Tenant be liable for any environmental contamination of the Premises occurring prior to Tenant's execution of this Lease and Tenant's indemnification shall not apply to such preexisting environmental contamination.

B. Notwithstanding anything to the contrary contained in this Lease, Landlord makes no representations or warranties as to the absence or existence of hazardous substances, hazardous wastes or other environmental contamination in the Premises. Landlord shall, to the fullest extent allowable by law, be responsible for and indemnify, defend and hold harmless Tenant from any liability and costs associated with any liability, including, without limitation, reasonable attorney's fees, arising out of or incident to the presence of any hazardous substances, hazardous wastes or other environmental contamination as defined under the Storage Tank and Spill Prevention Act or any other applicable federal, state or local environmental law, whether asserted by private or public entities, on the Premises and occurring prior to Tenant's occupancy of the same.

20. Events of Default - The following events shall be deemed to be events of default by the Tenant under this Lease:

A. The Tenant shall fail to pay any installment of rent or any other obligation hereunder involving the payment of money and such failure shall continue for a period of ten (10) days after the due date.

B. The Tenant shall fail to comply with any term, provision, covenant, rule or regulation, whether herein contained or hereafter established, of this Lease, other than as described in subparagraph A, above, and shall not cure such failure within fifteen (15) days after

written notice thereof to the Tenant, provided, however, that if the Tenant shall within said fifteen (15) day period take reasonable steps to cure such default and diligently pursues the same to completion, the Tenant shall not be deemed in default hereof

C. The Tenant shall become insolvent, or shall make a transfer in fraud of creditors, or shall make an assignment for the benefit of creditors.

D. The Tenant of the Tenant's obligations under this Lease shall file a petition under any section or chapter of the Bankruptcy Act, or the Tenant of the Tenant's obligations under this Lease shall be adjudged bankrupt or insolvent in proceedings filed against the Tenant of the Tenant's obligations under this Lease.

E. A receiver or trustee shall be appointed for the Premises or the Building of for all or substantially all of the assets of the Tenant or of any guarantor of the Tenant's obligations under this Lease.

F. The Tenant shall desert or vacate or shall commence to desert or vacate the Premises and/or the Building or any substantial portion of the Premises and/or the Building or shall remove or attempt to remove, without the prior written consent of the Landlord, all or a substantial portion of the Tenant's goods, wares, equipment, fixtures, furniture or other personal property.

G. The Tenant shall do or permit to be done anything that creates a lien upon the Premises and/or the Building.

The foregoing individually shall constitute an "Event of Default" and collectively "Events of Default" by the Tenant.

21. Rights Of Landlord Upon Default By Tenant - Upon the occurrence of an Event of Default:

A. If the Landlord so elects, this Lease shall thereupon become null and void, and the Landlord, without prejudice to any other remedy that the Landlord may have for possession of the Building and the Premises or

for any arrearage in rent (including, without limitation, any interest which may have accrued pursuant to the terms of this Lease) shall have the right to reenter or repossess the Premises and the Building, either by force, summary proceedings, surrender or otherwise, and disposes and remove therefrom the Tenant, or other occupants thereof, and their effects, without being liable to any prosecution therefor, as the agent of the Tenant, and the Tenant immediately shall pay the Landlord, without further notice from Landlord, the rent herein reserved and agreed to be paid by the Tenant for the portion of the lease term remaining at the time of reentry or repossession as if by the terms of this Lease it were payable in advance. It is further agreed that the Tenant shall compensate the Landlord for all

expenses incurred by the Landlord in regaining possession of the Premises and the Building (including, without limitation, any increases in insurance premiums for the Building caused by the vacancy of the Premises or the Building), all expenses incurred by the Landlord in releting the Building (including, without limitation, the cost of repairs, remodeling, replacements, advertisements and real estate brokerage fees), all concessions granted to a new tenant upon releting the Building or the Premises (including, without limitation, renewal options), all attorneys' fees, court costs and expenses of litigation, and all other costs of any nature whatsoever incurred by the Landlord as a direct or indirect result of the Tenant's default (including, without limitation, any adverse reaction by the Landlord's mortgagees and a reasonable allowance for the Landlord's administrative efforts, salaries and overhead attributable directly or indirectly to the Tenant's default and the Landlord's pursuit of its rights and remedies provided herein and under applicable law). The Landlord shall provide Tenant with ten (10) days prior written notice of its intention to re-enter the Premises or institute legal proceedings in the exercise of the Landlord's remedies set forth herein. The Tenant waives and will waive all rights to trial by jury in any proceeding hereafter instituted by the Landlord against the Tenant in respect to the Premises. In addition, the Tenant agrees to pay to the Landlord on demand the amount of all loss and damages which the Landlord shall suffer by reason of any termination of this Lease effected pursuant to this subparagraph A.

B. Without any notice or demand whatsoever, the Landlord may take any one or more of the actions permissible at law to insure performance by the Tenant of the Tenant's covenants and obligations under this Lease. In this regard, it is agreed that if the Tenant deserts or vacates the Building or the Premises, the Landlord may enter upon and take possession of the same in order to protect them from deterioration and continue to demand from Tenant monthly payments of the rent and other charges and expenses set forth in this Lease, without any obligation to relet the Building or any portion thereof; but if the

Landlord does, at its sole discretion, elect to relet the Building or the Premises, such action by the Landlord shall not be deemed as an acceptance of Tenant's surrender of the Premises or the Building unless the Landlord expressly notifies the Tenant of such acceptance in writing. The Tenant hereby acknowledges that the Landlord shall otherwise be reletting the Premises as the Tenant's agent and the Tenant furthermore hereby agrees to pay to the Landlord on demand any deficiency that may arise between the monthly rentals and other charges provided in this Lease and that actually collected by the Landlord. It is further agreed in this regard that upon the occurrence of an Event of Default described in Paragraph 20 of this Lease, the Landlord shall have the right to enter upon the Premises and the Building by force if necessary without being liable for prosecution or any claim for damages therefor, and do whatever the Tenant is obligated to do under the terms of this Lease; and the Tenant agrees to reimburse the Landlord on demand for any expenses that the Landlord may incur in thus effecting compliance with the Tenant's obligations under this Lease, and the Tenant further agrees that the Landlord shall not be liable for any damages resulting to the Tenant from such action.

22. Right Of Entry And Inspection By Landlord - The Landlord or its representatives may enter the Premises or the Building, at any reasonable time, for the purpose of inspecting the Premises, performing any work which the Landlord elects to undertake made necessary by reason of the Tenant's Default under the terms of this Lease, exhibiting the Premises for sale, lease or mortgage financing, or posting notices of non-responsibility under any mechanic's lien law, and Tenant agrees to make no claim against Landlord by reason of any interference with Tenant's business caused by Landlord's entry.

23. Destruction Of Premises

A. No destruction or damage to the Building or any other improvement on the Premises by any casualty caused by the Tenant's negligent use and enjoyment of the Premises, including, without limitation, fire, shall entitle the Tenant to surrender possession thereof, to terminate this Lease, to violate any of its provisions, or to cause any rebate or abatement in rent then due or thereafter becoming due under the terms hereof.

B. In the event that the Premises is totally destroyed or so damaged by fire or other casualty not occurring through the fault or negligence of the Tenant or its agents, employees, licensees or invitees, that the same cannot be repaired or restored within One Hundred Eighty (180) days from the date of the fire or other casualty, this Lease shall absolutely cease and determine, and the rent shall abate for the balance of the lease term.

C. If the damage caused as described in subparagraph B is only partial and such that the Premises can be restored to its original condition within One Hundred Eighty (180) days from the date of the fire or other casualty, the Landlord, at its option, shall restore the Premises with reasonable promptness, reserving the right to enter upon the Premises for that purpose, even though the effect of such entry is to render the Premises or a portion thereof untenantable. In either event the rent shall be apportioned and suspended during the time the Landlord is in possession, taking into account the portion of the Premises rendered untenantable and the duration of the Landlord's possession. Lessor shall make its election to repair the Premises or terminate this Lease by giving written notice thereof to the Tenant at the Premises within thirty (30) days from the date Landlord receives notice that the Premises has been destroyed or damaged by fire or other casualty.

D. Landlord shall not be liable for any damage, compensation or claim by reason of inconvenience or annoyance arising from the necessity of repairing any portion of the building of which the Premises is a part, the interruption in the Tenant's use of the Premises, or the termination of this Lease by reason of the destruction of the Premises, provided that the Landlord makes the said repairs with reasonable promptness.

E. Damage by fire or other casualty rendering more than forty percent (40%) of the floor area of the Premises untenantable shall constitute total destruction hereunder.

24. Insurance -

A. Tenant, at its own cost and expense, at all times after the Commencement Date of this Lease, shall obtain and maintain, in full force and effect, for the benefit of Landlord and Tenant (and any institutional mortgagee, with a standard mortgagee endorsement), policies of insurance against loss or damage to the building and the premises by fire and such other casualties as may be included within either fire and extended coverage insurance, or all-risk insurance, boiler insurance, plate glass insurance and such other insurance as may reasonably be required from time to time by any mortgagee.

B. After Tenant takes possession of the Building and Premises, Tenant, at Tenant's sole cost and expense, shall maintain and keep in effect throughout the Lease term, insurance against liability for bodily injury (including death) or property damage in or about the Building and/or the Premises under a policy of comprehensive general public liability insurance, with such limits as to each as may be reasonably required by Landlord from time to time, but not less than a combined single limit of One Million Dollars

($1,000,000.00) and Two Million Dollars ($2,000,000.00) in the aggregate for bodily injury (including death) and for property damage. The aforementioned policy of comprehensive general public liability shall name Landlord as an additional insured party. All policies of insurance relating to the Building and/or the Premises, including the public liability insurance referred to in this subparagraph 26.B, and the fire and casualty insurance referred to in subparagraph 26.A, shall provide that they shall not be cancelable without at least thirty (30) days prior written notice to Landlord and to any mortgagee named in an endorsement thereto and shall be issued by an insurer and in a form satisfactory to Landlord. At least ten (10) days prior to the Commencement Date, a Certificate or Certificates of Insurance shall be delivered to Landlord by the Tenant. If Tenant shall fail, refuse or neglect to obtain, pay for or to maintain any insurance that Tenant is required to provide, or fails to furnish Landlord with satisfactory evidence of coverage on any such policy, Landlord shall then have the right to purchase or pay for such insurance directly. All such payments made by Landlord shall be recoverable by Landlord from Tenant, together with interest thereon, as additional rent, promptly upon being billed therefore.

C. Each of the parties hereto hereby releases the other, to the extent of the releasing party's insurance coverage, from any and all liability for any loss or damage covered by such insurance which may be inflicted upon the property of such party, even if such loss or damage shall be brought about by the fault or negligence of the other party, its agents or employees; provided, however, that this release shall be effective only with respect to loss or damage occurring during such time as the appropriate policy of insurance shall contain a clause to the effect that this release shall not affect said policy or the right of the insured to recover thereunder. If any policy does not permit such a waiver, and if the party to benefit therefrom requests that such a waiver be obtained, the other party agrees to obtain an endorsement to its insurance policies permitting such waiver of subrogation if it is available. If an additional

premium is charged for such wavier, the patty benefiting therefrom agrees to pay the amount of such additional premium promptly upon being billed therefor.

D. Tenant will not do anything or fail to do anything which will cause the cost of Landlord's insurance to increase or which will prevent Landlord from procuring policies (including, but not limited to, public liability insurance) from companies and in a form satisfactory to Landlord. If any breach of this subparagraph D by Tenant shall cause the rate of fire or other insurance to be increased, Tenant shall pay the amount of such increase as additional rent promptly upon being billed therefor.

25. Failure of Tenant to Perform --

A. If the Tenant shall at any time fail to make any payment within ten (10) days after a written request from the Landlord after the same shall be due or perform any act on its part to be made or performed under the terms of this Lease within thirty (30) days after written notice from the Landlord, then the Landlord may, but shall not be obligated so to do, and without further notice to or demand upon the Tenant and without waiving or releasing the Tenant from any obligation in this Lease contained, make any such payment or perform any such act on the part of the Tenant to be made or performed as in this Lease provided. All sums so paid by the Landlord and all necessary incidental costs and expenses in connection with the performance of any such act by the Landlord, together with interest thereon at two points above the prime rate of Meridian Bank per annum from the date of making of such expenditure, shall immediately become due and be payable by the Tenant on demand. All sums which may become payable to the Landlord by Tenant, as in this subparagraph A provided, shall be deemed additional rent, and the Landlord shall have (in addition to any other right or remedy of the Landlord) the same rights and remedies in the event of the nonpayment of any such sums by the Tenant as in the case of Default by the Tenant in the payment of the minimum rent.

B. All of the remedies hereinbefore given to the Landlord and all rights and remedies given to it by law and equity shall be cumulative and concurrent. No determination of this Lease or the taking or recovering of the Premises shall deprive the Landlord of any of its remedies or actions against the Tenant for rent due at the time or which, under the terms hereof, would in the future become due as if there had been no determination, or for any and all sums due at the time or which, under the terms hereof, would in the future become due as if there had been no determination, nor shall the bringing of any action for rent or breach of covenant, or the resort to any other remedy herein provided for the recovery of rent be construed as a waiver of the right to obtain possession of the Premises.

26. Indemnification of Landlord - In addition to any and all other obligations of the Tenant, after taking possession of the Building and the Premises, Tenant shall indemnify and save harmless the Landlord and Landlord's agents against and from all liabilities, obligations, damages, penalties, claims, costs, charges and expenses, including, without limitation, any and

all architects' and attorneys' fees, which may be imposed upon or incurred by or asserted against the Landlord or the Landlord's agents by reason of any of the following occurring during the term of this Lease:

A. Any injuries to persons or property occurring on or about the Premises or the Building and arising as a result of the negligence of the Tenant and/or its agents, contractors, servants, employees, licensees or invitees; or

B. Any failure on the part of the Tenant to perform or comply with any of the covenants, agreements, terms or conditions in this Lease on its part to be performed or complied with.

The provisions of this Paragraph 26, as well as any and all other provisions in this Lease requiring the Tenant to indemnify and save the Landlord and Landlord's agents harmless, shall survive the termination of this Lease.

27. Condemnation -

A. If all of the Premises are taken or condemned for a public or quasi-public use (a sale in lieu of condemnation to be deemed a taking or condemnation for purposes of this Lease), this Lease shall terminate as of the date title to the condemned real estate vests in the condemnor and the rent and Additional Rent herein reserved shall be apportioned and paid in full by Tenant to Landlord to that date and all rent prepaid for periods beyond that date shall forthwith be repaid by Landlord to Tenant and neither party shall thereafter have any liability hereunder.

B. If only part of the Premises are taken or condemned for a public or quasi-public use and if such taking or condemnation shall render the Premises unsuitable for the business of the Tenant, then the term of this Lease shall cease and terminate as of the date on which possession of the Premises is required to be surrendered to the condemning authority and the rent and additional rent herein reserved shall be apportioned and paid in full by Tenant to Landlord to that date and all rent prepaid for periods beyond that date shall forthwith be repaid by Landlord to Tenant and neither party shall thereafter have any liability hereunder and Tenant shall have no claim against Landlord for the value of any unexpired term of this Lease. In the event such partial taking is not extensive enough to render the Premises unsuitable for Tenant's business, the Lease shall continue in full force and effect except that the rent and additional rent due hereunder shall be reduced in the same proportion that the floor area of the Premises so taken bears to such floor area immediately prior to such taking, such reduction commencing as of the date Tenant is required to surrender possession of such portion. Landlord shall promptly restore the Premises, to the extent of condemnation proceeds available for such purpose, as nearly as practicable to a condition comparable to their condition at the time of such condemnation, less the portion lost in the taking. Tenant shall be responsible for making all repairs and alterations to Tenant's fixtures, equipment and furnishings as a result of such taking or condemnation. For

purposes of determining the amount of funds available for restoration of the Premises from the condemnation award, said amount shall be deemed to be that part of the total award which remains after payment of Landlord's reasonable expenses in recovering the same and any amounts due to any mortgagee of Landlord, and which represents a portion of the total sum so available (excluding any award or other compensation for land) which is equitably allocable to the Premises.

C. In the event of any condemnation or taking as provided above, whether whole or partial, the Tenant shall not be entitled to any part of the award as damages or otherwise for such condemnation and Landlord and any mortgagee of Landlord are to receive the full amount of such award as their respective interests may appear. Tenant hereby expressly waives any right or claim to any part of it and assigns to Landlord any such right or claim to which Tenant might become entitled.

D. Although all damages in the event of any condemnation are to belong to the Landlord and any mortgagee of Landlord as aforesaid, whether such damages are awarded as full compensation for diminution in value of the leasehold or to the fee of the Premises, Tenant shall have the right, to the extent that same shall not diminish the Landlord s or such mortgagee's award, to claim and recover from the condemning authority, but not from Landlord or such mortgagee, such compensation as may be separately awarded or recoverable by Tenant under the applicable eminent domain code in effect where the complex of which the Premises is a part is located in Tenant's own right for or on account of, and limited solely to, any cost to which Tenant might be put in removing Tenant's merchandise, furniture, trade fixtures, leasehold improvements and equipment.

28. Assignment And Sub-Lease - Accept for assignments to, and sub-leases involving, controlled subsidiaries of the Tenant, Tenant shall not assign, mortgage or pledge this Lease or underlet or sublease the Building or the Premises or any part thereof; or permit any other person, firm or corporation to occupy the Premises, Building or any part of either, without the specific prior written consent of the Landlord, and if written consent is given, Landlord shall retain the liability of the Tenant for completion of the terms of the Lease. Such approval by Landlord shall not unreasonably be withheld. Tenant shall not be required to obtain Landlord's prior written approval for sub-leases involving, or an assignment of this lease, a controlled subsidiary of the Tenant.

29. Tenant's Estoppel Certificate - Within ten (10) days after notice from the Landlord, the Tenant shall execute and deliver to Landlord a statement in writing certifying such matters as requested by Landlord, including that this Lease is unmodified and in full force and effect, or in full force and effect, as modified, stating the modifications, the amount of the rent, the dates to which the rent has been paid in advance and the amount to any security deposit or prepaid rent.

30. Termination and Holding Over - The term of this Lease shall end on the last day of the calendar month next succeeding fifteen (15) years from the Commencement Date, without the necessity of notice from either party to the other. In the event Tenant remains in possession of the Premises and/or the Building after the expiration of the original lease term without the execution of a new Lease, Tenant shall be deemed to be occupying said Premises as a Tenant from month to month at a rental equal to the rental and common area costs herein on the last day of the regular lease term, plus fifty percent (50%) of such amount and the Tenant shall otherwise subject to all the conditions, provisions and obligations of this Lease insofar as the same are applicable to a month to month tenancy.

31. Construction Observation - During the course of construction, the Tenant shall be entitled to make periodic visits to the construction site, but such visits shall not relieve the Contractor from the obligation to construct the building in accordance with the Plans and Specifications.

32. Notices - All notices herein required shall be given by Certified Mail and shall be effective as of the date of mailing. Notices to the Landlord shall be addressed to 2201 Ridgewood Road, Suite 400, Wyomissing, Pennsylvania 19610, Attn: Mervin A. Heller, Jr. and to the Tenant at the Building or to c/o Secretary-Treasurer, 11 Robinson Street, Pottstown, Pennsylvania 19464 or to such other address as the Landlord or Tenant may provide from time to time after written notice to the other party.

33. Relationship of the Parties - Nothing herein contained shall be deemed or construed by the parties hereto, nor by any third party, as creating the relationship of principal and agent or of partnership or of joint venture between the parties, it being understood and agreed that neither the method of computation of rent, not any other provisions contained herein, nor any acts of the parties, shall be deemed to create any relationship between the parties hereto other than the relationship of landlord and tenant.

34. Governing Law and Venue - This Lease shall be governed by, and construed in accordance with, the internal laws of the Commonwealth of Pennsylvania. The Venue for any action under this Lease shall be Berks County, Pennsylvania.

35. Captions - The captions used herein are for convenience only and shall not limit or amplify the provisions hereof.

36. Binding Effect - The terms, provisions and covenants contained in this Lease shall apply to, inure to the benefit of, and be binding upon the parties hereto and their respective heirs, successors, legal representatives and permitted assigns except as otherwise expressly provided herein.

IN WITNESS WHEREOF, the parties hereto have hereunto set their hands and seals and have caused this instrument to be executed by their duly authorized officers the day and year first above written.

DaMe Enterprises, Landlord
/s/ Darryl Shoff
/s/ Mervin A. Heller

STV Group, Incorporated - Tenant

By: /s/ Peter W. Knipe

Attest: /s/ Anna Marie Boore

ADDENDUM TO LEASE AGREEMENT

THIS ADDENDUM, made the 21st day of August, 1995, to the Lease Agreement between DAME ENTERPRISES, a Pennsylvania partnership (hereinafter called "Landlord"), of the one part, and STV GROUP, INCORPORATED, a Pennsylvania corporation, with its principal place of business located at 11 Robinson Street, Pottstown, Pennsylvania, 19464 (hereinafter called "Tenant"), of the other part.

RECITALS

WHEREAS, the parties hereto entered into a certain Lease Agreement dated the 21st day of August, 1995, (the "Agreement") for the rental of a certain office building to be constructed on a parcel of real estate located generally at the intersection of Route 422 and Old Airport Road, Amity Township, Berks County, Pennsylvania; and,

WHEREAS, the parties desire to clarify certain terms of the Agreement.

NOW, THEREFORE, in consideration of the mutual covenants set forth herein, and intending to be legally bound hereby, the parties agree as follows:

1. The parties acknowledge that the Preliminary Plans and Specifications required by paragraph two

(2), subparagraph A, of the Agreement to be attached as Exhibit "B" were not finalized at the time of the execution of the Agreement and, upon approval, will be signed, dated and attached. 2. The following paragraph shall be substituted for paragraph thirty (30) of the Agreement:

"30. Termination and Holding Over - The term of this Lease shall end on the last day of the calendar month upon which the expiration of the fifteen (15) year term from the Commencement Date occurs, without the necessity of notice from either party to the other. By way of example, if fifteen (15) years from the Commencement Date expires on July 7th, the Lease will terminate on July 31st. Any rent due for a partial month shall be pro rated. In the event Tenant remains in possession of the Premises and/or the Building after the expiration of the original lease term without the execution of a new Lease, Tenant shall be deemed to be occupying said Premises as a Tenant from month to month at a rental equal to the rental and common area costs herein on the last day of the regular lease term, plus fifty percent (50~) of such amount, and the Tenant shall otherwise be subject to all the conditions, provisions and obligations of this Lease insofar as the same are applicable to a month to month tenancy."

3. In all other respects, the terms and conditions of the Agreement dated August 21st, 1995, shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have hereunto set their bands and seals and have caused this instrument to be executed by the duly authorized officers the day and year first above written.

LANDLORD:

DAME ENTERPRISES,
A Pennsylvania Partnership

/s/ Mervin A. Heller
/s/ Darryl Shoff

TENANT: STV GROUP, INCORPORATED
BY: /s/ Peter W. Knipe

ATTEST: /s/ Anna Marie Boore

SECOND ADDENDUM TO LEASE AGREEMENT

THIS SECOND ADDENDUM made the 5th day of January 1996, to the Lease Agreement between DAME ENTERPRISES, a Pennsylvania partnership (hereinafter called "Landlord"), of the one part, and STV GROUP, INCORPORATED, a Pennsylvania corporation, with its principal place of business located at 11 Robinson Street, Pottstown, Pennsylvania, 19464 (hereinafter called "Tenant"), of the other part.

RECITALS

WHEREAS, the parties hereto entered into a certain Lease Agreement and Addendum, both dated the 21st day of August, 1995, (the "Agreement") for the rental of a certain office building to be constructed on a parcel of real estate located generally at the intersection of Route 422 and Old Airport Road, Amity Township, Berks County, Pennsylvania; and,

WHEREAS, the parties desire to amend certain terms of the Agreement.

NOW, THEREFORE, in consideration of the mutual covenants set forth herein, and intending to be legally bound hereby, the parties agree as follows:

1. The following paragraph shall be substituted for paragraph thirteen (13) of the Agreement:

"13. Land Use and Development Approval - The Landlord and Tenant each acknowledge that this Lease is being executed prior to the Landlord's acquisition of the Premises whereon the Building shall be erected. The Landlord and Tenant further acknowledge that the Landlord's obligations hereunder are specifically conditioned on the Landlord's acquiring good and marketable title to the Premises and obtaining all land use and development approvals necessary to

allow the Landlord to construct the Building in accordance with the plans therefor, whether preliminary or final on or before January 30, 1996 (the "Lease Termination Date"). In the event that the Landlord is not able to acquire good and marketable title to the Premises or is unable to obtain any and all land use and development approvals necessary to allow the Landlord to construct the Building in accordance with the plans therefor, whether preliminary or final, prior to the Lease Termination Date, this Lease shall immediately become null and void and neither party shall have any obligation to the other under the terms of this Lease and any security deposit and rent paid by the Tenant to the Landlord shall be returned immediately with interest at a rate equal to that earned by Landlord prior to termination and return of the security deposit. Notwithstanding anything m heretofore stated, if the building being constructed is not ready for occupancy, through no fault of the Tenant, on or before November 13, 1996, the terms of this Lease, at the option of the Tenant, shall become null and void."

2. In all other respects, the teens and conditions of the Agreement and Addendum dated August 21st, 1995, shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have hereunto set their hands and seals and have caused this instrument to be executed by the duly authorized officers the day and year first above written.

LANDLORD:

DAME ENTERPRISES,
A Pennsylvania Partnership
/s/ Mervin A. Heller
/s/ Darryl Shoff

TENANT:

STV GROUP, INCORPORATED
BY: /s/ Peter W. Knipe

ATTEST: /s/ Lori Jo Berk

Exhibit 10.35

CORPORATE HEALTH INSURANCE COMPANY
(A Minneapolis, Minnesota Domiciled Company)
Principal Executive Offices
980 Jolly Road
Blue Bell, Pennsylvania 19422

COMPREHENSIVE MAJOR MEDICAL GROUP HEALTH INSURANCE POLICY

Providing Health Insurance With Optional Prescription Coverage

NON-PARTICIPATING

This Comprehensive Major Medical Group Health Insurance Policy (the "Policy") is a legal contract between Corporate Health insurance Company ("CHI" or the "Company") and the policyholder indicated on the Schedule of Benefits (the "Policyholder"), which is set forth in the Summary of Benefits distributed to each eligible employee of the Policyholder and incorporated herein by reference.

In consideration of a signed application and payment of the required premiums. the Company agrees to provide insurance for eligible employees of the Policyholder and their eligible dependents while such persons are covered under this Policy and are insured for the applicable coverage. Benefits are subject to the terms, conditions. exclusions and limitations of this Policy. Certain identified benefits are subject to pre-certification requirements. which if not followed will result in reduced benefits.

This Policy takes effect 12:01 a.m. Eastern Standard Time on the Effective Date at the Policyholder's address.

Corporate Health Insurance Company has caused its President and Secretary to execute and witness this Policy

/s/	/s/
Secretary	President

TABLE OF CONTENTS

I. GENERAL INFORMATION

1. POLICY NUMBER: PA 18927I-Custom

2. POLICYHOLDER NUMBER: PA 18927I

3. NAME AND ADDRESS OF POLICYHOLDER:
STV Group
11 Robinson Street
Pottstown, PA 19464

4. EMPLOYER IDENTIFICATION NUMBER (E.I.N.) ASSIGNED BY INTERNAL REVENUE SERVICE: 23-1698231

5. TYPE OF POLICY: Group Health Insurance Policy - Custom Plan

6. THE NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE COMPANY:

CORPORATE HEALTH INSURANCE COMPANY
980 Jolly Road
P.O. Box 1109
Blue Bell, Pennsylvania 19422
1-800-204-2300

7. POLICY EFFECTIVE DATE: July 1, 1996

II. ELIGIBILITY

1. Covered Persons

This Policy will cover the following Covered Persons:

(i) all Eligible Employees of the Policyholder and its subsidiaries and affiliates specifically identified in writing by the Policyholder to the Company; and

(ii) their Eligible Dependents.

2. Eligibility Date

The "Eligibility Date" for each Covered Person will be:

(i) if the Covered Person is an Eligible Employee, the later of the date of hire by the Policyholder (or, if applicable, the date on which the waiting period imposed by the Policyholder ends) and the Effective Date of this Policy; or

(ii) if the Covered Person is an Eligible Dependent, the later of the date of hire (or, if applicable, the date on which the waiting period imposed by the Policyholder ends) of the Eligible Employee to whom such Covered Person is a Dependent and the Effective Date of this Policy.

3. When Coverage Begins

(a) If an Eligible Employee enrolls on or before the Effective Date of this Policy, coverage will begin under this Policy on the Effective Date for such Eligible Employee and any Eligible Dependents of such Employee identified as Covered Persons in the Policy Enrollment Form.

(b) If an Eligible Employee enrolls after the Effective Date of this Policy, coverage will begin on the first day of the calendar month after the Eligible Employee enrolls under this Policy.

(c) An Eligible Employee will be deemed to have enrolled under this Policy when the Eligible Employee has completed, signed and delivered a Policy Enrollment Form, identifying any Eligible Dependents as Covered Persons, to the Company and such Policy Enrollment Form has been accepted by the Company at its sole discretion.

(d) Should the Eligible Employee not be working full-time on the day he or she would ordinarily become covered under this Policy, the coverage for such Employee and any Eligible Dependents will be delayed until he or she returns to full-time work.

(e) Limitation: Each Eligible Employee will have 31 days from his or her

Eligibility Date to enroll for coverage. No Evidence of Good Health will be required for any Eligible Employee enrolling within such 31 days. All Eligible Employees enrolling after such 31 days will be required to submit Evidence of Good Health for his or herself and for each Eligible Dependent. If such Employee fails to provide Evidence of Good Health satisfactory to the Company, the Company may reject the Employee's enrollment application for insurance under this Policy. Coverage under this Policy for enrollees after such 31 days who provides satisfactory Evidence of Good Health will begin no earlier than the first day of the calendar month after CHI's approval of Evidence of Good Health.

(f) For purpose of this Article only, each Eligible Employee who enrolls under this Policy during any designated open enrollment period of the Policyholder shall be deemed and treated as a new employee of the Policyholder.

4. Return to Work After Voluntary Termination of Employment

If an Eligible Employee returns to active full-time employment with the Policyholder at any time following voluntary termination of employment with the Policyholder, the waiting period described herein for new Employees will apply, unless the Eligible Employee returns within 12 months after the date of the voluntary termination.

5. Dependent Coverage

(a) A Covered Employee's spouse and a Covered Person's dependent children can also be covered under the Policy pursuant to the terms hereof.

(b) The Covered Employee's spouse is eligible for dependent coverage unless:

(i) The Covered Employee and his or her spouse are legally separated or divorced or have obtained an annulment;

(ii) Both the Covered Employee and his or her spouse are employees of the Policyholder. The Covered Employee and his or her spouse may choose to be covered as individual employees of the Policyholder, or one may cover the other as a Dependent, but both of them may not cover the other as a Dependent;

(iii) Such spouse is in active Military Service;

(iv) Such spouse is of the same sex; or

(v) Such spouse is not a legal spouse, under the laws of the Commonwealth of Pennsylvania.

(c) The Covered Person's natural or legally adopted child is eligible from birth so long as the child is:

(i) Less than age 23, or if a full-time student, less than age 23;

(ii) Not married; and

(iii) Not on active duty in any of the armed forces.

(d) Child/children under legal guardianship (including foster children) or children under court order will be included under this Policy under the same conditions and restrictions applicable to a Covered Person's natural or legally adopted children.

(e) The Covered Employee's spouse and child/rep meeting the requirements described above are referred to in this Policy as "Eligible Dependents."

6. Enrolling the Eligible Employee's Eligible Dependents

(a) The Eligible Employee can enroll for family coverage at the same time he or she becomes eligible for his or her individual coverage.

(b) If the Eligible Employee has no Dependents when the Eligible Employee first enrolls but later gains one, the Eligible Employee may enroll for family coverage within 31 days of the date the Eligible Employee gains the Dependent. This includes Dependents gained by marriage, birth adoption, legal guardianship or court order. During the first 31 days after the birth of a child, the child will be

automatically covered for all eligible benefits. For coverage of a child beyond the first 31 days after birth and for coverage of a spouse during and beyond the first 31 days after marriage, enrollment must be made and the first premium charge for that Dependent must be paid within that 31 day period.

(c) Note: Except for newborn child's coverage during the first 31 days after birth. if the Eligible Employee does not enroll his or her Dependents within 31 days after the Dependent becomes eligible. satisfactory Evidence of Good Health for each Dependent will be required. If satisfactory Evidence of Good Health is not provided for such Dependent, the Company may reject the enrollment application for insurance of such Dependent under this Policy. Coverage for such

Dependent providing satisfactory Evidence of Good Health will then begin no earlier than the first day of the calendar month following CHI's approval of the Evidence of Good Health. However, no Evidence of Good Health will be required for any Dependent who enrolls within such 31 days.

(d) If a Dependent, except a child covered at birth, is confined for medical care or treatment in any institution or at home when coverage would normally start, the Dependent will not be covered until given a final release by a Physician from all such confinement.

7. When Dependent Coverage Stops

Except as otherwise specifically provided in this Policy, coverage for Dependents shall end when the dependent relationship with the Eligible Employee ends or when coverage for the Eligible Employee of whom such person is a Dependent ends. When coverage for a Dependent ends, the Dependent will have an opportunity to obtain continuation of medical coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA). For more information on COBRA and the right to continued medical coverage, see Section 1 of Article IX of this Policy.

8. Extension of Coverage for Dependents

(a) Under certain circumstances described below, coverage could continue for an Eligible Dependent after the time coverage would normally stop under this Policy.

(b) A child who is otherwise eligible hereunder and is physically or mentally incapable of self-support upon attaining the limiting age may be continued under the coverage provided hereunder so long as he or she remains incapacitated and unmarried at that time, subject to the coverage of the Covered Employee to whom such child is dependent is continuing in effect.

(c) To be eligible for the continued coverage described in this Section of a Dependent child beyond the time coverage would normally end, proof of his or her incapacity must be submitted to CHI within 31 days after such Dependent's attainment of the limiting age. Proof of the incapacity will be required from time to time to keep this coverage in effect. Each time CHI asks for proof that a Covered Dependent is incapacitated, CHI may require the Covered Dependent to have a Physician's examination at the Covered Person's expense. CHI may specify the Physician.

(d) The continued coverage of a dependent child under this Section shall terminate on the earliest of the following dates:

(i) the date such child is no longer incapacitated according to the Policy;

(ii) the date proof of the child's incapacity is not provided when asked; or

(iii) the date his or her Dependent's coverage terminates pursuant to Article II, Section 7 or Article XIII of this Policy.

III. ENROLLMENT CHANGES

Enrollment and benefit coverage under this Policy may be changed only upon a change in family status of the Covered Employee.

A "change of family status" occurs when:

1. A Covered Employee gets married or divorced;

2. A Covered Employee's child is born or legally adopted;

3. A Covered Employee's spouse or child dies; or

4. A Covered Employee's spouse has a loss of group insurance coverage.

Unless otherwise permitted under Article II, a Covered Employee may change his or her benefit coverage or enroll new Dependents only if Evidence of Good Health has been submitted and approved by CHI for each individual involved.

Furthermore, if a Dependent of a Covered Employee, other than a newborn child, is confined in a Hospital, Skilled Nursing Facility, at home or any other institution on the date coverage would become effective, then such coverage will be postponed until the day after the Dependent is no longer so confined and a final release from such confinement is provided by the Physician.

IV. POLICY BENEFITS AND PAYMENTS

If, as a result of an illness or injury, a Covered Person incurs eligible medical expenses which exceed the Deductible Amount set forth in the Schedule of Benefits during a calendar year, the Company will pay for such excess in accordance with the co-payment and co-insurance provisions of the Schedule of Benefits, subject to all other terms and conditions set forth in this Policy.

1. Deductible Amount

The Deductible Amount is the specified amount of eligible expenses which a Covered Person or a Family Unit (as the case may be) is required to pay before CHI pays any benefits under this Policy. Covered expenses which are used in satisfying the Deductible Amount must be incurred and applied to such deductible within the applicable calendar year.

The Deductible Amount applies to each Covered Person, subject to any family Deductible Amount set forth in the Schedule of Benefits, if applicable. The Deductible Amount must be satisfied once each calendar year, except for:

(a) the Common Accident Provision: if the Deductible Amount applies to accident expenses and if two or more members of one family incur covered expenses because of disabilities resulting from injuries sustained in any one accident, the Deductible Amount will be applied only once with respect to all covered expenses incurred as a result of the accident; and

(b) the Carryover Provision: if any part or all of the Deductible Amount has been satisfied during the last three months of such calendar year, the Deductible Amount for the next calendar year will be reduced by the amount applied.

The Deductible Amount is not applicable to certain eligible medical expenses noted in the Schedule of Benefits, for which you or your family member need to pay any Deductible Amount prior to being paid benefits under the Policy.

2. Co-Payment and Co-Insurance

After the applicable Deductible Amount has been paid by the Covered Person or the Family Unit (as the case may be), the eligible expenses for Covered Medical Services will be paid by CHI and the Covered Persons in accordance with the co-payment and co-insurance provisions set forth in the Schedule of Benefits. Certain Covered Medical Services will be subject to co-insurance provisions, which require the payment obligations in excess of the Deductible Amount to be shared between CHI and the Covered Person in accordance with percentages of Reasonable and Customary Charges set forth in the Schedule of Benefits. Certain other Covered Medical Services will be subject to co-payment provisions, which require an initial sum specified in the Schedule of Benefits to be paid by the Covered Person and the balance of Reasonable and Customary Charges to be paid by CHI.

Certain Covered Medical Services specified in the Schedule of Benefits may not be subject to co-insurance or co-payment requirements.

3. Out-of-Pocket Maximum

During any calendar year, the Covered Person or the Family Unit (as the case may be) will not be required to pay an aggregate amount in excess of the out-of-pocket maximum amount specified in the Schedule of Benefits (the "Out-of-Pocket Amount"). If during any calendar year the Covered Person or the Family Unit (as the case may be) has paid pursuant to the above co-insurance or co-payment provision an aggregate amount greater than the Out-of-Pocket Amount, CHI will pay for 100% of the balance of the eligible expenses, up to the amount of the maximum benefit amounts set forth in the Schedule of Benefits.

The co-insurance and co-payments paid by the Covered Person or the Family Unit will be included in the Out-of-Pocket Amount. However, the Deductible Amount paid by the Covered Person or the Family Unit will not be included in the Out-of-Pocket Amount.

4. Maximum Benefits

The benefits payable under this Policy for all eligible medical expenses incurred by any Covered Person shall not exceed the applicable maximum benefits specified in the Schedule of Benefits. Such maximum benefits may be in the form of a maximum amount payable during lifetime or a specified period or in the form of a maximum number of days or visits for which benefits are payable under the Policy. Different Covered Medical Services may be subject to one or more different maximum benefits.

5. Restoration and Reinstatement

If a Covered Person has received his or her maximum benefits under the Policy, then on the first day of each calendar year $1,000 shall be reinstated, but in no event shall the reinstated amount exceed the applicable maximum benefits set forth in the Schedule of Benefits. However, any Covered Person who wishes immediate reinstatement of the full Policy maximum shall again be entitled to receive full benefits by submitting Evidence of Good Health at his or her own expense. The new maximum benefits will take effect on the first day of the month following CHI's approval at its sole discretion of Evidence of Good Health. This restoration and reinstatement provision will not apply to certain Covered Medical Services, as specified in the Schedule of Benefits.

6. Re-Entry Into Policy

Any person who was formerly covered under the Policy, either as an Eligible Employee or as a Dependent, and who again becomes covered hereunder within a one-year period from the termination date of his or her previous coverage, either as an employee or as a Dependent, shall not have his or her full maximum

benefits restored solely by reason of the fact that s/he has become covered for a second or subsequent time. The maximum benefits with respect to such person, as set forth in the Schedule of Benefits, shall be reduced by any benefits previously paid under this Policy.

V. PRE-CERTIFICATION

When a Physician recommends that a Covered Person be hospitalized or receive certain other medical services or supplies specified in the Schedule of Benefits, there are certain procedures that must be followed.

The Covered Person, a member of his or her family, a hospital staff member, or the attending Physician, must notify CHI to pre-certify the admission or treatment, as the case may be, prior to receiving any of the services or supplies that require pre-certification pursuant to the Schedule of Benefits or this Policy.

The Company will reduce the benefits payable under this Policy by the percentage set forth in the Schedule of Benefits if the procedures for pre-certification set forth herein are not followed. Each Covered Person will be responsible to pay the unpaid balance of the benefits.

To obtain pre-certification, call CHI at 1-800-509-3400. This call must be made:

1. Prior to any planned admission into Hospital and prior to receiving such other eligible services or supplies that require pre-certification according to the Schedule of Benefits or this Policy;

2. Within 24 hours after the time of an emergency admission or as soon thereafter as reasonably possible; and

3. As soon as the attending Physician confirms that a Covered Person is pregnant and again within 24 hours of the birth or as soon thereafter as reasonably possible.

When calling CHI, the caller must provide:

1. The Covered Person's name and the Covered Person's social security number;

2. The treating Physician's name, address and phone number;

3. The name of the Hospital or treatment facility and the anticipated admission or treatment date; and

4. The Policyholder's name and Policyholder Policy Number.

There is no requirement to call in advance before seeking treatment for an emergency.

Case Management

Certain medical conditions for which a claim is made under the Policy may be referred to Case Management (CM).

Only those conditions for which Covered Medical Expenses are expected to exceed a certain dollar amount, and for which there is a potential lower cost treatment alternative, will be referred to CM.

CM is a program which provides a case-by-case analysis and medical treatment plan suggestions that address the need of catastrophically ill or injured individuals. It concentrates on severe injuries and illnesses, such as spinal cord injuries or head trauma, when early intervention and individual case management will prove effective to a patient's recovery.

The decision to refer any case to CM will remain with CHI, who will rely on the criteria established by the CM service provider to determine which claims are recommended for CM, except that no alternative treatment will be provided to the Covered Person under CM without prior consent of the Covered Person and the attending Physician.

In certain instances a recommendation to use alternative treatment not normally covered by the Policy may be made when such treatment endorses quality care, Medical Necessity and cost effectiveness. Under these circumstances, any such alternative treatment will be covered by the Policy.

VI. COVERED MEDICAL SERVICES

Subject to the terms, conditions, exclusions and limitations set forth in the Schedule of Benefits (including the co-payment, co-insurance and maximum benefit amounts set forth therein) and in this Policy, the Company will pay and provide to each Covered Person the benefits described below.

This Policy does not cover charges in excess of Reasonable and Customary Charges (as defined herein) and does not provide benefits for services or supplies other

than those Medically Necessary (as defined herein). Therefore, the term "charges" used below shall refer only to Reasonable and Customary Charges for Medically Necessary services or supplies. The coverage under this Policy is also subject to other exclusions set forth in Article VII of this Policy.

Acupuncture

The charges for the administration of acupuncture when provided for pain management in lieu of anesthesia.

Alcoholism and Drug Addiction Treatment

For alcoholism and drug addiction treatment, please refer to "Substance Abuse Treatment" below.

Ambulance Transportation

The charges for ambulance service. Coverage is limited to transportation to and from the nearest facility that can give necessary care and treatment.

Ambulatory Surgery

The charges for services and supplies furnished in connection with performance of a surgical procedure at an Ambulatory Surgical Facility or the outpatient department of a Hospital.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-509-3400 prior to treatment. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Limitations/Exceptions

Coverage is limited to charges for the following:

1. Services and supplies furnished by the Ambulatory Surgical Facility or Hospital on the date of the procedure;

2. Services of the operating Physician for performing the procedure and for: a. Related pre- and post-operative care; and b. The administering of an anesthetic; and

3. Services of any other Physician for the administering of a general anesthetic.

This Policy does not cover Ambulatory Surgery charges incurred:

(a) For the services of a Physician who renders technical assistance to the operating Physician, unless required in connection with the procedure; or

(b) While the Covered Person is confined as a full-time Inpatient in a Hospital.

Anesthesia

The charges for the administration of anesthetics by a Physician (other than the surgeon, assistant surgeon or the attending Physician) or registered nurse anesthetist (R.N.A.).

Assistant Surgeon

The charges for the professional services of a legally qualified Physician to render technical assistance to the operating surgeon when Medically Necessary in connection with a surgical procedure performed. However, no benefits are payable for surgical assistance rendered in hospitals where it is routinely available as a service provided by a hospital intern, resident or house officer. The assistant surgeon's charges are determined by using the surgeon's Reasonable and Customary Charges.

Birthing Center

The charges for services and supplies furnished by a Birthing Center for:

1. Prenatal care;

2. Delivery of a child or children; and

3. Post-partum care rendered within twenty-four (24) hours after the delivery.

Also included are charges for the services shown below if received in connection with the above services and supplies furnished by the Birthing Center:

1. Charges by the operating Physician or certified nurse midwife for:

   a. Performing an obstetrical procedure;
   b. Related pre- and post-operative care; and
   c. Administering an anesthetic.

2. Charges by any other Physician for the administering of a general anesthetic.

Limitations/Exclusions

This Policy does not cover Birthing Center charges incurred:

1. For the services of a Physician or certified nurse midwife who renders technical assistance to the operating Physician; or

2. For which pregnancy-related expenses are not covered under this Policy.

Blood and Blood Plasma

The charges for blood and blood plasma, and blood plasma expanders when not replaced on behalf of the Covered Person.

Cardiac Rehabilitation Services

The charges for cardiac rehabilitation therapy rendered by a licensed therapist, when prescribed by and provided under the supervision of the attending Physician.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-509-3400 prior to receiving services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Chemotherapy

The charges for the treatment of malignant disease by chemical or biological antineoplastic agents for cancer chemotherapy and cancer hormone treatments and for services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer, whether performed in a Physician's office, as an Inpatient or Out-Patient at a Hospital, or in any other medically appropriate treatment setting.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-509-3400 prior to treatment. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Chiropractic Care

The charges for detection and correction by manual means of structural imbalance

or subluxation resulting from or related to distortion, misalignment or subluxation of or in the vertical column.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-509-3400 prior to treatment. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Consultation

The charges for consultation services by a Professional Provider, provided that the consultation services are given to the Covered Person at the request of the attending Physician while confined as an Inpatient in a Hospital, a Skilled Nursing Facility or a Substance Abuse Treatment Facility.

Consultation consists of an examination of the Covered Person and a review of his or her x-ray and laboratory examinations and medical history, but not staff consultations required by hospital rules and regulations.

Diagnostic Services

The charges for Diagnostic Services.

Durable Medical Equipment

The charges for rental or initial purchase (or necessary repair) of Durable Medical Equipment prescribed by a Physician for the treatment of an Illness or Injury. It does not include any changes made to the Covered Person's home, automobile, or personal property, such as air conditioning or remodeling. Rental coverage is limited to the purchase price of the Durable Medical Equipment.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-509-3400 prior to leasing or purchasing any equipment in excess of $1,500. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Emergency Services

The charges for Emergency Services received within 48 hours after the onset of a

Medical Emergency. Surgery (e.g., suturing, burn care fracture care, etc.) payment will be made as a surgical benefit.

After being admitted into a facility for Emergence Services, CHI must be notified at 1-800-509-3400 within 24 hours of the admission or as soon as reasonably possible. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for such notification are not followed.

Hemodialysis

The charges for hemodialysis treatment.

Home Health Services

The charges for Home Health Services provided by a licensed Home Health Agency pursuant to a Home Health Plan.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-509-3400, and CHI must approve the Home Health Plan, prior receiving Home Health Services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Limitations/Exclusions

Coverage is limited to one visit per day. Each period of up to four (4) hours or less will be considered one visit, and each visit by a Home Health Agency is counted as one visit.

Hospice Care

The charges for Hospice Services if the attending Physician certifies that the Covered Person is a Terminally Ill Person and recommends admission into a Hospice Care Program.

To qualify for payment under the Policy, Hospice Services must be:

1. Provided while the Terminally Ill Person is a Covered Person;

2. Provided within six (6) months of the Terminally Ill Person's entry or re-entry (after a remission period) in the Hospice Care Program; and

3. Furnished or arranged by a Hospice.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-509-3400, and CHI must approve the Hospice Care Program, prior receiving Hospice Services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for

pre-certification are not followed.

Limitations/Exclusions
Coverage is limited to one or more of the following charges:

1. For the confinement of a Terminally Ill Person as an Inpatient in a Hospice facility;

2. For Home Health Services furnished to the Terminally Ill Person in the person's home;

3. For social services furnished to the Terminally Ill Person or to the Family Unit by a Social Worker;

4. For palliative care (medication/treatment directed toward relief); or

5. For respite care.

Hospital

The charges for Out-Patient services and supplies, and the following Inpatient charges when a Covered Person is confined in a Hospital:

1. Room and board and general nursing care charges for semi-private accommodations (designated as such by the Hospital) or, if the Covered Person utilizes private accommodations because the Covered Person's medical condition requires isolation for his or her health and the attending Physician orders such private accommodations, charges for private accommodations; and

2. Charges for all other hospital services and supplies, including special meals and dietary services, medicines, laboratory tests, use of operating rooms and special equipment anesthetics and x-rays, provided and billed by hospital.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-509-3400 prior to hospital admission as an Inpatient. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Limitations/Exclusions
The Policy does not cover hospital charges for any day that the Covered Person

does not receive any medical treatment after being admitted to a Hospital.

Immunization for Children

The charges for child immunization, up to the minimum benefits mandated by the Pennsylvania Department of Health.

Coverage will be provided for those child immunizations, including the immunizing agents, which as determined by the Department of Health, conform to the standards of the U. S. Department of Health and Human Services. These benefits will be exempt from Deductible Amounts and other dollar limits.

Infertility Services

The charges for services to diagnose infertility. Services to treat infertility are not covered by this Policy.

Inpatient Physician Services

The charges for medical treatment given by the attending Physician to a Covered Person while confined as an Inpatient in a Hospital or Skilled Nursing Facility.

Limitations/Exclusions Inpatient Physician services coverage does not include charges for:

1. Surgical services;

2. Diagnostic Services;

3. Maternity services;

4. Any therapy;

5. For psychiatric treatment; or

6. Treatment rendered to a Covered Person who has exceeded the maximum number of days of confinement or the maximum benefit amount for Inpatient Physician services, as set forth in the Schedule of Benefits.

Mammography

The charges for female Covered Person's expenses for mammography services, up to

one routine mammography every calendar year if the Covered Person is age 40 or older. In addition, any mammography recommended by a Physician.

Maternity-Related Care

The charges for female Covered Person's expenses incurred as a result of pregnancy, miscarriages and Medically Necessary and elective abortions. Life threatening abortions will be covered as any other surgery.

The Covered Person, a member of his or her family, a hospital staff member' put preferably the attending Physician, must notify CHI at 1-800-509-3400 as soon as pregnancy is confirmed and within 24 hours after birth of a child or as soon thereafter as reasonably possible.

Mental or Nervous Disorders

For coverage of mental or nervous disorder, please refer to "Psychiatric Treatment" below.

Newborn Baby Care

The charges for care of newborn children, including Hospital charges for nursery room and board and miscellaneous expenses.

Occupational Therapy

The charges for occupational therapy rendered by a licensed therapist for Illnesses and Injuries of the Covered Person.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-509-3400 prior to treatment. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Limitations/Exclusions
Coverage is limited only to treatment for up to such number of days per incident of Illness or Injury set forth in the Schedule of Benefits, beginning with the first day of treatment.

Office Visits

The charges for diagnosis or treatment of any Injury or Illness at a Physician's office.

Organ Transplants

The charges for services which are directly and specifically related to organ transplants when performed at a Hospital. Where the Covered Person is the recipient, coverage hereunder includes the hospitalization of donors, and for those hospital services directly and specifically related to the transplantation

of the organ to the Covered Person, to the extent that the Covered Person (recipient) would be entitled to such benefits and the donor is not otherwise insured or covered by another health care plan.

The purchase price of the organ is not covered under this Policy. Coverage under this Policy is limited to organ transplants meeting the following requirements:

1. The attending Physician certifies that the organ transplant is Medically Necessary;

2. The covered Person must be the recipient; and

3. The transplant is accepted by the general medical community at the time of the procedure as appropriate treatment for the specific conditions of the Covered Person.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-509-3400 prior to treatment. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Oxygen

The charges for oxygen and the rental equipment for its administration when prescribed by the attending Physician.

Papanicolaou Smear (Pap Smear)

The charges for a female Covered Person's expenses for a routine pap smear in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

Physical Therapy

The charges for physical therapy rendered by a licensed therapist for Illnesses and Injuries of the Covered Person.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-509-3400 prior to receiving services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Preventive Care

The charges for an annual gynecological examination including a pelvic examination and clinical breast examination by a Physician.

The charges for immunizations (other than immunization for children covered elsewhere in this Policy) and physical examinations (other than papanicolaou smears and mammography covered elsewhere in this Policy) by a Physician, subject to the limitations set forth in the Schedule of Benefits.

Private Duty Nursing

The charges for private duty professional nursing services from a L.P.N. or R.N. for a Covered Person's non-hospitalized acute-illness or injury

Private duty nursing care furnished for Custodial Care is not covered.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-509-3400 prior to receiving services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Psychiatric Treatment

The charges for the following Inpatient and Out-Patient services for a Covered Person for the treatment of a Mental Illness.

Inpatient: The hospital services and supplies provided to a Covered Person for the treatment of a Mental Illness while confined as an Inpatient at a Hospital or a Psychiatric Hospital.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-509-3400 prior to admission. The Company will reduce the benefits under this Policy by the percentage or dollars (as the ease may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Out-Patient: The following Out-Patient services for the treatment of a Mental Illness rendered by a licensed psychiatrist, psychologist, psychotherapist or psychiatric Social Worker at a Mental Health Treatment Facility:

1. Oral and written diagnostic tests;

2. Consultation visits;

3. Diagnostic visits;

4. Physician's personal treatment visits; and

5. Group therapy.

Radiation Therapy

The charges for the treatment of any Illness or Injury by x-ray (but not dental x-rays, unless directly related to a Covered Medical Service), gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes, including the cost of radioactive materials.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-509-3400 prior to receiving services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the ease may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Reconstructive/Corrective Surgery

The charges for reconstructive surgery if such surgery is required to:

1. To restore normal functions of a body part (other than a tooth or structure that supports the teeth) which is malformed as a result of a birth defect or as a direct result of Illness or Injury or surgery performed to treat an Illness; or

2. Repair an Injury which occurs while the person is covered under this Policy. Surgery must be performed in the calendar year of the accident which causes the Injury or in the next calendar year.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-509-3400 prior to receiving surgery. The Company will reduce the benefits under this Policy by the percentage or dollars (as the ease may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Reconstructive surgery coverage does not include Cosmetic Surgery.

Respiratory Therapy

The charges for respiratory therapy rendered by a licensed therapist for Illnesses and injuries of the Covered Person.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-509-3400 prior to receiving services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Skilled Nursing Facility

The charges listed below when a Covered Person is confined as an Inpatient in a Skilled Nursing Facility while recovering from an Illness or Injury. Coverage is limited to services and supplies furnished while the Covered Person is under continuous care of his or her Physician, requires 24-hour nursing care and the confinement in a Skilled Nursing Facility is required by his or her Physician:

1. Room and board and general nursing care charges for semi-private accommodations (designated as such by the Hospital) or, if the Covered Person utilizes private accommodations because the Covered Person's medical condition requires isolation for his or her health and the attending Physician orders such private accommodations, charges for private accommodations; and

2. Charges for all other skilled nursing services and supplies, including special meals and dietary services and medicines.

Skilled Nursing Facility care coverage does not include Custodial Care.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-509-3400 prior to admission. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Speech Therapy

The charges for speech therapy rendered by a qualified speech therapist to restore or rehabilitate any speech loss or impairment caused by Injury or Illness, a previous speech therapeutic process, or as a result of surgery for an Injury or Illness.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending physician, must obtain pre-certification by CHI at 1-800-509-3400 prior to receiving services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Substance Abuse Treatment (including Alcoholism and Drug Addiction)

The charges for the following Inpatient and Out-Patient services to treat Substance Abuse or Dependency, subject to the limitations set forth below and any additional limitations set forth in the Schedule of Benefits:

1. Out-Patient Care: Covered Medical Services include the following Out-Patient services in a Substance Abuse Treatment Facility for treatment for medical conditions resulting from the Substance Abuse or Dependency: (1) Physician, psychologist, nurse, certified addictions counselor and trained staff services; (2) rehabilitation therapy and counseling; (3) family counseling and intervention; (4) psychiatric, psychological and medical laboratory tests; and (5) drugs, medicines, equipment use and supplies.

Each Covered Person is eligible for thirty (30) Out-Patient full visits per calendar year. Each Covered Person is also eligible for thirty (30) additional Out-Patient full visits or equivalent partial visits per calendar year at a Substance Abuse Treatment Facility, which may be exchanged on a two-for-one basis for up to fifteen (15) non-hospital, residential alcohol or drug treatment days described in Paragraph 3 below. Treatment for Substance Abuse or Dependency shall be provided according to an individualized treatment plan, subject to a lifetime limit of one hundred and twenty (120) Out-Patient full visits or equivalent partial visits.

2. Inpatient Detoxification: Covered Medical Services include the following Inpatient services at a Hospital or a Substance Abuse Treatment Facility for detoxification and treatment for medical conditions resulting from the Substance Abuse or Dependency: (1) lodging and dietary services; (2) Physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

   Each Covered Person is eligible for seven (7) Inpatient days of per calendar year, subject to a lifetime limit of four (4) separate such admissions. Inpatient rehabilitation beyond detoxification in the Hospital is not covered hereunder.

3. Inpatient Rehabilitation: Covered Medical Services include the following Non-Hospital Substance Abuse Residential Facility care: (l) lodging and dietary services; (2) Physician, psychologist, nurse,

certified addictions counselor and trained staff services; (3) rehabilitation therapy and counseling; (4) family counseling and intervention; (5) psychiatric, psychological and medical laboratory tests; and (6) drugs, . medicines, equipment use and supplies.

Each Covered Person is eligible for thirty (30) days per calendar year for such residential treatment in a Non-Hospital Substance Abuse Residential Facility, subject to a lifetime limit of ninety (90) days of such services.

4. Court-ordered chemical dependency admissions are covered but only to the extent of the covered benefits described above.

In the case of Paragraph 2 or 3 above, the Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must submit to CHI prior to treatment a certificate from a Physician that the Covered Person is suffering from Substance Abuse or Dependency and needs treatment.

Voluntary Sterilization

The charges for male or female voluntary sterilization procedures. The Policy will not cover reversal procedures.

VII. GENERAL EXCLUSIONS

This Policy Does Not Cover Charges, Expenses or Costs:

1. For services or supplies not Medically Necessary for the diagnosis or treatment of an Illness or Injury.

2. Which exceeds the Reasonable and Customary Charges or exceeds the maximum benefit amounts set forth in the Schedule of Benefits.

3. Caused by war (declared or undeclared) or any act of war.

4. Suffered while on full-time active duty in the armed forces of any country or international authority.

5. Incurred in connection with any injury or illness which is compensable under any workers' compensation or occupational disease act or law or the federal Longshoreman's and Harbor Worker's Compensation Act.

6. For services received in a veteran's administration hospital, a public

health service hospital, or any facility operated by the U.S. government or any of its agencies, except to the extent that there is an unconditional requirement to pay those charges.

7. For medical and dental care received by retirees from armed forces or their dependents pursuant to and covered by programs established under federal law.

8. For the treatment of or care for mental retardation, defects and deficiency, except that this exclusion does not apply to Mental Illnesses specifically covered in Article VI.

9. For dental services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth and gums, including but not limited to apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, and dental implants, except for accidental injuries to sound natural teeth.

10. For optical services: The Policy does not cover charges for examinations to determine the need for (or change of) eyeglasses or lenses of any type except initial replacements for loss of the natural lens, eye surgery such as radial keratotomy when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), or exams for the correction of vision and radial keratotomy eye surgery to improve visual acuity.

11. For services rendered by the Covered Person or his or her Close Relative.

12. For medical services or supplies not prescribed or rendered by a Physician.

13. Directly related to attempted suicide or an intentionally self-inflicted injury (whether sane or insane).

14. For provision or replacement of the following items: arch supports; elastic hose; birth control devices including, but not limited, to IUDs, diaphragms and condoms; false teeth; braces; traction apparatus; canes; cervical collars; walkers; corrective shoes; wheelchairs; corsets; crutches; wigs or cranial prosthesis; diapers; special appliances, supplies or equipment. This exclusion does not apply to Durable Medical Equipment specifically covered by Article VI.

15. For Custodial Care.

16. For Cosmetic Surgery except reconstructive surgery specifically covered by Article VI

17. Resulting from the commission of or attempt to commit a felony by the Covered Person.

18. For personal convenience items or services such as telephones, barber services, meals, formulas, radio and television rentals, homemaker services and other like items and services.

19. Applied toward satisfaction of the Deductible Amount or the co-payment or co-insurance amount payable by the Covered Person.

20. For blood, blood plasma and blood products that are replaced on behalf of the Covered Person.

21. For actual or attempted impregnation or fertilization which involves either a Covered Person or a surrogate as a donor or a recipient.

22. For examinations, adjustment of, or purchase of a hearing aid.

23. For career and pastoral counseling.

24. For services or supplies of an Educational, Experimental or Investigative nature. This exclusion includes, but is not limited to:
    - All phases of clinical trials;
    - All treatment protocols based upon or similar to those used in clinical trials;
    - Drugs approved by the Federal Food and Drug Administration under its Treatment Investigatory New Drug regulation or equivalent;
    - Federally approved drugs used for treatment indications not generally recognized by the medical community.

25. For the reversal of any sterilization procedure or any related care.

26. For sex transformations or other transsexual surgery or related services not necessitated by an Injury or Illness covered by this Policy.

27. For services rendered for academic reasons.

28. For orthoptic therapy (vision exercises).

29. For weight reduction programs and gastric stapling for treatment of obesity.

30. Infertility services, including but not limited to, In-Vitro fertilization procedures, Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian transfer (ZIFT) and other similar or related services; and infertility injectables or other infertility-related supplies.

31. For bereavement counseling services, except as specifically provided for under the Hospice Services in Article VI.

32. For treatment of temporomandibular joint dysfunction with/intra oral devices or any other method to alter vertical dimension.

33. For hypnosis not used as an integral part of a Covered Medical Service covered under Article VI

34. For telephone consultations, failure to keep a scheduled visit, or completion of a claim form.

35. For any services or supplies not specifically described herein.

36. For services or supplies covered by any automobile insurance policy up to the amount of coverage limitation under such policy.

37. For prescription drugs.

The Company shall determine whether a service or supply is covered under this Policy or excluded from coverage under this Policy.

VIII. GENERAL PROVISIONS

1. Notice of Claim

Written notice of claim must be furnished to the Company within 90 days after Covered Medical Services have been rendered to the Covered Person. A notice of claim form may be obtained from CHI or the Policyholder. However, in case of a claim for which the Policy provides any periodic payment contingent upon continued provision of Covered Medical Services, this notice may be furnished within 90 days after termination of each period for which the Company is liable. Failure to furnish the notice of claim within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give the notice of claim within 90 days, provided the notice of claim is furnished as soon as reasonably possible. However, except in the absence of legal capacity of the claimant, the notice of claim may not be furnished later than one year from the date when the notice of claim was originally required.

2. Time for Payment of Claim

Benefits payable under the Policy will be paid promptly upon receipt by CHI of

satisfactory notice of claim, unless the Policy provides for periodic payment. Where the Policy provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory notice of claim.

3. Payment of Claims

All or any portion of any indemnities provided by the Policy on account of hospital, nursing, medical or surgical services may, at the Company's option, be paid directly to the hospital or other persons rendering such services; but it is not required that the service be rendered by a particular hospital or person. Any payment made by the Company in good faith pursuant to this provision will fully discharge the Company's obligation to the extent of the payment. The Covered Person may request that payments not be made pursuant to this provision. The request must be made in writing and must be given to the Company not later than the time of filing notice of claim. Payment made prior to receipt of the Covered Person's written request at the Company's principal executive office will be deemed to be payment made in good faith.

The Covered Person shall be responsible for the payment of all charges for any service or supply in excess of the Reasonable and Customary Charges or otherwise not covered by this Policy.

4. Review and Appeal Procedures
Reviews of Pre-Certification Denials

If a Covered Person is denied coverage for a procedure during the pre-certification process described in Article V, the Covered Person will be advised of the reason(s) for the denial and of his or her right to a prompt review by a person who did not participate in the denial decision.

If a review is requested, in addition to reviewing the reasons for the denial, CHI may discuss the case with the treating Physician in an effort to agree on care that would be covered under the Policy.

If the review does not result in a satisfactory resolution, the Covered Person will receive a written notice explaining the reason(s) for the denial.

Appeals of Denied Claims or Other Denials

If a Covered Person is denied coverage for a claim or denied coverage for a procedure during pre-certification process, the Covered Person will be advised in writing of the reason(s) for the denial. This notice will set forth

the reasons for such denial. If the Covered Person wishes to appeal this

decision, the Covered Person may write to the address which appears on the notice (to the attention of the person who signed the letter, if any).

The Covered Person may appeal a denial of benefits within 30 days of the date of the rejection by sending a letter stating why the Covered Person thinks the claim should not have been denied, including a copy of the denial letter and with any additional claim. The Policyholder number, claim number, if any, and the date of service for which benefits were denied must be included will become final and incontestable.

Upon receipt of the letter and any additional information the Covered Person provides, the Covered Person's records will be reviewed; and the results of this review will be sent to the Covered Person promptly. In unusual cases, as when review of the claim or denial of coverage requires examination by medical personnel, including consulting physicians, the review may be extended.

5. Choice of Physician

Each Covered Person has free choice of any Physician, Hospital or other provider.

6. Time Limit on Certain Defenses

No claim for loss incurred after one year from commencement of the individual Covered Person's insurance will be reduced or denied on the grounds that the disease or physical condition existed prior to the commencement of the Covered Person's insurance.

7. Contract

The entire contract between the Company and the Policyholder consists of the Policy, the Summary of Benefits and the applications of the Policyholder and each Covered Employee. All statement contained in the applications will, in the absence of fraud, be deemed representations and not warranties. No statement made by an applicant for insurance will be used to void the insurance or reduce the benefits, unless contained in a written application and signed by the applicant. No agent has the authority to make or modify the Policy, or to extend the time for payment of premiums, or to waive any of the Company's rights or requirements.,

No modification of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by an executive officer of the Company and delivered to the Policyholder.

8. Incontestability

The validity of a Covered Person's insurance will not be contested, except for non-payment of premium, after his or her insurance under the Policy has been continuously in force for one year during his or her lifetime. No statement made by a Covered Employee relating to his or her insurability or that of his or her Dependents will be used in defense to a claim under the Policy unless: (a) it is

contained in a written application signed by the Covered Employee; and (b) a copy of the application has been furnished to the Covered Employee or to his or her beneficiary.

9. Misstatements of Age

If the age of any Covered Person has been misstated, an equitable adjustment will be made in the premiums or, at the Company's discretion, the amount of insurance payable. Any premium adjustment will be based on the premium that would have been charged for the same coverage on a Covered Person of the same age and similar circumstances.

10. Physical Examination and Autopsy

The Company, at its own expense, will have the right and opportunity to examine a Covered Person, when and as often as may reasonably be required during the pendency of a claim under the Policy and to make an autopsy in case of death, where it is not forbidden by law.

11. Legal Action

No action at law or in equity may be brought to recover on the Policy unless and until the expiration of 60 days after notice of claim has been furnished to CHI in accordance with the requirements of this Policy. No such action may be brought after the expiration of three (3) years after the time notice of claim is required to be furnished.

12. Conformity With State Statutes

Any provision of the Policy which, on its Effective Date, is in conflict with the statutes of the state in which it is issued, is hereby amended to conform to the minimum requirements of those statutes.

13. Assignment

No assignment of the Policy, or any part of it, will be binding on the Company unless approved in writing by the President or Executive Vice President of the Company. The Company does not assume any responsibility for the validity of any assignment.

14. Rights of Employees

This Policy does not provide any benefit not specifically described herein. This Policy does not constitute a contract of employment and does not affect the right of the employer to discharge any Employee.

15. Facility of Payment

If, in the opinion of the Company, a Covered Person is not competent to execute a valid release for payment of any benefit to which he is entitled under this Policy, the Company may, but shall not be required to, make payment to such individual(s) or institution(s) as have assumed the care and support of such Covered Person. In the event the Covered Person dies before payment is made to him of all benefits to which he is entitled under the Policy, the Company may, but shall not be required to, make payment to such individual(s) or institution(s) as may be, in the opinion of the Company, equitably entitled thereto, including without limitation, individual(s) or institution(s) to which the Covered Person may have assigned such benefits prior to his death. Any payment made in accordance with the foregoing provisions shall fully discharge the Company to the extent of such payments.

16. Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of the provisions of the Policy, the Company may release to, or obtain from, any other plan or policy administrator, insurance company, or other organization or individual any information, concerning any individual, which the Company consider to be necessary for those purposes. Any individual claiming benefits under this Policy will furnish the information that may be necessary to implement the provisions.

17. Deductible Amounts

For each Covered Medical Expense, the individual Deductible Amount stated in the Schedule of Benefits must be incurred with respect to a Covered Person before benefits become payable. If, during a calendar year, such deductibles are equal to the family Deductible Amount shown in the Schedule of Benefits, no further deductible amount shall apply with respect to any remaining expenses incurred by members of that Family Unit during the remainder of that calendar year.

18. Incorporation of Summary of Benefits

The Summary of Benefits is hereby incorporated in and made a part of this Policy.

IX. CONTINUATION OF COVERAGE

1. Consolidated Omnibus Budget Reconciliation Act of 1985, As Amended ("COBRA")

Upon timely notice from the Employer, CHI will make available continuation coverage, as required by COBRA, for all Covered Persons determined to be qualified beneficiaries, as defined in Subsection 162(k)(7)(B) of the Internal Revenue Code, as amended from time to time, and Subsection 607(3) of the Employee Retirement Income Security Act (ERISA), as amended from time to time. The Employer shall retain full responsibility for notifying Covered Persons of their rights to continuation coverage and administering the exercise of continuation rights, as required by COBRA. CHI shall have no obligation to ensure that any notices received from the Employer comply with the requirements of COBRA. For purposes of COBRA, CHI is not the plan administrator.

A. Each Covered Employee has a right to continue coverage if:

1. Employment with the Employer ends for a reason other than gross misconduct; or

2. Work hours are reduced which result in a loss of coverage.

B. Each Covered Dependent has a right to continue coverage if:

1. The Covered Employee's employment with the Employer ends for a reason other that gross misconduct;

2. The Covered Employee's work hours are reduced;

3. The Covered Employee dies;

4. In the case of the Covered Employee's spouse, when such spouse ceases to be an Eligible Dependent as a result of divorce or legal separation;

5. The Covered Employee becomes entitled to Medicare; or

6. In the case of a Dependent child, when such child no longer satisfies the eligibility requirements for coverage as an Eligible Dependent under this Agreement.

Similar rights may apply to certain retirees and their dependents if the employer commences certain bankruptcy proceedings and these individuals lose coverage.

Under COBRA, the Covered Employee or a family member has the responsibility to inform the Employer of a divorce, legal separation, or a child losing dependent status under the Employer's health plan within 60 days of the later of the date of the event or the date on which coverage would end under the plan because of the event. The Employer has the responsibility to notify the Employer of the

Covered Employee's death, termination of employment, reduction in hours or Medicare entitlement.

When the Employer is notified that one of these events has happened, the Employer will in turn notify the qualified beneficiary within 14 days of the notification that he/she has the right to choose continuation coverage. The qualified beneficiary has at least 60 days from such notification or the qualifying event, whichever date is later, to inform the Employer of his or her decision to elect continued coverage. The qualified beneficiary will then have 45 days after notifying the Employer of his or her decision to pay the retroactive premium.

In the case of the Covered Employee's termination of employment or reduction in work hours, the coverage may be continued for up to 18 months. The 18 months of coverage may be extended to 36 months if one of the other events described in Part B above occurs to a dependent within the initial 18 months of coverage. The qualifying

events listed in Part B, other than B(1) and B(2), will entitle the dependents for up to 36 months of continuation coverage. The 18 months may also be extended to 29 months if an individual is determined to have been disabled for Social Security disability purposes at the time of the initial qualifying event and the Employer is notified of the disability of the Social Security Administrator determination within 60 days of its disability determination. The affected individual must also notify the Employer within 30 days of any final determination that the individual is no longer disabled.

However, coverage will cease earlier if one of the following events occurs:

1. The Employer ceases to provide any group health insurance to any of its employees;

2. The qualified beneficiary fails to make timely payments of any premium required;

3. The qualified beneficiary is covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition that the qualified beneficiary may have;

4. The qualified beneficiary is entitled to benefits under Medicare; or

5. The qualified beneficiary extended coverage for up to 29 months

due to a disability and there has been a final determination that the qualified beneficiary is no longer disabled.

2. Employee Conversion Option

When a Covered Employee's coverage under this Policy terminates for reasons other than failure to make the required premium contributions, the benefits may be converted to an individual policy (the "Converted Policy") issued by the Company.

This conversion privilege is available:

(a) to an Eligible Employee if s/he has been continuously insured under this Policy for at last three (3) months immediately prior to the termination;

(b) to an Eligible Dependent spouse if the coverage terminates because of his or her spouse/Employee's death, or because of divorce or annulment of marriage; and

(c) to an Eligible Dependent child if the coverage terminates because of the Eligible Dependent's age or because of the death of his or her parent/Covered Employee.

The conversion privilege is not available to any Covered Person if:

(i) if the Covered Person is, or is eligible to be, within 31 days of termination of coverage under this Policy, covered for similar benefits by: (1) another group plan, medical service subscriber contract, medical practice or other prepayment plan, or (2) any governmental program;

(ii) if issuing the Converted Policy to the Covered Person would result in over-insurance, as determined by CHI; or

(iii) if coverage under the Policy terminated because any required premium contribution was not paid when due.

Application and payment of the first premium under the Converted Policy must be made to the Company within 31 days immediately following termination of coverage under this Policy.

If continuation of coverage as described above is elected, this conversion option will apply at the end of the maximum continuation period under this Policy.

The Converted Policy will be issued as follows:

(A) The Covered Policy will in the form CHI has them available for conversion which is most similar to the coverage being converted. The coverage under the Converted Policy may be different from the coverage provided under this Policy;

(B) The Converted Policy may exclude any condition for which the Covered Person was not covered under this Policy, provided a 12-month period has not elapsed from the original Effective Date of this Policy; and

(C) The premium payable for the Converted Policy will be based on the CHI's rate then applicable to the class of risk to which the Covered Person belongs, the age of the Covered Person, and the form and amount of . coverage provided, on the effective date of the Converted Policy.

If the Covered Employee and one or more of his Dependents were covered by the Policy, the Converted Policy must cover all previously insured Covered Persons who are eligible for conversion coverage. The Company may, at its option, issue a separate Covered Policy to cover any Dependent.

3. Extension of Benefits Upon Termination of Policy

Except as set forth below, if the Covered Person is an Inpatient on the day coverage under this Policy terminates, the benefits of coverage under this Policy shall be provided until the earlier of:

A. the date on which the maximum amount of benefits under this Policy has been paid; or

B. the date on which the Inpatient stay ends; or

C. the 90th day after the date of termination.

If this Policy is terminated because the Employer participates in or obtains medical coverage under a health benefit plan or arrangement made available by another organization, the liability of CHI shall cease as of the date of such termination, and no benefits will be provided for any services or supplies provided after such date.

X. COORDINATION OF BENEFITS

All benefits provided under this Policy are subject to this Article, and will not be increased by virtue of this Article.

1. Definitions

In addition to the Definitions set forth in Article XV of this Policy, the following definitions only apply to this Article:

a. "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:

(1) group, blanket or franchise insurance coverage;

(2) service plan contracts, group practice, individual practice and other prepayment coverage;

(3) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; or

(4) any coverage under governmental programs, and any coverage required or provided by any statute.

The term "Plan" shall exclude any school accident-type coverages or group or group-type hospital indemnity benefits of $100 per day or less.

b. "Dependent" means, for any Plan, any person who qualifies as a Dependent under that Plan.

c. "Allowable Benefits" means the eligible charges for Covered Medical Services under this Policy.

d. "Benefits Paid or Payable" means the amounts actually paid for Covered Medical Services.

2. Effect on Benefits

a. This Article shall apply in determining the benefits of this Policy if, for Covered Medical Services received, the sum of the Benefits Payable under this Policy and the Benefits Payable under other Plans would exceed the Allowable Benefits.

b. Except as provided in Subsection c. of this Section 2, the Benefits Payable under this Policy for Covered Medical Services will be reduced so that the sum of the reduced benefits and the Benefits Payable for Covered Medical Services under other Plans does not exceed the total of Allowable Benefits.

c. If (1) the other Plan contains a provision coordinating its benefits with those of this Policy and its rules require the benefits of this Policy to be determined first, and (2) the rules set forth in Subsection e. of this Section 2 require the benefits of this Policy to be determined first, then the benefits of the other Plan will be ignored in determining the benefits under this Policy.

d. If the other Plan does not include a coordination of benefits provision, such Plan will be primary.

e. If the other Plan does include a coordination of benefits provision:

(1) The Plan covering the patient other than as a Dependent will be primary.

(2) Where both Plans cover the patient as a dependent child, the Plan covering the patient as a dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in a calendar year shall be the primary Plan. But, if both parents have the same birthday, the

Plan which covered the parent longer will be the primary Plan. If the parents are separated or divorced, the following will apply:

(a) The Plan which covers the child as a Dependent of the parent with custody will be the primary Plan.

(b) If the parent with custody has remarried, the Plan which covers the child as a Dependent of the stepparent with custody will determine its benefits before the Plan covering the child as a Dependent of the parent without custody.

(c) Where there is a court decree which establishes financial responsibility for the health care expenses of the dependent child, the Plan which covers the child as a Dependent of the parent with such financial responsibility will be the primary Plan as long as the Plan of that parent has actual knowledge of the court decree.

(d) If the specific terms of the court decree state that the parents shall 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 shall follow the

order of benefit determination rules outlined in the first paragraph of 2. e. 2).

In the event CHI is coordinating with a Plan that uses the male/female rule regarding dependent children, the introductory paragraph of this clause (2) shall be replaced with to the following introductory paragraph:

Where both Plans cover the patient as a dependent child, the Plan covering the patient as a dependent child of a male will be the primary Plan, except that if the parents are separated or divorced, the following will apply:

(3) Where the determination cannot be made in accordance with clause (1) or (2) above, the Plan which has covered the patient for the longer period of time will be the primary Plan; provided that,

(a) the benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the Dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee as a Dependent of such person; and

(b) if either Plan does not have a provision regarding laid-off or retired employees, and, as a result, the benefits of each plan are determined after the other, then the provisions of clause (3)(a) above shall not apply.

f. Services provided under any governmental program for which any periodic payment of rate is made by the Covered Person shall always be the primary Plan, except when prohibited by law, or when the Covered Person has elected Medicare secondary.

3. Facility of Payment

Whenever payments should have been made under this Policy in accordance with this Article, but the payments have been made under any other Plan, CHI has the right to pay to any organization that has made such payment any amount it determines to be warranted to satisfy the intent of this Article. Amounts so paid shall be deemed to be Benefits Paid under this Policy and to the extent of the payments for Covered Medical Services, CHI shall be fully discharged from liability under this Policy.

4. Right of Recovery

a. Whenever payments have been made by CHI for Covered Medical Services in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, irrespective of to whom paid, CHI shall have the right to recover the excess from among the following, as CHI shall determine: any person to or for whom such payments were made, any insurance company, or any other organization.

b. The Covered Employee, personally and on behalf of his or her Covered Dependents shall, upon request, execute and deliver such documents as may be required and do whatever else is reasonably necessary to secure CHI's rights to recover the excess payments.

5. CHI shall not be required to determine the existence of any Plan or amount of Benefits Payable under any Plan except this Policy, and the payment of benefits under this Policy shall be affected by the Benefits Payable under any and all other Plans only to the extent that CHI is furnished with information relative to such other Plans by the Employer or Covered Person or any other insurance company or organization or person.

6. When the benefits are reduced under the primary Plan because a Covered Person does not comply with the Plan articles, or does not maximize benefits available under the primary Plan, the amount of such reduction will not be considered an Allowable Benefit. Examples of such provisions are those related to second surgical opinions and pre-certification of admissions and services.

7. CHI may, without the consent or notice to any person, release to or obtain from any other insurance company, or other organization or person, any information, with respect to any Covered Person which CHI deems necessary to determine the applicability of, and implement the terms of, this Article, or any similar provision of any other Plan. Any person claiming benefits under this Policy will furnish to CHI any information necessary to implement this Article.

XI. MEDICARE

When a Covered Person is eligible for Medicare, that person must sign and deliver an election card to the Company, stating whom that Covered Person wants to be his primary insurer. If the Covered Person elects Medicare as his primary source of coverage and belongs to a group covered by the Policy covering twenty (20) persons or more, all Policy benefits otherwise payable to that Covered Person shall discontinue. If belonging to a covered group of less than twenty (20) persons, all Policy benefits otherwise payable with respect to the Covered Person will be reduced by any service or supply provided, or any benefits paid

or payable, under Part A and Part B of Medicare.

For the purposes of this Article, benefits will be paid on the basis that the Covered Person is covered by both Part A and Part B of Medicare. If the Covered Person should not receive benefits under either Part A or Part B because of:

(a) failure to enroll when required;

(b) failure to pay any premiums that may be required for full coverage of the person under Medicare; or

(c) failure to file any written request or claim required for payment of Medicare benefits;

the Company will make determination of the total benefits that would have been payable under Medicare in the absence of this failure.

"Part A" means the "Hospital Insurance Benefits for the Aged" portion of Medicare.

"Part B" means the "Supplementary Medical Insurance for the Aged" portion of Medicare.

XII. SUBROGATION

In the event of any payment under the Policy, the Company will, to the extent of the payment under the Policy, be subrogated to all the rights of recovery of the Covered Person arising out of the acts or omissions of any person or organization. The Covered Person hereby agrees to reimburse the Company for any benefits paid hereunder, out of any moneys recovered from any person or organization as the result of judgment, settlement or otherwise. After any benefits under this Policy are paid by the Company, the Covered Person also agrees to execute and deliver all necessary instruments and to furnish such information and such reasonable assistance as may be required to facilitate enforcement of its rights hereunder. In the event the Company recovers an amount greater than the benefit paid, the excess, will be paid to the Covered Person. The Covered Person shall do nothing after loss to prejudice these rights. This Article will not apply, however, to a recovery obtained by any Covered Person from any insurance company on a policy under which the Covered Person is entitled to indemnity. as a named insured person or an insured Dependent of a named person. For purposes of this Article only, "Covered Person" will include anyone receiving payment under the Policy, either directly or indirectly.

This Article does not pertain to medical malpractice insurance pursuant to Pennsylvania Law, Chapter 4, Article V1, Section 602 (40 P.S. Section 1301.602), and is limited for Pennsylvania No-Fault Insurance pursuant to Pennsylvania Law Chapter 4, Article VI(J), Section III(4) (40 P.S. Section 1009. 111), as now constituted or later amended.

The Subrogation rights under this Article shall be enforced only to the extent and at those times permitted by law and shall not be enforceable to the extent prohibited by any Pennsylvania statute or regulation.

XIII. POLICYHOLDER/EMPLOYER PROVISIONS

Premiums

1. The premiums for this Policy shall be based upon the administrative requirements of CHI and the cost of Covered Medical Services and shall be payable in advance according to the mode of payment agreed upon. At the end of the first calendar year or at any time thereafter, the premiums for this Policy may be readjusted by CHI based upon the experience under the Policy.

2. The Employer is solely responsible for the payment of premiums with respect to its Covered Employees and their Covered Dependents. Payment shall be made directly to CHI.

3. The first premium will be the sum of the individual premiums determined by applying the premium rates, shown in the initial schedule of premium rates, to the amount of insurance then in force at the respective ages of the Covered Persons insured on the Effective Date of the Policy. The premium for each successive month will be the sum of the individual premiums determined by applying the premium rates then in effect to the amount of insurance then in force at the respective ages of the Covered Persons insured on the premium due date.

4. The premium rates will be guaranteed for the first twelve (12) months following the issuance of the Policy. CHI reserves the right to change, after such guaranteed period, the premium rates by written notice to the Policyholder at least thirty (30) days prior to the date of the change.

5. Any change in premium rates necessitated by an amendment of the Policy will be effective on the effective date of the amendment. If the effective date of the amendment is any day other than the premium due date, then a pro

rata premium adjustment will be made to the applicable month.

6. There will be no premium adjustment for Covered Person who may be added or terminated between premium due dates. If notice of a Covered Person's termination received by CHI more than thirty (30) days after their termination, any unearned premium will be credited only from the first premium due date prior to the receipt of such notice. This provision will not extend the Covered Person's insurance beyond the termination date.

Grace Period

If the Policyholder has not previously given written notice to CHI that the Policy is to be discontinued, the grace period of thirty one (31) days will be granted to the Policyholder for payment of every premium after the first premium. During the grace period, the Policy will continue in force, unless prior to the date payment was due the Policyholder gave timely written notice to CHI that the Agreement is to be canceled. If the premiums are not paid within the grace period, the Policy will be discontinued, but the Policyholder will still be liable to CHI for all unpaid premiums, including the premiums for the grace period. If during the grace period CHI receives written notice from the Policyholder that the Policy is to be discontinued, the Policy will be discontinued on the date notice is received, but the Policyholder will still be liable to CHI for the payment of all premiums then unpaid, together with a pro rata premium for the period commencing with the date on which the last premium became due and ending with the date of receipt of written notice by CHI.

Term of Policy and Right to Terminate

This Policy is issued for an indefinite term, commencing on the Effective Date shown on the face page. The Policy continues in force, so long as premiums are paid when due, until terminated in accordance with the terms of this Policy.

The Policyholder may terminate the Policy by giving written notice to CHI. Termination by the Policyholder will be effective on the latter of: (a) the day specified in the notice; or (b) the day the notice is received by CHI. CHI

may terminate any or all insurance under the Policy, as of any premium due date, by giving written notice to the Policyholder at least thirty (30) days prior to that date.

Notice

Written notice to the Policyholder will be deemed to be effective on the date it is placed in the United States mail, postage prepaid and properly addressed to

the principal place of business of the Policyholder. Notice will be deemed to be properly addressed if it reflects the last address provided to CHI by the Policyholder.

Individual Certificates

CHI will issue a Summary of Benefits, describing the insurance protection to which each Covered Person is entitled and to whom payable. Copies of the Summary of Benefits will be issued to the Policyholder for delivery to each Covered Employee.

Registry

The Policyholder shall furnish CHI with:

(a) the names of all individuals initially eligible for insurance or who later become eligible for insurance under the Policy, even if they do not become insured;

(b) the names of all Covered Persons who become insured or whose insurance terminates, together with the respective date; and

(c) any information required to initiate, maintain or terminate coverage on each Eligible Person.

CHI will have the right, at reasonable times, to inspect all books and records of the Policyholder which relate to the insurance under the Policy.

XIV. PRE-EXISTING CONDITIONS LIMITATION

No payment will be made to any Covered Person under this Policy for any charge relating to any condition which was precluded by the group policy (if any) that this Policy replaced, which existed prior to the date the individual became covered under this Policy and for which the individual received medical advice or treatment within 90 days immediately preceding the date coverage under this Policy commenced, unless the charge is incurred:

1. More than six (6) consecutive months after the Covered Person has been covered under this Policy during which time no medical advice or treatment was received; or

2. If the Covered Person is a Covered Employee, collectively more than twelve (12) consecutive months after the Covered Employee has been actively employed with the Employer and has been covered under this

Policy and/or another group health insurance policy issued to the Employer; or

3. If the Covered Person is a Covered Dependent, collectively more than twelve (12) consecutive months after the Covered Dependent has been covered under this Policy and/or another group health insurance policy issued to the Employer.

This Article applies only to Employees and Dependents who become covered under this Policy after the Effective Date of this Policy.

XV. DEFINITIONS

For the purposes of this Policy, unless the context clearly indicates otherwise, the following words and phrases have the following meanings. The following words and phrases are not intended to imply that coverage for them is provided under this Policy.

Ambulatory Surgical Facility - A specialized facility licensed, where required, to render surgical procedures on an Out-Patient basis, which has an organized staff of Physicians, has been approved by the Joint Commission on Accreditation of Health Care Organizations, the Accreditation Association for Ambulatory Healthcare, Inc., or CHI, and which:

1. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Out-Patient basis;

2. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;

3. does not provide Inpatient accommodations;

4. provides the full-time services of one or more RNs for patient care in the operating rooms and in the post-anesthesia recovery room; and

5. provides at least one operating room and at least one post-anesthesia recovery room; is equipped to perform diagnostic x-ray and laboratory examinations; and has available trained personnel and necessary equipment to handle foreseeable emergencies;

6. maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require post-operative confinement; and

7. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

Birthing Center - A free-standing facility licensed, where required, to provide maternity care, which:

1. Is organized and staffed to provide prenatal care, delivery and immediate post-partum care;

2. Is directed by at least one Physician who is a specialist in obstetrics and gynecology;

3. Has a Physician or certified nurse midwife present at all births and during the immediate post-partum period;

4. Has at least two (2) beds or two (2) birthing rooms for use by patients while in labor and during delivery;

5. Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear;

6. Accepts only patients with low risk pregnancies; and

7. Has a written agreement with a Hospital in the area for emergency transfer of a patient or a child.

Close Relative - The Covered Person, his or her spouse, a child, brother, sister, or parent of the Covered Person or his or her spouse.

Company - Corporate Health Insurance Company, a Minnesota corporation, and its successor, if any.

Co-payment - The flat, fixed-dollar amount which shall be payable by a Covered Person pursuant to this Policy to a provider of services or supplies, regardless of, but not in excess of, the charge for such services or supplies, such amount to be set forth in the Schedule of Benefits with respect to applicable Covered Medical Service.

Cosmetic Surgery - Any surgery not Medically Necessary, including, without limitation, ear piercing, rhinoplasty or lipectomy, except cosmetic surgery resulting from the complication of such Cosmetic Surgery.

Covered Dependent - Any Eligible Dependent whose coverage became effective and has not terminated.

Covered Employee - Any Eligible Employee whose coverage became effective and has

not terminated.

Covered Person - Any Eligible Employee or Eligible Dependent whose coverage became effective and has not terminated.

Covered Medical Services - Those services and supplies which are Medically Necessary and are otherwise covered by this Policy and for which charges are Reasonable and Customary.

Custodial Care - Any type of care that does not require the skills of technical or professional personnel or are not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility Care. Custodial Care includes, but is not limited to:

- Help in walking, getting into or out of bed, bathing, dressing, eating and other functions of daily living of a similar nature;
- General supervision of exercise programs including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services;
- Bowel training and management;
- General safety/health precautions and preventive procedures such as turning to prevent bedsores; and
- Providing patient recreation and/or companionship.

Deductible Amount - The amount of charges for Covered Medical Services a Covered Person must incur and pay during the calendar year under this Policy. The Deductible Amount will differ depending upon whether the Covered Person is covered under an individual coverage or a family coverage. If covered under an individual coverage, the Covered Person must pay the Deductible Amount for "individual," as set forth in the Schedule of Benefits, before becoming entitled to benefits under the Policy. If covered under a family coverage, the Covered Person and his or her Family Unit must pay the Deductible Amount for "family," as set forth in the Schedule of Benefits, before becoming entitled to benefits under the Policy.

Dentist - Licensed Doctor of Dental Surgery or Doctor of Dental Medicine.

Dependent - Includes a spouse or child, whether by birth or adoption, of an Eligible Employee.

Detoxification - The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means. the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological risk to the patient at a reasonable minimum.

Diagnostic Services - the following procedures prescribed by a Professional Provider because of specific symptoms to determine a definite condition or disease. Diagnostic Services include, but are not limited to:

A. diagnostic radiology, consisting of x-ray, ultrasound and nuclear medicine;

B. diagnostic pathology, consisting of laboratory and pathology tests;

C. diagnostic medical procedures, consisting of ECG, EEG, and other diagnostic medical procedures; and

D. allergy testing consisting of percutaneous, intracutaneous and patch tests.

Durable Medical Equipment - Equipment prescribed by the attending Physician which is:

- Not primarily and customarily used for non-medical purposes;
- Designed for prolonged use; and
- For a specific therapeutic purpose in the treatment of an Illness or Injury.

Durable Medical Equipment includes, but is not limited to, prosthetic appliances and orthopedic braces.

Educational - a service or supply the primary purpose of which is to provide the Covered Person with any of the following training in the activities of daily living: instruction in scholastic skills such as reading and writing; preparation for occupation; or treatment for learning disabilities.

Eligible Dependent - Any Eligible Employee's Dependent who satisfies the eligibility requirements of Article I.

Eligible Employee - Any active employee full-time of the Policyholder who regularly works at least 30 hours per week and otherwise satisfies the eligibility requirements of Article I.

Emergency Services - Medical services required for the initial treatment of a Medical Emergency. These services shall not include treatment for occupational injury for which benefits are covered under workers' compensation law or similar occupational disease law. The condition of the Covered Person must be of

sufficient severity to warrant immediate attention.

Employer - The Policyholder.

Evidence of Good Health - A statement from an Eligible Employee or an Eligible Dependent attesting to the "good health" of such person or his or her Eligible Dependents. A standard form available from the Policyholder's human resources department will be provided for this purpose. The Eligible Employee or the Eligible Dependent is responsible for any and all related costs.

Experimental or Investigative - the use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the general medical community does not accept as standard medical treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which approval has not been granted at the time the services were rendered.

Family Unit - A Covered Employee and his or her Covered Dependents.

Home Health Agency - Any organization certified as a home health agency under the Medicare law or otherwise approved by CHI for the delivery of non-Physician patient care in the home of a Covered Person.

Home Health Plan - A program for care and treatment of a Covered Person established and approved in writing by such Covered Person's attending Physician, together with such Physician's certification that the proper treatment of the Injury or Illness would require confinement as a resident Inpatient in a Hospital or confinement in a Skilled Nursing Facility the absence of services and supplies provided as part of the Home Health Plan.

Home Health Services - Those items and services defined as "home health services" in the Medicare law and set forth in 42 CFR Part 417.101 et seq.

Hospice - A facility which is licensed as such, where required, and provides short periods of stay for a Terminally Ill Person in a home-like setting for either direct care or respite care. This facility may be either free-standing or affiliated with a Hospital. It must operate as an integral part of the Hospice Care Program.

Hospice Care Program - A formal program directed by a Physician to help care for a Terminally III Person. This may be through either

- A centrally-administrated, medically directed and nurse-coordinated program which

- Provides a coherent system primarily of home care; and
- Is available 24 hours a day, seven (7) days a week; or

o Confinement in a Hospice.

The program must meet standards set by the National Hospice Organization and approved by CHI. If such a program is required by a state to be licensed, certified, or registered, it must also satisfy such requirement.

Hospice Services - Services and supplies furnished or arranged by a Hospice to a Terminally Ill Person.

Hospital - An institution accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association or under Medicare Law, or as otherwise determined by CHI as meeting reasonable standards, which:

1. is a duly licensed, where required; and

2. is primarily engaged in providing Inpatient diagnostic and surgical and therapeutic services for the diagnosis, treatment and care of injured or ill persons by or under the supervision of Physicians; and

3. provides 24-hour nursing service by or under the supervision of Registered Nurses; and

4. is not a Skilled Nursing Facility, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the treatment of Mental Illness, place for the treatment of Substance Abuse or Dependency, Hospice, rehabilitation center, or place for the treatment of pulmonary tuberculosis.

Illness - Sickness or disease which requires medical service or supply covered by this Policy.

Injury - Bodily harm which results from an accident and which requires medical service or supply covered by the Policy.

Inpatient - A person who is admitted to a Hospital, a Psychiatric Hospital, a Skilled Nursing Facility or a Substance Abuse Treatment Facility and incurs room and board charges.

L.P.N. - A full-time licensed practical nurse, other than a Close Relative, who

is recognized by the state in which care is given as qualified to perform limited nursing functions.

Medical Emergency - a sudden, unexpected onset of a medical condition manifesting itself by acute symptoms or a traumatic bodily injury resulting from an accident, which is of sufficient severity that the absence of immediate medical attention could reasonably result in:

1. Death of the Covered Person;
2. Serious harm the Covered Person's health; or
3. Serious or permanent impairment to bodily functions or any bodily organ or part.

The non-availability of a private Physician or the fact that the Physician may refer the Covered Person to the emergency room does not, by itself, constitute a Medical Emergency. Medical Emergencies include, but are not limited to:

(a) uncontrolled or excessive bleeding;
(b) suspected heart attack;
(c) inability to breath;
(d) appendicitis;
(e) serious burns;
(f) poisoning;
(g) severe pain and suffering; and
(h) convulsion or unconsciousness.

Medically Necessary - Medical service or supply which is provided by a Professional Provider for the diagnosis or the direct care and treatment of a Covered Person's Injury or Illness and which is:

1. Appropriate for the symptoms and diagnosis or treatment of the Covered Person's Injury or Illness; and

2. In accordance with current standards of good medical practice.

Confinement as an Inpatient in a Hospital or other facility is considered Medically Necessary when the Covered Person needs to be confined because of the nature of the services being delivered the Covered Person or when treatment for his or her condition cannot be given safely and adequately if performed on an Out-Patient basis.

Medicare - The programs health care for the aged and the disabled established by Title XVIII of the Social Security Act, as first enacted by the Social Security Amendment of 1965 or as later amended.

Mental Illness - An emotional, nervous or mental disorder means a neurosis, psychoneurosis, psychopathy or psychosis and mental, emotional or nervous disorder without demonstrable organic origin.

Mental Health Treatment Facility - A facility, licensed by the Department of

Health, for the care or treatment of person with a Mental Illness and in which services are provided by or under the supervisions of a Physician.

Military Service - Service in any Army, Navy, Air Force, Marines, Coast Guard, or other branch of the military.

Non-Hospital Substance Abuse Residential Care - The provision of medical, nursing, counseling or therapeutic services to patients suffering from alcohol or drug abuse or dependency in a residential environment, according to individualized treatment plans.

Out-Patient - A patient who receives diagnosis or treatment at a facility, but does not incur room and board charges.

Physician - A person, other than a Close Relative of the Covered Person, who is duly licensed member of a medical profession and is practicing within the scope of his or her license.

Policy - this Comprehensive Major Medical Group Health Insurance Policy issued by the Company to the Policyholder.

Policy Enrollment Form - A printed form approved by CHI that an Eligible Employee must complete, execute and deliver to CHI to be eligible for coverage under this Policy.

Policy Year - The twelve (12) month period commencing on a date agreed to between the Policyholder and CHI or, if no such agreement exists, the twelve (12) month period of January l through December 31 inclusive.

Pre-Certification - A certification that a Covered Person must obtain prior to receiving any of the services or supplies that are identified by the Schedule of Benefits or this Policy as needing a Pre-Certification, which certifies the proposed Hospital admission and length of stay as Medically Necessary.

Prescription Drugs - Drugs and medicines which require a prescription by a Physician to dispense and are approved by the U.S. Food and Drug Administration for general use in treating the illness or injury for which they are prescribed. Prescriptions Drugs include oral contraceptives and vitamins.

Professional Provider - a person or practitioner licensed, where required, and performing services within the scope of such licensure. The Professional Providers include:

- R.N.
- chiropractor
- clinical laboratory
- Dentist
- nurse midwife
- optometrist
- physical therapist
- Physician
- podiatrist
- psychologist

Psychiatric Hospital - An institution which is primarily engaged in providing diagnosis and therapeutic services for the Inpatient treatment of Mental Illnesses and meets all of the following requirements:

1. Services are provided by or under the supervision of a Physician;

2. Provides continuous nursing services under the supervision of an RN.; and

3. Is not a Skilled Nursing Facility, Custodial Care home, health resort, place for rest, place for the treatment of Substance Abuse or Dependency, Hospice, rehabilitation center, or place for the treatment of pulmonary tuberculosis.

R.N. - A registered nurse, other than a Close Relative, who is licensed in the state in which care is given to perform all nursing functions.

Reasonable and Customary Charge - Any charge which, as determined by CHI, does not exceed (i) the usual or customary fee for comparable service or supply charged by other providers of similar services or supplies in the area where the service or supply is provided and who have training, experience and professional standing comparable to those of the actual provider of the service or supply or (ii) if no comparison exists, the reasonable fee (which may differ from the usual or customary fee) determined by CHI after considering unusual clinical circumstances and/or the actual cost of equipment and facilities involved in the treatment. When determining whether a charge is Reasonable and Customary, CHI may consider the severity of the condition being treated and any complications and unusual circumstances that may be involved.

Schedule of Benefits - The Schedule of Benefits set forth in the Summary of Benefits, which summarizes the benefits payable under the Policy. The terms of the Schedule of Benefits will be individually tailored to each Policyholder.

Semi-Private - A two (2) bed room in a Hospital. If the facility has no such rooms, the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Facility - An institution or a distinct part of an institution which is licensed, where required, or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services (on an Inpatient basis to patients requiring 24-hour skilled nursing but not requiring confinement in an acute care Hospital) as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as a certified skilled nursing facility under Medicare law, or as otherwise determined by CHI to meet the reasonable standards applied by any of the aforesaid authorities.

A Skilled Nursing Facility does not include a rest home, a home for the aged, a place for Custodial Care or educational care, or a treatment facility for alcoholism, drug addiction, or mental illness.

Social Worker - A duly licensed or certified social worker with at least two (2) years or three thousand (3,000) hours of post-masters clinical social work practice in a clinical program established by the state regulatory board or agency.

Substance Abuse or Dependency - Any use of alcohol or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Substance Abuse Treatment Facility - A Hospital or non-Hospital facility, licensed by the Department of Health, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.

Terminally Ill Person - A Covered Person who life expectancy is six (6) months or less, as certified by the attending Physician.

TotalDisability or Totally Disabled - A Covered Employee shall be considered totally disabled if, as a result of an illness or injury, he or she is unable to engage in any gainful occupation for which s/he is reasonably fitted by education, training, or experience, and is not performing work of any kind for wage or profit. A Covered Dependent will be considered totally disabled if, because of an illness or injury, he or she is prevented from engaging in all the normal activities of a person of like age and sex.

Exhibit 10.36

UNITED STATES HEALTH CARE SYSTEMS OF PENNSYLVANIA, INC.,
dba THE HEALTH MAINTENANCE ORGANIZATION OF
PENNSYLVANIA, INC. dba
U.S. HEALTHCARE

GROUP MASTER CONTRACT

United States Health Care Systems of Pennsylvania, Inc., dba The Health Maintenance Organization of Pennsylvania, Inc. dba US Healthcare (referred to in this Contract as "HMO") operates a comprehensive prepaid program of health care which provides health care services and benefits to Members in order to protect and promote their health and preserve and enhance patient dignity.

HMO agrees with the Contract Holder, subject to all the conditions and provisions of this Contract, to provide the services and benefits and other rights and privileges which are set forth in this Contract, as may be revised or amended from time to time.

This Contract and all attachments and endorsements incorporated herein by reference are delivered by HMO in consideration of the Contract Holder's payment of premiums and shall take effect on the Contract Effective Date.

Under the Contract, the Subscriber engages HMO to make arrangements through which medical and hospital benefits may be accessed in accordance with the covenants and conditions hereafter provided and in reliance upon the statements of each Subscriber in his/her Enrollment Application.

The Contract is not in lieu of and does not affect any requirement for coverage by Workmen's Compensation Insurance.

This Contract is governed by the laws of the state in which filed. The Contract specifications and the conditions and provisions on this and the following pages, including the cover sheet, any amendments, riders or endorsements included at delivery or added thereafter, are part of the Contract.

NO SERVICES ARE DELIVERABLE UNDER THIS CONTRACT IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE 30-DAY GRACE PERIOD AND SECTION VIII.A OF THIS GROUP MASTER CONTRACT.

SECTION I - DEFINITIONS

The following words and phrases when used in this Contract shall have, unless the context clearly indicates otherwise, the meaning given to them below:

1. Contract. This Group Master Contract issued to the Contract Holder by HMO and as subsequently amended by operation of law and as filed with and approved by applicable public authority.

2. Contract Holder. An employer or organization who agrees to remit the premiums for coverage payable to HMO. The Contract Holder shall act only as an agent of HMO Members in the Contract Holder's Group, and shall not be the agent of HMO for any purpose.

3. Coordination of Benefits. A Coordination of Benefits (COB) provision is one that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more Plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which Plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a Plan when, by the rules established by this provision it does not have to pay its benefits first. This provision does not apply to student accident or group hospital indemnity plans.

4. Copayment. An amount required to be paid by or on behalf of a Member in connection with benefits set forth in Section 11 of this Contract.

5. Custodial or Domiciliary Care. Any type of care that does not meet the requirements of post-hospital Skilled Nursing Facility Care as defined by the Medicare Law and set forth in 42 CFR Part 409.30 et seq. Custodial care includes but is not limited to any type of care where the primary purpose of the total care provided is to attend to the Member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel (for example, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of noninfected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by Members, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of HMO, based on medically accepted standards can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service}.

6. Dependent. Any person in a Subscriber's family who meets all the eligibility requirements of Section IV.B of this Contract, has enrolled in HMO, and is subject to premium requirements set forth in Section X of this Contract.

7. Detoxification. The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the

Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient at a minimum.

8. Effective Date. The commencement date of coverage under this Contract as shown on the records of HMO.

9. Emergency Service. Professional health services medically necessary immediately to preserve life or stabilize health, available on an inpatient or outpatient basis, 24 hours per day, seven days per week.

10. Group. Those employees in the eligible class(es) as shown on the Cover Sheet of this Contract who enroll in HMO and whose premiums are remitted to HMO by the Contract Holder.

11. Health Professionals. Physicians and other professionals, including certified nurse midwives, who are engaged in the delivery of health care services and who are licensed if required by law.

12. Homebound Member. A Member who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or which restricts his ability to leave his place of residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person.

13. Home Health Services. Those items and services defined as "home health services" by the Medicare Law and set forth in 42 CFR Part 417.101 et seq., if approved and coordinated in advance by HMO and provided upon the prior written or verbal referral and direction of the Member's Primary Care Physician. These services include: (a) Skilled nursing services, provided by or under the supervision of a registered professional nurse to a Homebound Member; (b) Services of a home health aide, rendered to a Homebound Member under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist, provided, however, that the primary purpose of the total Home Health Services rendered to the Member is skilled in nature; (c) Medical Social Services rendered to a Homebound Member by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of the Member's medical condition; (d) short-term physical or speech therapy provided by or under the supervision of a qualified speech pathologist or physical therapist as set

forth in Section II.H of the Group Master Contract and short-term occupational therapy (except for vocational rehabilitation or employment counseling) rendered by or under the supervision of a qualified occupational therapist in connection with other Home Health Services, provided the Member's Primary Care Physician certifies that such services will result in significant practical improvement in Member's condition within a sixty (60) day period.

14 Home Health Agency. Any organization certified as a home health agency under the Medicare law or otherwise approved by HMO for the delivery of non-physician patient care in the home of a Member.

15. Hospital. An institution rendering inpatient and outpatient services, accredited as a Hospital by either the Joint Commission on Accreditation of Health Care Facilities or the Bureau of Hospitals of the American Osteopathic Association. A Hospital may be a general, acute care institution or a specialty institution provided that, in either case, it is appropriately accredited as aforesaid, and licensed by the proper state authorities.

16. Hospital Services. Those services which are listed in Section II of this Contract.

17. Medical Services. Those professional services of physicians, paramedical personnel, certified nurse midwives and other health professionals including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.

18. Medical Social Services. Services of a medical or psychiatric social worker which are provided by Participating Providers, upon the prior written referral of the Member's

Primary Care Physician, to assess and assist the Member in resolving, if possible, emotional, marital and environmental factors related to the Member's illness, need for care, response to treatment and adjustment to care. Medical Social Services shall also include counseling services provided to the Member upon the prior written referral of the Member's Primary Care Physician and the provision to the Member of information, if available, relating to community health and social welfare agencies and related family counseling services, of which the Member may avail himself but which are not covered by HMO.

19. Medically Necessary or Medical Necessity. Appropriate and necessary services as determined by HMO which are rendered to a Member for a

condition requiring, according to generally accepted principles of good medical practice, the diagnosis or direct care and treatment of an illness or injury and which are not provided only as a convenience.

20. Medicare Law. Title XVIII of the federal Social Security Act and all amendments and successors thereto.

21. Member. A Subscriber or Dependent as defined in this Section.

22. Non-Hospital Facility. A facility, licensed by the Department of Health, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.

23. Non-Hospital Residential Care. The provision of medical, nursing, counseling or therapeutic services to patients suffering from alcohol or drug abuse or dependency in a residential environment, according to individualized treatment plans.

24. Open Enrollment Period. A period of not less than ten (10) consecutive working days, each calendar year, when eligible employees of Contract Holder may enroll in HMO without a waiting period or exclusion or limitation based on health status or, if already enrolled in HMO, may transfer to an alternative health plan offered by Contract Holder.

25. Outpatient Care. The provision of medical, nursing, counseling or therapeutic services to a Member who does not require an overnight stay in a hospital or non-hospital facility on a regular and predetermined schedule, according to an individualized treatment plan.

26. Participating Gynecologist. A Specialist Gynecological Physician who has contracted with HMO to provide annual gynecological examination services to members. A referral from the Participating Primary Physician is not required for this service when the Member chooses a Participating Gynecologist that is shown on the Member's Identification Card.

27. Partial Hospitalization. The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a hospital or non-hospital facility licensed as an alcoholism or drug abuse treatment program by the Department of Health, designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.

28. Participating Home Health Agency. A Home Health Agency which has entered into a contractual agreement with HMO to provide home health services as described in

Section II of this Contract, to Members on a per visit or otherwise agreed upon basis.

29. Participating Hospital. A Hospital which has entered into a contractual agreement with HMO to provide services as described in Section II of this Contract, to Members on a per diem or otherwise agreed upon basis.

30. Participating Mental Health Provider. A licensed professional providing diagnostic, therapeutic or psychological services who has entered into a contractual agreement with HMO. HMO may contract with Participating Mental Health Providers on a geographic and/or per capita basis.

31. Participating Physician. A Primary Care Physician, Specialist Physician, or other Health Professional who has contracted with HMO to provide medical care and services to Members.

32. Participating Provider. A Provider which or who has entered into a contractual agreement with HMO for the provision of services to Members on an agreed upon basis.

33. Participating Skilled Nursing Facility. A Skilled Nursing Facility which has entered into a contractual agreement with HMO to provide skilled nursing facility services, as described in Section II of this Contract, to Members on a per diem or otherwise agreed upon basis.

34. Part-Time or Intermittent Services. Covered services provided to a Member on an infrequent basis, for no more than three hours a day, three days a week or, on occasion; for up to eight hours a day, seven days a week if medically necessary, recommended by the Primary Care Physician for a limited period of time, and approved in advance by HMO.

35. Physician. A duly licensed member of a medical profession, practicing within the scope of such license.

36. Physical Therapy. Therapy using physical modalities to achieve its goals.

37. Plan/Another Plan/The Plan. Any of these which provides benefits or services for, or because of, medical or dental care or treatment:

    1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. Coverage other than school accident-type coverage and Group hospital indemnity contracts of $100 per day or less are excluded.

    2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time). In addition, the "Plan" shall not include a law or plan when, by law, its benefits are

excess to those of any private insurance plan or other non-government plan.

38. Primary Care Physician. A Physician who supervises, coordinates and provides initial care and basic medical services as a general or family care practitioner, or in some

cases, as an internist or a pediatrician to Members; initiates their referral for specialist care and maintains continuity of patient care.

39. Provider. A Physician, Health Professional, Hospital, Skilled Nursing Facility, Home Health Agency or other entity or person providing services to Members under this Contract.

40. Skilled Nursing Facility. An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as a certified skilled nursing facility under Medicare law, or as otherwise determined by HMO to meet the reasonable standards applied by any of the aforesaid authorities.

41. Specialist Physician. A Physician who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

42. Subscriber. A person who meets all applicable eligibility requirements of Section IV.A of this Contract, has enrolled in HMO, and is subject to premium requirements set forth in Section X of this Contract.

43. Substance Abuse. Any use of alcohol or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

SECTION II - BENEFITS

A. Outpatient Benefits. Except in an emergency as described in Section II.G of this Contract, the following services will be provided to Members when medically necessary and only at or through the Primary Care Physician's office that is shown on Member's Identification Card, or elsewhere upon prior written referral by Member's Primary Care Physician:

1. Office visits during office hours, and during non-office hours when medically necessary. Member is responsible for a copayment for each such visit in the amount shown on the Copayment Schedule, as may be amended from time to time upon filing with and approval by the applicable public authority and agreed to by the Contract Holder, (hereinafter the "current Copayment Schedule").

2. Home visits by Member's Primary Care Physician when medically necessary. Member is responsible for a copayment for each home visit in the amount shown on the current Copayment Schedule.

3. Periodic health evaluations to include:

   a. Well child care from birth including immunizations and booster doses of all immunizing agents used in child immunizations which, as determined by the Pennsylvania Department of Health conform to the standards of the (Advisory Committee on Immunization Practices of the Center for disease Control), U.S. Department of Health and

Human Services Immunization benefits are exempt from deductible and dollar limits;

b Routine physical examinations;

c. Pelvic examinations;

d. Routine ear and hearing examinations;

e. Routine allergy injections and immunizations (but not if solely for the purpose of travel); and

f. Routine eye examinations;

g. For children through age 11, preventive dental care at HMO Participating Dental Facilities, limited to:

   1) Oral prophylaxis (cleaning) as necessary;

   2) Topical application of fluorides and the prescription of fluorides for systematic use when not available in the

community water supply; and

3) Oral examination and hygiene instruction.

Copayment: Member is responsible for a copayment in the amount listed on the attached Schedule of Benefits for the Primary Dentist Visit.

4. Diagnostic Services including laboratory and x-ray services, laboratory specimen collection, EKGs and other diagnostic services.

a. Female members age 40 or older are entitled to one routine mammography by a participating provider every contract year. Member is required to obtain a referral from their participating primary care physician to their participating provider prior to receiving this benefit.

5. Casts and dressings.

6. Short term rehabilitation services and Physical therapy (see II.H) when Member's Primary Care Physician certifies that these services will result in a significant improvement in Member's condition within a sixty (60) day period.

7. Emergency care. Member's Primary Care Physician provides or arranges for on call coverage twenty-four (24) hours a day, seven (7) days a week.

8. Ambulance service is provided:

a. in an emergency, but subject to the notification requirements set forth in Section II.G of this Contract; or

b. when certified as medically necessary by Member's Primary Care Physician and approved in advance by HMO.

9. Health education and information. Periodically health education and health care information literature is made available to a Member at no expense to the member.

10. Home Health Services as defined in Section I.A.13, and Hospice services provided upon the prior written referral of the Member's Primary Care Physician for the palliative care of a Member's terminal illness.

11. Infertility services. except injectables and infertility related supplies, and other services listed in Section III.B.25.

12. Initial provision of prosthetic appliances and initial provision of orthopedic braces, with shoes when necessary, used to treat congenital defects. Instruction and appropriate services required for Member to properly use the item (such as attachment or insertion). False teeth and other items listed in Section III.B.13 are excluded.

13. Manipulative Services are available through the Participating Provider Network upon referral from Member's Primary Care Physician or by selecting an Osteopathic Physician who provides these services as the Member's Primary Care Physician.

14. Medical Social Services as listed in Section II.F. Copayment. Member is responsible for a copayment in the amount shown for Primary Care Physician visits, routine eye exam visits and routine gynecological visits on the current Copayment Schedule.

B. Specialist Physician Benefits. Except in an emergency as described in Section II.G of this Contract, benefits will be provided to the Member by a Participating Specialist Physician at his office or at a Participating Hospital outpatient department during office or business hours upon prior written referral by Member's Primary Care Physician. A referral for the routine gynecological exam is not required if the Member has chosen a Participating Gynecologist that is shown on the Member's Identification Card. Services include but are not limited to the following:

1. Allergy Care (except routine injections, which must be administered by Member's Participating Primary Care Physician)

2. Anesthesia

3. Cardiology

4. Endocrinology

5. Gynecology and Obstetrics

6. Internal Medicine

7. Neurology

8. Oncology

9. Ophthalmology

10. Oral Surgery (limited to bony impactions of teeth, bone fractures, removal of tumors and orthodontogenic cysts or other HMO approved surgical procedures)

11. Orthopedics

12. Otolaryngology

13. Pathology

14. Pediatrics

15. Pulmonology

16. Radiology (except dental x-rays, unless related to covered services)

17. Surgery

18. Urology

Copayment. Member is responsible for a copayment in the amount shown for Specialist Physician Office Visits on the current Copayment Schedule.

Emergency. In an emergency as described in Section II.G of this Contract, the services listed above will be covered without prior written referral, subject to all conditions and requirements set forth in Section II.G.

C. Inpatient Hospital & Skilled Nursing Facility Benefits. A Member who is hospitalized by a Participating Physician upon prior written referral from the Member's Primary Care Physician, provided the admission has been precertified by HMO, is entitled to the following benefits when medically necessary only at Participating Hospitals and Participating Skilled Nursing Facilities (or at non-participating facilities upon prior written authorization by HMO); however, Participating Skilled Nursing Facilities benefits are limited to those which are medically necessary and which constitute Skilled Nursing Care as defined by the Medicare law:

1. Semi-private room and board accommodations

2. Private accommodations will be provided when medically necessary upon certification of Member's Primary Care Physician. A Member who occupies a private room without such certification shall be directly liable to the Hospital or Skilled Nursing Facility for the difference between payment by HMO to the Hospital or Skilled Nursing Facility of the per diem or other agreed upon rate for semi-private accommodation established between HMO and the Participating Hospital or the Participating Skilled Nursing Facility and the private room rate.

3. General nursing care

4. Use of intensive or special care facilities when medically necessary

5. X-Ray examinations including CAT scans but not dental x-rays

6. Use of operating room and related facilities

7. Magnetic resonance imaging

8. Drugs, medications, biologicals, when medically necessary

9. Cardiography/Encephalography

10. Laboratory testing and services

11. Pre- and post-operative care

12. Special tests when medically necessary

13. Nuclear medicine

14. Physical and rehabilitation therapy as provided by Section II.A.6 and II.H of this Contract

15. Oxygen and oxygen therapy

16. Anesthesia and anesthesia services

17. Administration and processing of whole blood, blood plasma and blood derivatives

18. Intravenous injections and solutions

19. Surgical, medical and obstetrical services provided by the participating hospital

20. Private duty nursing when medically necessary and certified as such by the Participating Specialist Physician in concurrence with Member's Primary Care Physician and approved in advance by an HMO Medical Director.

21. Non-experimental or non-investigational transplants are a covered benefit. Transplants considered to be non-experimental or non-investigational by HMO/PA in its sole discretion are kidney transplants, corneal transplants, liver transplants for children with biliary atresia, and bone marrow transplants for. certain conditions, specifically aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

In addition, HMO will cover the medical and hospital services costs

and related organ acquisition costs for certain other transplants including but not

limited to heart, liver transplants other than for children with biliary atresia and other organ transplants when deemed no longer experimental or investigational by HMO in its sole discretion subject to the grievance procedure All transplants must be ordered by Member's Primary and Participating Specialist Physician and approved by HMO's Medical Director in advance of the surgery. All transplants must additionally be performed at hospitals specifically approved and designated by the HMO to perform these procedures.

Copayment. Member is responsible for a copayment in the amount shown for Inpatient Services on the current Copayment Schedule.

Emergency. In an emergency as described in Section II.G of this Contract, the services listed above will be covered without prior written referral, subject to all the conditions and requirements set forth in Section II.G.

D. Substance Abuse Benefits

1. Outpatient. Benefits include diagnosis, medical treatment and medical referral services by Member's Primary Care Physician for the abuse of or addiction to alcohol or drugs.

Member is eligible for thirty (30) outpatient visits per year for treatment of substance abuse or dependency upon referral by Member's Primary Care Physician. Member is additionally eligible upon referral by Member's Primary Care Physician, for up to thirty (30) more outpatient full or equivalent partial session visits, which may be exchanged on a two-for-one basis for up to fifteen (15) non-hospital, residential alcohol or drug treatment days described in Paragraph 3 below. Treatment for substance abuse or dependency shall be provided according to an individualized treatment plan, subject to a lifetime limit of one hundred-twenty (120) visits. Benefits include: (1) physician, psychologist, nurse, certified addictions counselor and trained staff services; (2) rehabilitation therapy and counseling; (3) family counseling and intervention; (4) psychiatric, psychological and medical laboratory tests; (5) drugs, medicines, equipment use and supplies.

2. Inpatient. Inpatient care benefits for detoxification, medical treatment and referral services for substance abuse or addiction. The

following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

3. Inpatient Non-Hospital Residential Facility. Medical, nursing, counseling or therapeutic services for substance abuse or dependency in a residential environment, according to an individual treatment plan. Upon referral by Member's Primary Care Physician, Member is eligible for thirty (30) days per year for such residential treatment in facilities appropriately licensed by the Department of Health. This benefit is subject to a ninety (90) day lifetime limit. The following services shall be covered: - (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) rehabilitation therapy and counseling; (4) family counseling and intervention; (5) psychiatric, psychological and medical laboratory tests; (6) drugs, medicines, equipment use and supplies.

Copayment - Member is responsible for copayment in the amount shown for Inpatient Non-Hospital Services on the current Copayment Schedule.

E. Mental Health Benefits. The following services are made available by the Participating Mental Health Provider upon referral by the Member's Primary Care Physician as may be necessary and appropriate for short term evaluation or crisis intervention, mental health services or both.

1. Outpatient. Each Member is entitled to receive up to twenty 120) outpatient visits during any period of 365 consecutive days to a psychiatrist, clinical psychologist, or psychiatric social worker in individual, group or family therapy sessions.

Copayment. Member is responsible for a copayment for each visit in the amount shown for Outpatient Mental Health Visits on the current Copayment Schedule attached to this Contract. A visit is 45-60 minutes of therapy.

2. Inpatient. A Member is entitled to receive up to thirty-five (35) days of inpatient care for the treatment of mental or nervous disorders during any period of 365 consecutive days upon referral by Member's Primary Care Physician or if provided or arranged for by the Participating Mental Health Provider. Any inpatient stay without a prior referral or which is not arranged by the Mental Health Provider

is a non-covered service under this Contract.

Copayment. Member is responsible for a copayment in the amount shown for Inpatient Services on the current Copayment Schedule.

F. Medical social services and other health services to include:

1. pre- and post-hospital planning;

2. referral to (but not payment for) community health and social welfare agency services;

3. referral to (but not payment for) related family counseling services except as specified in Section II.D.

4. referral to family planning services, and referral to and payment for services of appropriate agencies as necessary; and

5. referral to appropriate Specialists and payment for infertility services except injectables and infertility related supplies.

G. Emergency Care Benefits - Within and Outside the HMO Service Area.

1. HMO will reimburse Member for the reasonable cost as determined by HMO of emergency medical and hospital services performed within or outside the HMO service area by non-participating providers without prior written referral only if:

a. The service rendered is provided as a benefit under this Contract and is not a service which is normally treated on a non-emergency basis; and

b. HMO and Member's Primary Care Physician are notified within 24 hours of the emergency service and HMO is furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days of the date that services were rendered. Failure to

immediately notify or to furnish written proof within 30 days will not invalidate or reduce any claim for reimbursement if HMO determines that Member's failure to do so was reasonable under the circumstances, but in no event shall reimbursement be made until HMO receives proper written proof; and

c. The HMO's medical review determines that the Member's symptoms were severe, occurred suddenly, and immediate medical attention was sought by Member. Conditions which require immediate treatment include the following:

1. uncontrolled or excessive bleeding

2. acute pain or conditions requiring immediate attention, such as suspected heart attack, severe shortness of breath or appendicitis

3. serious burns

4. poisoning

5. convulsions

6. unconsciousness

2. Reimbursement. HMO may limit reimbursement to the reasonable cost as determined by HMO for emergency services by a non-participating provider, located either within or outside the HMO service area, to those expenses which are incurred up to the time the Member is determined to be medically able to travel or to be transported to an HMO Participating Provider. In the event that transportation is medically necessary, Member will be reimbursed for the reasonable cost as determined by HMO of same. Reimbursement may be subject to payment by Member of all copayments which would have been required had similar benefits been provided during office hours and upon prior written referral to a Participating Provider.

3. Copayments. Member is responsible for a copayment for each emergency visit to a physician's office and a copayment for each emergency visit to a hospital outpatient department or emergency room in the amount shown on the then current Copayment Schedule. The copayment for an emergency room visit will not apply in the event that Member was referred for such visit by the Member's Primary Care Physician for services that could have been rendered in the Primary Care Physician's office.

H. Rehabilitation Benefits.

1. Speech Therapy

Speech therapy benefits are available on a short term basis. The benefit consists of treatment within a 60 day period per incident of illness, beginning with the first day of treatment, if the Member's Primary Care Physician certifies that the treatment will result in a significant improvement of the Member's condition within this time period and treatment is approved by HMO's Medical Director.

2. Physical Therapy

Physical therapy benefits are available on a short term basis. The benefit consists of treatment within a 60 day period per incident of illness, beginning with the first day of treatment, if the Member's Primary Care Physician certifies that the treatment will result in a significant improvement

of the Member's condition within this time period and treatment is approved by HMO's Medical Director.

3. Occupational Therapy

Occupational therapy benefits are available on a short term basis. The benefit consists of treatment within a 60 day period per incident of illness, beginning with the first day of treatment, if the Member's Primary Care Physician certifies that the treatment will result in a significant improvement of the Member's condition within this time period and treatment is approved by HMO's Medical Director.

4. Cardiac Rehabilitation

Cardiac Rehabilitation benefits are available only as part of the Member's inpatient stay.

5. Pulmonary Rehabilitation

Pulmonary Rehabilitation benefits are available on a short-term basis. The benefits consist of treatment within a sixty (60) day period per incident of illness beginning with the first day of treatment. The Member's Primary Care Physician must certify that the treatment will result in a significant improvement of the Member's condition within this time period. The treatment must be approved by the HMO's Medical Director.

6. Cognitive Therapy

Cognitive therapy benefits are available on a short-term basis. The benefits consist of treatment within a sixty (60) day period per incident of illness beginning with the first day of treatment. The Member's Primary Care Physician must certify that the treatment will result in a significant improvement of the Member's condition within this time period. The treatment must be approved by HMO's Medical Director.

SECTION III -- EXCLUSIONS AND LIMITATIONS

A. In the event that alternative medical services can be provided to a Member that are equal in the quality of care to be provided, HMO reserves the right to provide coverage only for the least costly medical service, as determined by HMO, provided that the medical service is approved in advance by HMO as a medically appropriate alternative service.

B. The following are not benefits under this Contract:

1. Any service obtained by or on behalf of a Member without prior written referral by the Member's Primary Care Physician except in an emergency situation as described in Section II.G of this Contract.

2. Plastic or cosmetic surgery (including, but not limited to ear piercing, rhinoplasty, gynecomastia and reduction mammoplasty) and surgery or treatment relating to the consequences as a result of plastic surgery. This exclusion does not apply to surgery to correct the! results of injuries or congenital defects necessary to restore normal bodily functions.

3. Unless otherwise stated in this Contract, all dental services related to the care, filling, removal or replacement of teeth and treatment of injuries to or

diseases of the teeth, gums and temporomandibular joint, including but not limited to apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, temporomandibular joint dysfunction therapy, alveolectomy and treatment of periodontal disease.

4. Investigational, Ineffective or Experimental surgical or medical treatments or procedures, research studies, or other experimental health care procedures including, but not limited to, cancer chemotherapy protocols, AIDS clinical trials, and I.V. therapies unless approved by an HMO Medical Director prior to the treatment being rendered, subject to Section IX.B.

5. Treatment of military service related diseases, disabilities or injuries for which Member is legally entitled to receive

treatment at government facilities and which facilities are reasonably available to Member (within a two to three hour drive time). This exclusion does not apply to the care and treatment of newborn children as provided under Section VI.B. of this Contract.

6. Coverage of a non-HMO donor in a transplant procedure unless the recipient of the transplant is an HMO Member. In the event an HMO Member is the recipient, coverage will be provided under this Contract for a live non-HMO donor to the extent benefits are unavailable from any other source.

7. Except as provided in Section II.C.21., all experimental organ transplants and procedures and services associated with the preparation of such transplants.

8. Payment for benefits for which Medicare is the primary payer.

9. Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services as described in Section II.E. or to medical treatment of retarded Members in accordance with the benefits provided in Section II.

10. Care for conditions that state or local law requires to be treated in a public facility, including but not limited to mental illness commitments.

11. Provision of blood, blood plasma, blood derivatives or the cost of receiving the services of professional blood donors. Only administration and processing of blood is covered.

12. Routine reduction of nails, calluses and corns which are not medically necessary.

13. Except as provided in Section II.A. 12 of this Contract, provision or re placement of the following items are excluded:

arch supports	hearing aids
braces	TENS units
canes	traction apparatus
cervical collars	walkers
corrective shoes	wheelchairs
corsets	other Durable Medical Equipment (DME), special appliances, supplies or
crutches	
elastic hose	

false teeth equipment

14. Provision of personal convenience items or services such as telephones, barber services. guest meals, radio and television rentals, and other like items and services.

15. Custodial or domiciliary care (as defined in Section I).

16. Weight reduction programs except as provided by HMO.

17. Drugs and medicine except as provided by Section II.C.8 and Section II.D. of this Contract.

18. Special medical reports not directly related to treatment of the Member; e.g., employment physicals.

19. Private duty or special nursing care except as provided in Section II.C and specifically approved in advance by an HMO Medical Director.

20. Payment for services which are eligible for payment under the provisions of an automobile insurance contract or pursuant to any federal or state law which mandates indemnification for such services to persons suffering bodily injury from motor vehicle accidents, where permitted by state law.

21. Therapy or rehabilitation, except as provided by Section II.H of this Contract.

22. Chronic alcoholism or drug addiction treatment, except as provided by Section II.D of this Contract.

23. Reversal of voluntary sterilization and related follow-up care.

24. Transsexual surgery or related services.

25. InVitro fertilization procedures, related services, infertility injectables or other supplies, except as provided by Section II.A.11 of this Contract.

26. Immunizations obtained for the sole purpose of travel.

27. Costs related to any court appearance, proceeding or hearing.

28. Payment for benefits which are compensable under any workmen's compensation or occupational illness law are not covered services under this Contract.

29. Surgical operations or procedures for treatment of obesity,

including but not limited to gastric stapling or balloon procedures, unless medically necessary as determined by an HMO Medical Director.

30. Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).

31. All non-surgical medical services, diagnostic or therapeutics related to temporomandibular joint dysfunction.

DETERMINATIONS REGARDING DENIAL OF BENEFITS DUE TO INAPPROPRIATE USE OF THE HMO NETWORK ARE AT THE SOLE DISCRETION OF THE HMO.

SECTION IV - MEMBERSHIP ELIGIBILITY REQUIREMENTS

A. Subscriber Eligibility. To be eligible to enroll as a Subscriber, a person must be:

1. An employee of the Contract Holder eligible on his or her own behalf to participate in or currently enrolled in a health care plan offered by Contract Holder to the Group; and

2. a resident in the HMO service area.

B. Dependent Eligibility.

1. To be eligible to enroll as a Dependent, a person must be: a) the spouse of a Subscriber under this Contract; or b) a dependent unmarried child [includes natural, foster, step and legally adopted children and proposed adoptive children) residing in the HMO service area who is the age described in the current Schedule of Benefits.

2. Newborn children will be treated as Dependents from birth. This is subject to enrollment requirements in Section VI.B.

C. Change of Group Eligibility Rules. The eligibility of the Group, the composition of the Group and the eligibility requirements used to determine membership in the Group which exist at the effective date of this Contract are material to the execution of this Contract by HMO. No change in the eligibility or participation requirements of the Group shall be permitted to affect eligibility or enrollment under this Contract unless such change is agreed to by HMO and the Contract Holder, and is not otherwise contrary to applicable state laws, rules or regulations. Breach of this provision is

considered a material breach of this Contract and may be the basis for termination under Section XII.B.3.

SECTION V - ENROLLMENT AND ENROLLMENT ELIGIBILITY DATES

A. Enrollment Procedure Any person who satisfies the membership eligibility requirements described in Section IV is eligible to enroll in HMO in accordance with Subsection B, below by submitting a completed HMO enrollment application form to HMO.

B. Enrollment Eligibility Date. The Enrollment Eligibility Date is the date that a person who satisfies the membership eligibility requirements described in Section IV is eligible to enroll in HMO.

1. The Enrollment Eligibility Date for any person who satisfies the membership eligibility requirements described in Section IV on the Effective Date of this Contract shall be the same date as the Effective Date of the Contract.

2. The Enrollment Eligibility Date for any person who first satisfies the membership eligibility requirements described in Section IV after the Effective

Date of this Contract shall be the first Premium Due Date following the date that such person satisfied the membership eligibility requirements.

SECTION Vl - EFFECTIVE DATE OF COVERAGE

A. Effective Date of Coverage Other Than of a Newborn Child. Subject to payment of applicable premiums as provided by Section X and in accordance with the applicable provisions and conditions of this Contract, the effective date of a Member's coverage hereunder is:

1. The Member's Enrollment Eligibility Date (Section V.B above) provided that his or her completed HMO enrollment application form is received by HMO within thirty-one (31) days of the Member's Enrollment Eligibility Date; or

2. If a completed HMO enrollment application form is not received by HMO within thirty-one (31) days of the Member's Enrollment Eligibility Date (Section V.B), the effective date of Member's coverage is the next Open Enrollment Period during which Member's completed HMO enrollment application form is received by HMO, unless such member and

dependents have lost medical coverage due to spouse's layoff or termination of employment.

Employees must apply within thirty-one (31) days of the layoff or termination of employment and submit evidence of: 1) former medical coverage through the spouse's employer; and 2) termination of employment from the spouse's employer.

B. Effective Date of Coverage of a Newborn Child. Coverage of a newborn child of a Member is effective at the time of birth and shall automatically extend for a period of 31 days following birth. Coverage shall include sickness or injury, including medically diagnosed congenital defects, birth abnormalities, prematurity, and routine nursery care. The Subscriber shall have the right, within the 31 day period following the birth of the newborn child, to continue coverage for the child beyond the 31 day period by enrolling the newborn child as a Dependent Member in HMO, provided that the Member eligibility requirements as described in Section IV are satisfied, all premium payments required by Section X are paid for said child, and a completed HMO enrollment application form, specifically naming the newborn child to be added, is received by HMO within 31 days following the birth of the child.

SECTION VII - TERMINATION OF COVERAGE

Coverage of a Member or Members under this Contract will terminate under any of the following conditions, and termination will be effective on the date indicated, subject to the conversion privilege in Section VIII of this Contract, when applicable:

A. In the event that a Subscriber ceases to meet the eligibility requirements of Section IV.A of this Contract, coverage of Subscriber and Subscriber's Dependents who are Members, if any, will terminate on the next premium due date following the date on which the Subscriber ceased to meet the eligibility requirements.

B. In the event that a Subscriber's Dependent who is a Member pursuant to this Contract ceases to meet the eligibility requirements of Section IV.B of this Contract, coverage of such Dependent will cease on the next premium due date following the date on which the Dependent ceased to meet the eligibility requirements of Section IV.B.

C. In the event that Group coverage under this Contract terminates pursuant to Section XII, coverage of all Members under this Contract will terminate as provided in Section XII.

D. In the event that Subscriber or Subscriber's Dependents who are Members pursuant to this Contract, if any, fails to make any contribution or copayment required under this Contract, coverage of Subscriber and Subscriber's Dependents, if any, will terminate thirty (30) days after written notice is given to the Subscriber and Contract Holder by HMO of such failure. At the effective date of such termination, prepayments received by HMO on account of such terminated Member or Members for periods after the effective date of termination shall be refunded to Contract Holder, and HMO shall have no further liability or responsibility with respect to such Member or Members under this Contract.

E. In the event that a Subscriber becomes covered under an alternative health benefit plan or under any other plan which is offered by, through or in connection with the Group in lieu of coverage under this Contract, coverage of Subscriber and Subscriber's Dependents who are Members pursuant to this Contract. if any, will terminate under this Contract, effective the date alternate coverage begins.

F. In the event that a Member acts fraudulently or makes a material misrepresentation in applying for or obtaining coverage or benefits under this Contract, or misuses the HMO Identification Card, including but not limited to allowing or assisting a person other than the Member named on the Identification Card to obtain HMO benefits, Member's coverage under this Contract shall be terminated effective immediately upon written notice. In the absence of fraud or material misrepresentation, all statements made by any Member or any person applying for coverage under the Contract will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will result in the termination of coverage or reduction of benefits unless the statement is contained in writing and signed by the Member, and a copy of same has been furnished to Member prior to termination.

G. In the event a Member refuses upon request to cooperate and provide any facts necessary for HMO to administer its Coordination of Benefits or recovery provisions set forth herein, the coverage of such Member may be terminated upon thirty (30) days written notice by the HMO.

H. In the event that HMO or Participating Providers, after reasonable efforts, are unable to establish and maintain what it and Member agree to be a satisfactory relationship with each other, then the rights of such Member under this Contract may be terminated on not less than thirty (30) days' written notice to Member and Contract Holder, subject to the Grievance Procedure described in Section IX.M. At the effective date of such termination, prepayments received on account of such terminated Member or Members for periods after the effective date of termination shall be refunded to the Contract Holder, and HMO shall have no further liability or responsibility under this Contract with respect to such Member or Members.

I. In the event the coverage of a Subscriber terminates for any reason listed in this Section, coverage of Subscriber's dependents who are Members pursuant to this Contract, if any, will also terminate.

SECTION VIII - CONTINUATION AND CONVERSION

A. Continuation

1. Any Member who is receiving inpatient care in a hospital or skilled nursing facility on the date coverage under this Contract terminates is covered in accordance with the Contract until the earlier of i) when discharged from such inpatient stay, or ii) determination by the attending physician that care in the hospital or skilled nursing facility is no longer medically indicated, or iii) when the contractual benefit has been reached.

2. The continuation of coverage rules of this section, VIII A.2., do not apply to any Contract Holder who normally employed fewer than 20 employees on a typical business day during the preceding calendar year. This exception applies to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

   If a Member's coverage terminates due to termination of Subscriber's employment (other than by reason of Subscriber's gross misconduct) or reduction of hours of Subscriber's employment, Member may elect to continue coverage for 18 months after eligibility for coverage under this Contract would otherwise cease.

   If Member's coverage terminates due to a) divorce or legal separation, b) Subscriber's death, c) Subscriber's entitlement to Medicare benefits, or d) cessation of dependent child status under Section IV.B. of this Contract, Member may elect to continue coverage for 36 months after eligibility for coverage under this Contract would otherwise cease.

   Continuation coverage ends at the earliest of the following events:

   a. The last day of the 18-month period.

   b. The last day of the 36-month period.

   c. The first day on which timely payment of premium is not made subject to Section X.A..

   d. The first day on which the Contract Holder ceases to maintain any

group health plan.

e. The first day on which a Member is actually covered by any other group health plan. In the event the Member has a pre-existing condition, and the Member would be denied coverage under the new plan for a pre-existing condition, continuation coverage will not be terminated until the last day of the 18-month continuation period, or the date upon which the Member's pre-existing condition becomes covered under the new plan, whichever occurs first.

f. The date the Member is entitled to Medicare.

g. The date the Member no longer resides in the service area.

The 18-month coverage period may be extended if an event which would otherwise qualify the Member for the 36 month coverage period occurs

during the 18-month period, but in no event may coverage be longer than 36 months from the event which qualified the Member for continuation coverage initially.

In the event a Member becomes disabled within the meaning of the Social Security Act, and notifies the employer before the end of the initial 18-month period, continuation coverage may be extended up to an additional 11 months for a total of 29 months. This provision is limited to members who are disabled at the time of their qualifying event and only when the qualifying event is the employees reduction in hours or termination. The member may be charged a higher rate for the extended period.

Contract Holder is responsible for providing the necessary notification to Members as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986. Coverage for the sixty (60) day period will be extended only where the Subscriber or Dependent pays the applicable premium charges due within forty-five (45) days of submitting the application to the Contract Holder and Contract Holder in turn remitting same to HMO.

Premiums payable to HMO for the continuation of coverage under this Section shall be due in accordance with the procedures of Section X and shall be calculated in accordance with applicable federal law and regulations.

B. Conversion to Individual Coverage. Conversion is not initiated by HMO. The conversion privilege set forth in this Section must be initiated by the eligible Member. The Contract Holder is responsible for giving notice of the conversion privilege in accordance with its normal procedures; however, in the event continuation coverage ceases pursuant to Section VIII.A.2(a) or (b), Contract Holder shall notify Member at some time during the 180-day period prior to the expiration of coverage.

1. Eligibility.
In the event a Member ceases to be eligible for coverage under this Contract, he or she may, within thirty-one (31) days after termination of coverage under this Contract, convert to individual membership in HMO, effective as of the date of such termination, provided that Member's coverage under this Contract terminated for one of the following reasons:

a. The Group coverage under this Contract terminated and was not replaced with continuous and similar coverage by the Contract Holder; or

b. Subscriber ceased to meet the eligibility requirements of Section IV.A of this Contract, in which case Subscriber and Subscriber's Dependents who are Members pursuant to this Contract, if any, are eligible to convert; or

c. A Dependent ceased to meet the eligibility requirements of Section IV.B of this Contract because of his or her age or the death or divorce of Subscriber; or

d. Continuation coverage ceased under subsection (a) or (b) of Section VIII.A.2 of this Contract.

Any Member who is eligible to convert to individual membership, may do so in accordance with the rules and regulations governing such items as initial

payment, the form of the agreement and all terms and conditions thereunder as HMO may have in effect at the time of Member's application for conversion, without furnishing evidence of insurability.

SECTION IX - GENERAL PROVISIONS

A. Identification Card. The Identification Card issued by HMO to Members

pursuant to this Contract is for identification purposes only. Possession of an HMO Identification Card confers no right to services or benefits under this Contract, and misuse of such identification card may be grounds for termination of Member's coverage pursuant to Section VII.F of this Contract. If the Member who misuses the card is the Subscriber, coverage may be terminated for the Subscriber as well as any of the Subscriber's Dependents who are Members. To be eligible for services or benefits under this Contract, the holder of the card must be a Member on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her HMO Identification Card by any other person, such card may be retained by HMO, and all rights of such Member and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Grievance Procedure set forth in Section IX.M of this Contract.

B. Medical Necessity and Appropriateness. Members will receive designated benefits under the Contract only when medically necessary and appropriate. HMO may determine whether any benefit provided under the Contract was medically necessary and appropriate, and HMO has the option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to medical necessity are subject to review by the Quality Assurance Committee of HMO or its physician designee. HMO will not, however, seek reimbursement from an eligible Member for the cost of any benefit provided under the Contract that is later determined to have been medically unnecessary and inappropriate, when such service is rendered by the primary care physician or a provider referred by the primary care physician without notifying the member that such benefit would not be covered under the contract.

C. Hospital Rules. Members are subject to all the rules and regulations of each hospital and other facility in which benefits are provided.

D. Reports and Records. HMO is entitled to receive from any provider of services to Member, information reasonably necessary to administer this Contract subject to all applicable confidentiality requirements as defined in Section IX.L of this Contract. By accepting coverage under this Contract, Subscriber, for himself or herself, and for all Dependents covered hereunder, authorizes each and every provider who renders services to Member hereunder to disclose all facts pertaining to the care, treatment and physical condition of Member and render reports pertaining to same to HMO upon request and to permit copying of Member's records by HMO.

E. Refusal of Treatment. A Member may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a Participating Physician. If such Participating Physician (after a second Participating Physician's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so

advised, Member still refuses to follow the

recommended treatment or procedure, neither the Physician, nor HMO, Participating Hospital, Participating Skilled Nursing Facility or Participating Home Health Agency will have further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences or related conditions. HMO will provide written notice to Member of a decision not to provide further benefits for a particular condition. The decision is subject to the Grievance Procedure set forth in Section IX.M of this Contract. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

F. Assignment of Benefits. All rights of Members to receive benefits hereunder are personal to Member and may not be assigned.

G. Legal Action. No action at law or in equity may be maintained against HMO for any expense or bill unless brought within the statute of limitations for such cause of action.

H. Independent Contractor Relationship.

1. No Participating Provider or other provider, institution, facility or agency is an agent or employee of HMO. Neither HMO nor any employee of HMO is an agent or employee of any Participating Provider or other provider, institution, facility or agency.

2. Neither the Group nor the Contract Holder nor a Member is the agent or representative of HMO, its agents or employees, or an agent or representative of any Participating provider or other person or organization with which HMO has made or hereafter shall make arrangements for services under this Contract.

3. Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.

I. Coordination of Benefits With Other Group Health Plans. None of these coordination of benefits rules will serve as a barrier to the Member first receiving direct health services from HMO which are covered under this Contract.

The rules establishing the order of benefit determination between this Contract and any other plan covering the Member are as follows:

1. The benefits of a plan which does not have a coordination of benefits

with other health plans provision shall in all cases be determined before the benefits of this Contract.

2. For those plans which have applicable Coordination of Benefit clauses, the following rules will apply:

a. The benefits of a plan which cover the Member as other than dependent will be determined before the benefits of a plan which cover the Member as a dependent;

b. Except as stated in subparagraph (c) below, when a plan and another plan cover the same child as a dependent of different parents:

1) 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

2) 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) If the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;

4) The word "birthday" refers only to the month and day in a calendar year, not the year in which the person was born.

c. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1) First, the plan of the parent with custody of the child;

2) Then, the plan of the spouse of the parent with custody of the child;

3) Finally, the plan of the parent not having custody of the child; and

4) If the specific terms of a court decree 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.

d. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule (d) shall be ignored;

e. If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, Member, or Subscriber longer are determined before those of the plan which covered that person for a shorter time.

3. If a Member who has enrolled under this Contract is entitled to maternity benefits under another contract or policy of insurance (such as extended benefits for pregnancies which began while the Member was enrolled under a previously held policy), HMO will pay, subject to Copayments under this Contract, the difference between entitlements under this Contract and entitlements under the other contract or policy of insurance.

4. Member agrees to permit HMO to coordinate its obligations under this Contract with payment under any other contract or policy of insurance that covers Member.

5. For purposes of these provisions, HMO may release to or obtain from any insurance company or other organization any necessary information, subject to applicable confidentiality requirements, as defined in Section IX.L of this Contract. Any Member claiming benefits under this Contract must furnish to HMO all information deemed necessary by it to implement this provision.

J. Third Party Liability. With regard to any benefit to a Member under this Contract, unless unenforceable or prohibited by statute or regulation, HMO may subrogate and succeed to the Member's right of recovery against any person or organization. Each Member is required to answer all questions submitted by HMO concerning any accident, illness or injury, and also to execute and deliver such instruments and take such actions as HMO may

require to exercise its right of subrogation.

K. Inability to Provide Service. In the event that due to circumstances not within the reasonable control of HMO, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of HMO's Participating Providers or entities with whom HMO has arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or rendered impractical, HMO shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by HMO on the date such event occurs. HMO is required only to make a good-faith effort to provide or arrange for the provision of service, taking into account the impact of the event.

L. Confidentiality. Information contained in the medical records of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract, or in the compiling of aggregate statistical data, may not be disclosed without the consent of the Member.

M. Grievance Procedure.

1. Under the provisions of the Pennsylvania HMO Act and Department of Health Regulations, HMO has promulgated written Grievance Resolution Procedures (the "Procedures") for use by Members in the event of any breach of this Contract by HMO or any dissatisfaction, problem or claim arising from HMO services, benefits or Participating Providers. Said Procedures are available upon request to any Member or Contract Holder.

2. In summary form, said Procedures require a Member having an injury, problem or claim to contact the HMO by telephone or in writing. HMO will provide a Member requesting specific corrective action with a decision within 45 days of receipt of the request except where additional information is necessary. HMO's decision shall become final and binding unless a formal grievance is filed by the Member within 60 days of the date of the decision. A Grievance Committee shall review and investigate each grievance within 30 days of receipt unless additional information necessary to resolve the grievance is not received during such time. The written decision regarding the grievance will specify the reasons for the decision and the Member's appeal rights. The decision of the Grievance Committee shall become final

and binding unless the Member appeals to the Grievance Appeal Committee within 30 days of the date of the decision. The Grievance Appeal Committee, which will be comprised of no less than one-third HMO members, will hold an informal hearing to consider the appeal. The Member has a right to attend the hearing, but may choose not to do so. Upon submission of an appeal, HMO will provide the Member with a copy of the hearing procedures. The Grievance Appeal Committee will issue a decision within 10 days of the conclusion of the hearing. The decision of the Grievance Appeal Committee shall be final and binding unless the Member appeals to the Department of Health. At each step of the foregoing process, the Member should be as specific as possible as to remedy being sought from HMO. In situations involving emergency or urgently needed care, the Member should so notify HMO so it may handle the inquiry or grievance under special expedited procedures.

3. Said Procedures are subject to modification or supplementation by order or direction of the Department of Health. Members have the right to have an uninvolved HMO representative assist them in understanding the grievance process.

4. Said Procedures are mandatory and must be exhausted prior to the filing of an appeal with the Department of Health prior to the institution of any litigation in court or arbitration regarding either any alleged breach of this Contract by HMO or the subject matter of any inquiry, grievance or grievance appeal.

5. The Bureau of Health Financing & Program Development in the Pennsylvania Department of Health, Room 1026 Health & Welfare Building, P.O. Box 90, Harrisburg, PA 17108-0090, (717) 787-5193, is responsible for monitoring HMO's compliance with said Procedures.

N. Clerical Records

1. HMO shall maintain records of the Members.

2. The Group shall forward the information required by HMO in Section XI of this Contract in connection with the administration of this Contract.

3. All records of the Group which are incident to the coverage provided under this Contract shall be available for inspection by HMO at any reasonable time.

4. HMO shall not be liable for the fulfillment of any obligation dependent upon such information prior to its receipt in a form satisfactory to HMO.

5. Incorrect information furnished to HMO may be corrected, provided that HMO has not acted to its prejudice in reliance thereon. Coverage under this Agreement shall not be invalidated by failure of the Group due to clerical error, provided all premiums are properly adjusted and HMO, in its sole discretion, determines that a clerical error has been made. However in no case will any changes, additions, or deletions in HMO's Member list be made effective more than two (2) Premium Due Dates prior to the date HMO is notified, in a written form satisfactory to HMO, of the requested change, addition, or deletion.

O. Limitation on Services. Except in cases of emergency as provided under Section II.G of this Contract, services are available only from Participating Providers. HMO shall have no liability or obligation whatsoever on account of any service or benefit

sought or received by a Member from any Physician, Hospital, Skilled Nursing Facility, Home Health Agency or other person, entity, institution or organization unless prior arrangements are made by HMO.

SECTION X - PREMIUMS

A. Premiums are payable to HMO on or in advance of each Premium Due Date at the corporate offices of HMO unless otherwise specified by HMO in writing. The payment of any premium shall not maintain coverage under this Contract in force beyond the date when the next premium becomes payable; however, a thirty (30) day grace period, during which time this Contract will remain in force, shall be granted for payment of each premium after the first. The Contract Holder shall remain liable for i) the payment of the premium for the time coverage was in effect during the grace period, ii) the member shall remain liable for copayments owed.

B. HMO, upon approval of the State Insurance Department, reserves the right to fix new premium rates under this Contract at the end of each rate term. Notice of any new premium rates shall be given to the Contract Holder at least thirty (30) days prior to the date specified by HMO in order for the rates to become effective. Payment of the new rate shall be deemed receipt of notice and acceptance of change in rate.

SECTION XI - GROUP PERSONNEL DATA

A. The Contract Holder shall furnish to HMO each month during the period of this Contract, on forms approved by HMO, such information as may reasonably be required for the purpose of enrolling Members of the Group under this Contract, processing terminations, and effecting changes in family status

and transfer of employment of Members. HMO shall furnish to the Contract Holder such information concerning enrollment of Members and other matters as it may reasonably require. Contract Holder is responsible for providing written notice to the Members of the conversion privilege within 15 days before or after termination of coverage under this Contract, unless continuation coverage ceases pursuant to Section VIII.A. (2)(a) or (b), in which case Contract Holder shall notify Member prior to expiration of the continuation coverage.

B. Clerical errors or delays in keeping or reporting data relative to coverage will neither invalidate coverage which would otherwise be in force nor continue coverage which would otherwise be validly terminated if HMO, in its sole discretion, determines that a clerical error has been made. Upon discovery of such errors or delay, an adjustment of charges shall be made. This provision notwithstanding, in no case will adjustments in coverage or rates be made effective more than two (2) Premium Due Dates prior to the date HMO is notified in writing, on a form satisfactory to HMO, of the requested addition, deletion, or change in coverage.

SECTION XII - TERMINATION OF GROUP COVERAGE AND RENEWAL

A. This Contract may be terminated by HMO or Contract Holder on any premium due date by giving thirty (30) days' prior written notice.

B. This Contract may be terminated by HMO at any time under the following circumstances:

1. By giving thirty (30) days' prior written notice to Contract Holder if Contract Holder is guilty of fraud or material misrepresentation of fact in obtaining coverage hereunder: or

2. Upon default in the payment of premiums required under Section X of this Contract, subject to the thirty (30) day grace period described in X.A or if the Contract Holder becomes insolvent, files a petition in bankruptcy, files a petition seeking any reorganization, arrangement, composition or similar relief under any federal or state law regarding insolvency or relief for debtors, or makes an assignment for the benefit of creditors or similar undertaking, or if a receiver, trustee, or similar officer is appointed for the business or property of Contract Holder, or if Contract Holder has begun any voluntary or involuntary liquidation process; or

3. By giving thirty (30) days' prior written notice to Contract Holder if Contract Holder breaches the terms of Section IV.C.

SECTION XIII - MISCELLANEOUS

A. Contract Holder hereby makes HMO coverage available to persons who are eligible under Section IV of this Contract. However, this Contract shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by applicable public authority. This can also be done by mutual written agreement between HMO and Contract Holder without the consent of Members. By electing medical and hospital coverage pursuant to this Contract, or accepting benefits hereunder, all Members who are legally capable of contracting, and the legal representatives of all Members who are incapable of contracting, agree to all terms, conditions and provisions hereof.

B. Members or applicants shall complete and submit to HMO such applications or other forms or statements as HMO may reasonably request. Members represent that all information contained in such applications, forms or statements submitted to HMO incident to enrollment under this Contract or the administration hereof shall be true, correct, and complete to the best of Member's knowledge or belief.

C. HMO may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Contract.

D. No agent or other person, except a Vice President or President of HMO, has authority to waive any condition or restriction of this Contract, to extend the time for making a payment; or to bind HMO by making any promise or representation or by giving or receiving any information. No change in this Contract shall be valid unless evidenced by an endorsement on it signed by one of the aforesaid officers.

E. This Contract, including the Cover Sheet, constitutes the entire agreement between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this Contract shall be binding unless executed in writing by authorized representatives of the parties.

F. This Contract has been entered into and shall be construed according to applicable state and federal law.

G. HMO will furnish each Subscriber with a Member Handbook.

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,
dba THE HEALTH MAINTENANCE ORGANIZATION OF
PENNSYLVANIA, dba
U.S. HEALTHCARE
SCHEDULE OF BENEFITS
PATRIOT X QPOS PLAN
STV GROUP
Effective December 1, 1995

Benefit	Copayment
Primary Care Physician Office Visit	
During Office Hours	$10
Non-Office Hours and Home Visits	$15
Specialist Physician Office Visit	$15
Outpatient Therapies	$15
First OB Visit	$15
Routine Gynecological Exam(s)	$15
Hospital Outpatient Department Visit and Diagnostic Testing	$15
Outpatient Emergency Services	
Hospital Emergency Room or Outpatient Department	$35
Outpatient Mental Health Visits	Visits 1-20: $25
Outpatient Substance Abuse Visits	Visits 1-60: $15
Outpatient Surgery	$0

Group No: US018927-001 , PA05-018927-013, PA03-018927-027, PA04-018927-028, PA09-018927-029

Inpatient Services

Acute Care	$0
Mental Health	$0
Substance Abuse Detoxification	$0
Substance Abuse Rehabilitation	$0
Maternity	$0
Skilled Nursing Facility	$0
Non-Hospital Services	
First course of treatment	$0
Second and subsequent courses of treatment	50% of the cost of service

Dependent Eligibility	(a) Under 23 years of age, or (b) 23 years of age or older but incapable of self-support due to mental or physical incapacity, either of which commenced prior to age 23 for non-student Dependents and prior to age 23 for student Dependents, or (c) under 23 years of age and attending a recognized college or university, trade or secondary school on a full time basis, and (d) non-student Dependents will be covered until the end of the calendar year after they have reached the age of 23, and (e) student Dependents will be covered until the end of the calendar year after they have reached the age of 23.

Optional Benefits

Routine Eye Exam by Participating Ophthalmologist or Optometrist	$15
Primary Dentist Visit Copayment (for Preventive Dental Benefit for children, Section II.A.3.g of the Group Master Contract)	$5
Routine Gynecological Exam(s)	One visit per year
Durable Medical Equipment Copayment	$0

Maximum Annual Out-of-Pocket Limit $0

Group No: US018927-001, PA05-018927-013, PA03-018927-027. PA04-018927-028, PA09-018927-029

Prescription Drugs and Medications
Copayment $10

Lens Reimbursement Reimbursement Amount $35

Group No: US018927-001 , PA05-018927-013, PA03-018927-027, PA04-018927-028, PA09-018927-029

THE HEALTH MAINTENANCE ORGANIZATION OF PENNSYLVANIA
ENDORSEMENT
SECTION Vl - EFFECTIVE DATE OF COVERAGE

Section A.2, Effective Date of Coverage Other Than of a Newborn Child, is amended to read:

2. If a completed HMO enrollment application form is not received by HMO within thirty-one (31) days of the Member's Enrollment Eligibility Date (Section V.B), the effective date of Member's coverage is the next Open Enrollment Period during which Member's completed HMO enrollment application form is received by HMO, unless such Member and Dependents have lost medical coverage due to spouse's layoff or termination of employment.

   Employees must apply within thirty-one (31) days of the layoff or termination of employment and submit evidence of 1) former medical coverage through the spouse's employer and 2) termination of employment from the spouse's employer.

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA. INC..
dba THE HEALTH MAINTENANCE ORGANIZATION OF
PENNSYLVANIA dba U.S HEALTHCARE

E. Mental Health Inpatient Benefit

Section II. E. of the Group Master Contract and the Certificate of Coverage. or Individual Contract is hereby amended to add:

Member may exchange one (1) Mental Health inpatient benefit day for up to four (4) outpatient visits. Member may exchange up to a maximum of (10) inpatient days for a maximum of forty (40) additional outpatient visits under this rider.

Additionally Member may exchange one (1) inpatient day for two (2) days of treatment in a partial hospitalization program in lieu of hospitalization up to the maximum benefit limitation.

Requests for a benefit exchange must be initiated by the member's capitated Mental Health Provider under the guidelines set forth by the HMO. Member must utilize all outpatient mental health benefits available under the contract and pay all applicable copayments before an exchange will be considered. The Mental Health provider must demonstrate medical necessity for extended visits and be able to support the need for hospitalization if additional visits were not offered. Request for exchange must be approved in writing by HMO prior to utilization.

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.
d/b/a THE HEALTH MAINTENANCE ORGANIZATION OF PENNSYLVANIA, INC.
d/b/a U.S. HEALTHCARE

INJECTABLE BENEFITS AMENDMENT

United States Healthcare Systems of Pennsylvania, Inc. d/b/a The Health Maintenance Organization of Pennsylvania, Inc. d/b/a U.S. Healthcare, ("HMO") and Contract Holder agree to offer to the HMO Members the following injectable benefit subject to the following provisions:

A new section II.K is added to the Group Master Contract and the Certificate of Coverage:

K. Injectables

Unless specifically excluded, and when an oral alternative drug is not available, injectable medication is a covered benefit, including those

medications intended to be self administered. Medications must be deemed medically necessary and appropriate to the Member's needs or condition for covered services, prescribed by a participating provider and approved in advance of treatment by HMO. If the drug therapy treatment is approved for self-administration, Member is required to obtain covered medications at a U.S. Healthcare participating pharmacy designated to fill injectable prescriptions.

Experimental or investigational drugs or medications or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the NIH are not covered under this contract. The off-label use of injectable drugs or medications is not covered. Drugs related to the treatment of noncovered services are not covered. Drugs related to the treatment of infertility, contraception and performance enhancing steroids are not covered. Needles, syringes and other injectable aids are not covered.

A copayment for the primary care physician or specialist physician applies to this benefit when administered in the participating physician's office as listed on the attached Schedule of Benefits.

SECTION III - EXCLUSIONS AND LIMITATIONS is hereby amended to delete Exclusion III.B.17 listed in the Group Master Contract and the Certificate of Coverage in its entirety and replace it with the following exclusion:

17. Drugs and medicine except as provided by Section II.C.8, Section II.D, or II.K of this Contract.

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.
d/b/a THE HEALTH MAINTENANCE ORGANIZATION OF PENNSYLVANIA, INC.
d/b/a U.S. HEALTHCARE

ENDORSEMENT

HMO and Contract Holder agree to offer to Members the following benefit subject to the following provisions:

SECTION I - DEFINITIONS is amended to include the following definition:

Infertile condition or Infertility - The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year if the member is under the age of thirty-five (35), or after a period of six (6) months if the Member is age 35 or older, of unprotected sexual intercourse.

Participating Advanced Reproductive Technology ("ART") Specialist - A Specialist which or who has entered into a contractual agreement with HMO for the provision of the advanced reproductive technology services covered by this endorsement to

Members on an agreed upon basis.

Infertility Program - A program administered by HMO which consists of:

1. The evaluation of "infertile" Members to determine the appropriate infertility treatment for a Member; and

2. Determination of eligibility for the ART benefit; and

3. Precertification and approval for the ART benefit; and

4. Case management for the provision of infertility services covered under the Group Master Contract and Certificate of Coverage and the services listed hereunder.

Section II.A.11 is hereby amended to add the following additional infertility services to the Group Master Contract and the Certificate of Coverage:

Limited Advanced Reproductive Technology Benefit

1. Eligibility:

To be eligible under the Infertility Program:

a. Member must be covered under the Group Master Contract and the Certificate of Coverage as a Subscriber or a Dependent; and

b. Member must be diagnosed as infertile.

The ART benefit is not covered for male members when the cause of infertility is vasectomy or for female members when the cause of infertility is tubal ligation.

2. Access to the ART Benefit and Precertification:

To obtain the ART benefit described in paragraph 3 hereunder, Member must be:

a. Referred by Member's primary care physician or gynecologist to the Infertility Program, or Member may directly contact the HMO's Infertility Program Case Management unit by calling the Solutions number listed on Members ID card; and

b. Determined to be eligible for the ART benefit after an initial intake evaluation and consultation with a participating ART Specialist and recommendation by the ART Specialist that Member be accepted into the Infertility Program. Eligibility is also based on the participating ART Specialist's determination of the reasonable possibility of success based on the Member's medical history and the standards established by HMO; and

c. Pre-certified and approved by HMO for this benefit; and

d. Member has been issued a claim authorization for ART services from the HMO's Infertility Program Case Management Unit to a participating ART Specialist. Claim authorizations will only be issued by the Infertility Program Case Management Unit for all services related to infertility care and treatment.

3. Benefit:

This benefit covers one (1) egg harvesting and up to two (2) transfers through InVitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), or Gamete Intra-Fallopian Transfer (GIFT) only, during each twenty-four (24) month period from the date of the first visit for actual treatment from the participating ART Specialist and after the determination of eligibility as described above. Services under this benefit are only available from the participating ART Specialists for whom Member has been issued a claim authorization by the Infertility Program Case Management Unit.

SECTION III - EXCLUSIONS AND LIMITATIONS is hereby amended to delete Exclusion III.B.25 listed in the Group Master Contract and the Certificate of Coverage in it's entirety and replace it with the following exclusion:

III.B.25

Infertility injectable medications are not covered. Charges for the freezing and storage of cryopreserved embryos and charges for storage of sperm are not covered. Donor costs, including but not limited to the cost of donor eggs and donor sperm, are not covered. This ART benefit is only available from participating ART Specialists through the Infertility Program and is excluded from coverage on a non-referred or out-of-network referred basis. The costs for ovulation predictor kits are not covered.

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.
d/b/a THE HEALTH MAINTENANCE ORGANIZATION OF PENNSYLVANIA, INC.
d/b/a U.S. HEALTHCARE
ENDORSEMENT

Effective October 1, 1995

Section VIII.A.1 of the Group Master Contract and Certificate of Coverage, Continuation, is amended to add the following provision:

In the event a Subscriber's employment with Contract Holder is terminated involuntarily and without cause, Subscriber shall be entitled to continue coverage (including coverage of covered Dependents) immediately thereafter, without payment of additional premium, for a period equal to one month (i.e., the corresponding day of the following month, for example from February 15th to March 15th) for each year that Subscriber has continuously (i.e., no lapse of more than thirty (30) days) maintained coverage with HMO under a Group Contract, commencing with the date that Subscriber is effective under this Endorsement, to a maximum of three months of such coverage. All continued coverage utilized by Subscriber pursuant to this Endorsement shall be deducted from Subscriber's accumulated eligibility for continued coverage hereunder (i.e., if Subscriber has used one (1) month of a three (3) month accumulated continued coverage period, two (2) months will remain until such time as Subscriber again becomes eligible for three (3) months of continued coverage.) To be eligible for and obtain such continued coverage an application must be received by HMO within thirty (30) days after Subscriber's termination of employment and shall include (x) a signed representation from the Subscriber that the Subscriber is not eligible for other comprehensive group health coverage (such as through a spouse or other employer) or Medicare, and (y) a signed written certification from the Contract Holder that the Subscriber's employment was terminated involuntarily and without cause. In the event Subscriber exercises Subscriber's COBRA or other continuation rights under this Contract, continuation of coverage hereunder shall be in the form of the waiver of the applicable COBRA premium or other continuation premium.

CORPORATE HEALTH INSURANCE COMPANY

(A Minneapolis, Minnesota Domiciled Company)
Principal Executive Offices:
980 Jolly Road
Blue Bell, Pennsylvania 19422

SUMMARY OF BENEFITS
FOR
COMPREHENSIVE MAJOR MEDICAL
GROUP HEALTH INSURANCE POLICY

This Summary of Benefits describes the benefits available to you under the Comprehensive Major Medical Group Health Insurance Policy No. PA PA01,018927001, PA03, 018927-027, PA04, 018927-028, PA05 018927-013, PA09, 018927029, GN01, 018927-003, GN02, 018927-002, GN03, 018927-004, NE01, 018927005, DE01, 018927-006, NH01, 018927-007, MD01,018927-008, DC01, 018927009, R101, 018927-010, GA01, 018927-011, MD02, 018927-012, NJ01, 018927025, VA01, 012927-026 (the "Policy") issued by Corporate Health Insurance Company ("CHI" or the "Company") to STV Group ("the Policyholder").

Every attempt has been made to be informative about benefits available under the Policy and those areas where a benefit may be lost or denied. However, for a complete description of the benefits, please review this Summary of Benefits

together with the Policy. The benefits described in this Summary of Benefits are subject exclusively to the provisions and limitations set forth in the Policy.

The benefits described in this Summary of Benefits are those in effect as of December 1, 1995.

This Summary of Benefits will not constitute a Certificate unless the Certificate label is fixed to this Summary.

HOW TO SUBMIT CLAIMS FOR BENEFITS

- A notice of claim, which may be obtained from CHI or your human resources department, must be sent directly to CHI or its designee within 90 days after an eligible service or supply is received.

- Please be sure to provide all information required by the notice of claim, including the Policy number and the Policyholder's name and number.

- If you receive a bill for medical services, send it to CHI or its designee together with the notice of claim.

- Before submitting a claim for medical expenses, review this Summary of Benefits and the bills you have accumulated. Be sure you are submitting bills for which benefits are payable under the Policy. Make copies of all documents you are submitting.

- Bills must be complete. Each bill must be an original and should show:

    * Name of eligible person
    * Date(s) of service or supply
    * Charge for each service or supply
    * Diagnosis (reason for treatment)
    * Type(s) of charge(s) (CPT-4 code, if any, and/or description of service(s) provided)

PLEASE NOTE: The following will not be acceptable:

* Canceled checks
* Cash register receipts
* Balance due bills (bills that show only the amount owed)
* Photocopies

Should you need additional copies of the notice of claim, feel free to contact CHI between 8:00 AM - 5:00 PM (Eastern Standard Time) at 1-800-323-9930 or check with your human resources department. All payments will be made directly to the

provider, unless you notify CHI in writing otherwise. If you have any questions, please call or write:

Corporate Health Insurance Company
980 Jolly Road, P.O. Box 1109
Blue Bell, Pennsylvania 19422
1 -800-323-9930

INSURANCE POLICY HIGHLIGHTS

ELIGIBILITY
Active employees of the Policyholder and their eligible dependents. Dependent coverage is limited to employee's spouse and unmarried dependent children up to age 23; full-time students up to age 23.

PRE-CERTIFICATION
To be eligible for maximum benefits under the Policy, you are required to follow the procedures for pre-certification set forth below. Pre-certification is obtained by calling CHI at 1-800-541-3149. Pre-certification is required prior to receiving any of the eligible services or supplies that require pre-certification, as noted below in the Schedule of Benefits.

FAILURE TO COMPLY WITH THIS PRE-CERTIFICATION REQUIREMENT WILL RESULT IN A 50%

REDUCTION IN YOUR BENEFITS.

SCHEDULE OF BENEFITS

I. DEDUCTIBLE AMOUNT

The following deductible amount (the "Deductible Amount") must be paid by you or your family (as the case may be) for eligible medical expenses incurred during any calendar year. Any eligible medical expenses in excess of the applicable Deductible Amount will be paid by CHI and the covered person in accordance with the co-insurance and co-payment provisions set forth below in Section II.

Individual: $300
Family: $900

The Deductible Amount is not applicable to certain eligible medical expenses noted below in Section V, for which you or your family (as the case may be) need not pay any Deductible Amount prior to becoming entitled to benefits under the Policy.

II. CO-INSURANCE AND CO-PAYMENT

All eligible medical expenses in excess of the Deductible Amount will be paid by CHI and you as follows, until at such time during the calendar year you have paid up to your out-of-pocket maximum amount set forth below in Section III or CHI has paid the maximum benefits set forth below in Section IV or V:

CHI Pays: 80% of Reasonable & Customary Charges
You Pay: 20% of Reasonable & Customary Charges

Unless specifically required below in Section V, no co-payment will be payable on any eligible medical expenses. Certain eligible medical expenses specified below in Section V are not subject to any co-insurance or co-payment provisions.

CHl's obligation to pay eligible medical expenses under the Policy is further limited by the maximum lifetime individual benefit limitation set forth in Section IV below and other maximum benefit amounts set forth next to each eligible medical expense in Section V below.

III. OUT-OF-POCKET MAXIMUM

During any calendar year, you or your family (as the case may be) will not be required to pay an aggregate amount in excess of the following out-of-pocket maximum amount (the "Out-of-Pocket Amount"). If during any calendar year you have paid pursuant to the above co-insurance or copayment provision an aggregate amount greater than the Out-of-Pocket Amount below, CHI will pay for 100% of the balance of the eligible medical expenses, up to the amount of the lifetime individual maximum benefits amount set forth below in Section IV or the maximum benefit amounts set forth below in Section V (whichever is applicable).

Individual: $1,200
Family: $3,600

Unless otherwise noted below in Section V, the co-insurance and co-payments paid by the Covered Individual of the Family Unit will be included in the Out-of-Pocket Amount. However, the Deductible Amount paid by the Covered Individual or the Family Unit will not be included in the Out-of-Pocket Amount.

IV. LIFETIME INDIVIDUAL MAXIMUM BENEFIT

The maximum amount payable by CHI under the Policy for eligible medical expenses incurred by you or any member of your family (if applicable) shall not exceed $1,000,000.

V. ELIGIBLE MEDICAL EXPENSES

The Policy covers the following eligible services and supplies provided to you or your covered family members. However, the Policy covers only those services and supplies which were medically necessary and only up to reasonable and customary charges, subject to additional restrictions and limitations set forth below and in the Policy:

COVERED SERVICES	LIMITATIONS AND RESTRICTIONS
Acupuncture	In lieu of anesthesia only
Ambulance Transportation	To and from the nearest facility that can give necessary treatment
Ambulatory Surgery	Pre-Certification required
Anesthesia	
Assistant Surgeon	Benefits not payable for hospitals where surgical assistant is routinely available
Birthing Center	Benefits not to exceed those otherwise available for pregnancy under the Policy
Blood or Blood Plasma	Must not be replaced on behalf of the eligible person
Cardiac Rehabilitation Services	Pre-Certification required
Chiropractic Care	Pre-Certification required; CHI pays up to a maximum benefit amount of $1,000 per calendar year for detection and correction by manual means of structural imbalance or o subluxation resulting from or related to distortion, misalignment or subluxation of or in the vertical column
Consultation	Only for consultation requested by the attending physician and given while confined as an in-patient
Diagnostic Services	

Emergency	Services Notification must be made within 24 hours of any admission or as soon thereafter as reasonably possible; Emergency services must be received within 48 hours after the onset of the medical emergency
Hemodialysis	
Home Health Services	Pre-Certification required One visit per day; up to 4 hours constitute 1 home health care visit;
Hospice Care	Pre-Certification required; Maximum individual lifetime benefit of $10,000; Attending physician must certify that the covered person is terminally ill and must recommend admission into a hospice care program
Hospital Outpatient Care: Inpatient Care: (Room & Board at Semi-Private Room Rate*)	 Pre-Certification required Pre-Certification required

*Unless Private Room is Medically Necessary

Immunization for	No deductible and no co-insurance; Children Limited to minimum benefits mandated by the Department of Insurance
Infertility	Services to diagnose infertility only; Does not cover infertility treatment
Inpatient Physician Services	While confined as an inpatient in a hospital or skilled nursing facility
Mammography	No deductible and no co-insurance shall be applied to the charge; Up to 1 routine mammography per calendar year if the female eligible person is age 40 or older, and any additional mammography recommended by a physician for a female eligible person under

	age 40
Maternity-Related	Care Notification required soon after pregnancy is confirmed and within 24 hours after birth or as soon thereafter as reasonably possible
Newborn Baby Care	6
Office Visits	Only for diagnosis or treatment of an injury or illness at a physician's office
Organ Transplants	Pre-Certification required; Attending physician must certify medical necessity; Covered person must be the recipient
Oxygen	When prescribed by the attending physician
Papanicolaou Smear (Pap Smear)	Routine pap smear in accordance with the recommendations of the American College of Obstetricians and Gynecologists. No deductible or no co-insurance shall be applied to the charge.
Preventive	Care An annual gynecological examination, including a pelvic examination and clinical breast examination by a Physician. No deductible or no co-insurance shall be applied to the charge. The charges for immunizations (other than children's immunizations) and physical examinations (other than papanicolaou smears and mammography); Up to maximum benefit of $150 per individual per calendar year No deductible or no co-insurance shall be applied to the charges.
Private Duty Nursing	Pre-Certification required; Must be services of a L.P.N. or R.N. for non-hospitalized illness or injury
Psychiatric	Treatment Includes Mental, Psychoneurotic and Personality Disorders; Restoration and reinstatement provision of the Policy does

	not apply; Lifetime maximum benefit of $50,000
Outpatient:	Maximum benefit limited to 60 visits per calendar year; Maximum benefit of $1,500 per year; CHI pays 50% and You pay 50% Up to $30 per visit
Inpatient:	Pre-Certification required; Maximum benefit limited to 30 days per calendar year
Reconstructive/ Corrective Surgery	Pre-Certification required
Skilled Nursing Facility	Pre-Certification required; Maximum benefits limited to 240 days per calendar year and 35 physician visits per calendar year; Room and board at semi-private accommodations, unless isolation is required and the attending physician orders private accommodations

Substance Abuse Treatment	Pre-Certification required
Outpatient Care:	Limited to 30 visits per calendar year and 30 additional full visits or equivalent partial visits, which may be exchanged for up to 15 inpatient rehabilitation days on a 2-for-1 basis
*Inpatient Detoxification:	Limited to 7 inpatient days per calendar year, subject to a lifetime limit of 4 separate admissions
*Inpatient Rehabilitation:	Limited to 30 days per calendar year in a non-hospital substance abuse residential facility, subject to a lifetime limit of 90 days

*Room and board at Semi-Private room rate.

Therapies	Pre-Certification required Includes Cardiac Rehabilitation, Chemo, Occupational, Physical, Radiation, Respiratory, and Speech;

Voluntary Sterilizations	Does not cover reversal procedures

V1. EXCLUSIONS

Certain charges and expenses are not covered by the Policy, including those:

- For services or supplies not medically necessary for the diagnosis or treatment of an illness or injury
- In excess of the reasonable and customary charges or the maximum benefits provided by this Summary of Benefits
- Caused by war (declared or undeclared) or any act of war
- Suffered while on full-time active duty in the armed forces of any country or international authority
- Incurred in connection with any injury or illness which is compensable under any workers' compensation or occupational disease act or law or the federal Longshoreman's and Harbor Worker's Compensation Act
- For services received in a veteran's administration hospital, a public health service hospital, or any facility operated by the U.S. government or any of its agencies, except to the extent that there is an unconditional requirement to pay these charges
- For certain services received by retirees from armed forces or their dependents pursuant to and covered by programs established under federal law
- For the treatment of or care for mental retardation, defects and deficiency, other than psychiatric treatment specifically covered herein
- For dental services, except for accidental injuries to sound natural teeth

- For optical services
- For services rendered by you or your close relative
- For care, services, and supplies not prescribed or rendered by a Physician
- Directly related to attempted suicide or an intentionally self-directed injury

- For provision or replacement of the following items: arch supports; elastic hose; birth control devices including, but not limited, to IUDs, diaphragms and condoms; false teeth; braces; traction apparatus; canes; walkers; corrective shoes; corsets; wigs or cranial prosthesis; diapers; or certain special appliances, supplies or equipment.

- For custodial care

- For cosmetic surgery, except reconstructive surgery specifically covered by the Policy

- Resulting from the commission or attempt to commit a felony by the eligible person

- For certain convenience items or services

- Applied toward satisfaction of the deductible or the co-payment or coinsurance amount payable by the eligible person

- For blood or blood plasma that is replaced on behalf of the eligible person

- For actual or attempted impregnation or fertilization which involves either an eligible person or a surrogate as a donor or a recipient

- For examinations, proper adjustment of, or purchase of a hearing aid

- For career and pastoral counseling

- For services or supplies of an educational, experimental or investigatory nature

- For the reversal of any sterilization procedure performed on any family member

- For sex transformations or other transsexual surgery or related services not necessitated by an injury or illness covered by the Policy

- For certain services rendered for academic reasons

- For orthoptic therapy (vision exercises)

- For weight reduction programs and gastric stapling for treatment of obesity

- For certain bereavement counseling service

- For treatment of temporomandibular joint dysfunction with/intra-oral

devices or any other method to alter vertical dimension

- For hypnosis not used as an integral part of a treatment covered by the Policy
- For telephone consultations, failure to keep a scheduled visit, or completion of a claim form
- For any services or supplies not specifically described in the Policy
- For any services or supplies covered by any automobile insurance policy up to the amount of coverage limitation under such policy.
- For prescription drugs
- For orthotic devices

CHI shall determine whether a service or supply is covered under or excluded from coverage under the Policy.

PRE-CERTIFICATION

Prior to receiving hospitalization or certain other medical treatment requiring pre-certification as specified above in the Schedule of Benefits, the covered person, a member of his or her family, a hospital staff member, or the attending physician, must notify CHI to pre-certify the admission or treatment.

The Company will reduce the benefits payable under the Policy by 50% if the procedures for precertification set forth herein are not followed. Each covered person will be responsible to pay the unpaid balance of the benefits.

To obtain pre-certification, call CHI at 1-800-541-3149. This call must be made:

1. Prior to any planned admission into hospital and prior to receiving such other eligible treatment that require pre-certification according to the Schedule of Benefits or the Policy;
2. Within 24 hours after the time of an emergency admission or as soon thereafter as reasonably possible; and
3. As soon as the attending physician confirms that a covered person is pregnant and again within 24 hours of the birth or as soon thereafter as reasonably possible.

When calling CHI, the caller must provide:

1. The covered person's name and the covered person's social security number;

2. The treating physician's name, address and phone number;

3. The name of the hospital or treatment facility and the anticipated admission or treatment date; and

4. The Policyholder's name and Policyholder Policy Number.

There is no requirement to call in advance before seeking treatment for an emergency.

Case Management

Certain medical conditions for which a claim is made under the Policy may be referred to Case Management (CM).

Only those conditions for which medical expenses are expected to exceed a certain dollar amount, and for which there is a potential lower cost treatment alternative, will be referred to CM.

CM is a program which provides a case-by-case analysis and medical treatment plan suggestions that address the need of catastrophically ill or injured individuals. It concentrates on severe injuries and illnesses, such as spinal cord injuries or head trauma, when early intervention and individual case management will prove effective to a patient's recovery.

The decision to refer any case to CM will remain with CHI, who will rely on the criteria established by the CM service provider to determine which claims are recommended for CM, except that no alternative treatment will be provided to the covered person under CM without prior consent of the covered person and the attending physician.

In certain instances a recommendation to use alternative treatment not normally covered by the Policy may be made when such treatment endorses quality care, medical necessity and cost effectiveness. Under these circumstances, any such alternative treatment will be covered by the Policy.

DEPENDENT ELIGIBILITY

1. Dependent Coverage

(a) Your spouse and dependent children can also be covered under the Policy.

(b) Your spouse is eligible for dependent coverage unless:

(i) You and your spouse are legally separated or divorced or have obtained an annulment;

(ii) Both your and your spouse are employees of the Policyholder. You and your spouse may choose to be covered as individual employees of the Policyholder, or one may cover the other as a dependent, but both of them may not cover the other as a dependent;

(iii) Such spouse is in active military service;

(iv) Such spouse is of the same sex; or

(v) Such spouse is not a legal spouse, under the laws of the Commonwealth of Pennsylvania.

(c) Your natural or legally adopted child is eligible from birth so long as the child is:

(i) Less than age 23, or if a full-time student, less than age 23;

(ii) Not married; and

(iii) Not on active duty in any of the armed forces.

(d) Child/children under legal guardianship (including foster children) or children under court order will be included under the Policy under the same conditions and restrictions applicable to a covered person's natural or legally adopted children.

(e) Your spouse and child/rep meeting the requirements described above are referred to herein as "Eligible Dependents."

2. Enrolling Eligible Dependents

(a) You can enroll for family coverage when you become eligible for individual coverage.

(b) If you have no dependents when you first enroll but later gain one, you may enroll for family coverage within 31 days of the date you gain the dependent. This includes dependents gained by marriage, birth adoption, legal guardianship or court order. During the first 31 days after the birth of a child, the child will be automatically covered for all eligible benefits. For coverage of a child beyond the first 31 days after birth and for coverage of a spouse during and beyond the

first 31 days after marriage, enrollment must be made and the first premium charge for that dependent must be paid within that 31 day period.

(c) Note: Except for newborn child's coverage during the first 31 days after birth, if you do not enroll you dependents within 31 days after the dependent becomes eligible. satisfactory evidence of good health for such dependent will be required. If satisfactory evidence of good health is not provided for such dependent, CHI may reject the enrollment application for insurance of such dependent under the Policy. Coverage for

such dependent providing satisfactory evidence of good health will then begin no earlier than the first day of the calendar month following CHl's approval of the evidence of good health. However, no evidence of good health will be required for any dependent who enrolls within such 31 days.

3. When Dependent Coverage Stops

Coverage for dependents shall end when the dependent relationship with you ends or when your coverage under the Policy ends. When coverage for a dependent ends, the dependent will have an opportunity to obtain continuation of medical coverage as provided by the Consolidated Omnibus Budget Reconciliation Act.

4. Extension of Coverage for Dependents

(a) Under certain circumstances described below, coverage could continue for an Eligible Dependent after the time coverage would normally stop under the Policy.

(b) A child who is otherwise eligible and is physically or mentally incapable of self support upon attaining the limiting age may be continued under the coverage provided hereunder so long as he or she remains incapacitated and unmarried at that time subject to your coverage continuing in effect.

(c) To be eligible for the continued coverage described in this Section of a dependent child beyond the time coverage would normally end, proof of his or her incapacity must be submitted to CHI within 31 days after such dependent's attainment of the limiting age. Proof of the incapacity will be required from time to time to keep this coverage in effect. Each time CHI asks for proof that a covered dependent is incapacitated, CHI may require the covered dependent to have a

physician's examination at the covered person's expense. CHI may specify the physician.

(e) The continued coverage of a dependent child under this Section terminates on the earliest of the following dates:

(i) the date such child is no longer incapacitated;

(ii) the date proof of the child's incapacity is not provided when asked; or

(iii) the date your dependent's coverage otherwise terminates pursuant to the Policy.

ENROLLMENT CHANGES

Enrollment and benefit coverage under the Policy may be changed only upon a change in your family status.

A change of family status occurs when:

1. You get married or divorced;

2. Your child is born or legally adopted;

3. Your spouse or child dies; or

4. Your spouse has a loss of group insurance coverage.

GENERAL PROVISIONS
1. Notice of Claim

Written notice of claim must be furnished to the Company within 90 days after covered treatment has been rendered to the covered person. A notice of claim form may be obtained from CHI or the Policyholder. However, in case of a claim for which the Policy provides any periodic payment contingent upon continued provision of treatment, this notice may be furnished within 90 days after termination of each period for which the Company is liable. Failure to furnish the notice of claim within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give the notice of claim within 90 days, provided the notice of claim is furnished as soon as reasonably possible. However, except in the absence of legal capacity of the claimant, the notice of claim may not be furnished later than one year from the date when the notice of claim was originally required.

2. Time for Payment of Claim

Benefits payable under the Policy will be paid promptly upon receipt by CHI of satisfactory notice of claim, unless the Policy provides for periodic payment. Where the Policy provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory notice of claim.

3. Payment of Claims

All or any portion of any indemnities provided by the Policy on account of hospital, nursing, medical or surgical services may, at the Company's option, be paid directly to the hospital or other persons rendering such services; but it is not required that the service be rendered by a particular hospital or person. Any payment made by the Company in good faith pursuant to this provision will fully discharge the Company's obligation to the extent of the payment. The covered person may request that payments not be made pursuant to this provision. The request must be made in writing and must be given to the Company not later than the time of filing notice of claim. Payment made prior to receipt of the covered person's written request at the Company's principal executive office will be deemed to be payment made in good faith.

The covered person shall be responsible for the payment of ail charges for any service or supply in excess of the reasonable and customary charges or otherwise not covered by the Policy.

4. Choice of Physician

Each covered person has free choice of any physician, hospital or other provider.

5. Time Limit on Certain Defenses

No claim for loss incurred after one year from commencement of the individual covered person's insurance will be reduced or denied on the grounds that the disease or physical condition existed prior to the commencement of the covered person's insurance.

6. Incontestability

The validity of your insurance will not be contested, except for non-payment of premium, after your insurance under the Policy has been continuously in force for one year during his or her lifetime. No statement made by you relating to your insurability or that of your dependents will be used in defense to a claim under the Policy unless: (a) it is contained in a written application signed by you; and (b) a copy of the application has been furnished to you or your beneficiary.

7. Misstatements of Age

If the age of any covered person has been misstated, an equitable adjustment will be made in the premiums or, at the Company's discretion, the amount of insurance payable. Any premium adjustment will be based on the premium that would have been charged for the same coverage on a covered person of the same age and similar circumstances.

8. Physical Examination and Autopsy

The Company, at its own expense, will have the right and opportunity to examine a covered person, when and as often as may reasonably be required during the pendency of a claim under the Policy and to make an autopsy in case of death, where it is not forbidden by law.

9. Legal Action

No action at law or in equity may be brought to recover on the Policy unless and until the expiration of 60 days after notice of claim has been furnished to CHI. No such action may be brought after the expiration of three (3) years after the time notice of claim is required to be furnished.

10. Conformity With State Statutes

Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which it is issued, is deemed amended to conform to the minimum requirements of those statutes.

11. Assignment

No assignment of the Policy, or any part of it, will be binding on the Company unless approved in writing by the President or Executive Vice President of the Company. The Company does not assume any responsibility for the validity of any assignment.

12. Rights of Employees

Neither the Policy nor this Summary of Benefit constitutes a contract of employment and does not affect the right of the employer to discharge any employee.

13. Facility of Payment

If, in the opinion of the Company, a covered person is not competent to execute a valid release for payment of any benefit to which he is entitled under the Policy, the Company may, but shall not be required to, make payment to such individual(s) or institution(s) as have assumed the care and support of such covered person. In the event the covered person dies before payment is made to

him of all benefits to which he is entitled under the Policy, the Company may, but shall not be required to, make payment to such individual(s) or institution(s) as may be, in the opinion of the Company, equitably entitled thereto, including without limitation, individual(s) or institution(s) to which the covered person may have assigned such benefits prior to his death. Any payment made in accordance with the foregoing provisions shall fully discharge the Company to the extent of such payments.

14. Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of the provisions of the Policy, the Company may release to, or obtain from, any other plan or policy administrator, insurance company, or other organization or individual any information, concerning any individual, which the Company consider to be necessary for those purposes. Any individual claiming benefits under the Policy will furnish the information that may be necessary to implement the provisions.

SUBROGATION

If any benefit is provided to you under the Policy, CHI will be subrogated and succeed to your rights of recovery with respect to the services and supplies involved against a responsible third party and/or insurance company. Please see the Section entitled "Subrogation" under the Policy to review your rights and obligations in connection with CHl's subrogation rights.

COORDINATION OF BENEFITS

In addition to the Policy's benefits, the Policy has a Coordination of Benefits provision. The purpose of this provision is to conserve funds associated with health care. Coordination of Benefits is applicable only when you, your spouse or your dependent(s) are eligible for benefits under more than one group health plan.

When you receive health care services that are also covered under another plan, a determination is made as to which plan is "primary" and which plan is "secondary". The primary plan considers the services, without regard to the secondary plan. The secondary plan will then consider the balances on covered services according to its own limitations.

If the Policy is determined to be the secondary plan, CHI will not pay more than it would have had under the Policy there been no other coverage.

The primary plan will be determined in the following order:

1. If the other plan does not include a provision to coordinate benefits,

such plan will be the primary plan.

2. If the other plan does include a provision to coordinate benefits, then:

A. The plan covering the patient as the covered employee is the primary plan.

B. Except for situations where the parents of a child are separated or divorced, the plan of the parent whose date of birth occurs earlier in the policy year is the primary plan for that child. If both parents have the same birth date, the plan which covered the parent longer shall be primary.

Note: In the event this plan is coordinating with a plan that uses a rule based on the gender of the parent, benefits will be coordinated as follows:

Except for situations where the parents of a child are separated or divorced, the plan of the male parent is primary.

C. In those situations where the parents are separated or divorced, the primary plan is determined as follows:

1) the plan covering the parent with custody of the child is primary;

2) if the parent with custody of the child has remarried, the stepparent's plan will pay for covered services before the plan of the parent without custody; and

3) a court decree may determine the primary plan. You should advise your employer of any court decree.

D. When the determination cannot be made with the above rules, then the plan that has covered the patient for the longer period of time will be the primary plan, except:

- the plan which covers the patient as inactive employee (or a dependent of such a person) is the primary plan over a plan that covers a patient as a laid-off or retired person (or a dependent of such a person); and

- if either plan does not have this condition, then it does not apply and the plan which has been in effect the longer period of time is primary;

3. If services are provided under a governmental program for which the covered employee pays a periodic rate, that program is the primary plan, except when prohibited by law or when the covered employee elects Medicare as secondary coverage.

At its sole discretion, CHI may pay benefits first and determine liability later. If CHI pays first and it is determined that the Policy is the secondary plan, CHI has the right to recover the expense already paid in excess of its liability as the secondary plan. If the other health care plan is the primary plan, CHI may limit payment so that CHI will not pay more than the difference, if any, between the primary plan's payment and CHl's liability under the Policy. Benefits payable under another plan include benefits that would have been payable had the claim been duly made. When the Policy is determined to be primary, but payment was made by another plan, CHI has the right to reimburse the other plan, the amount which CHI determines is its liability.

CHI may release to or obtain from any person or organization any information about coverage, expenses and benefits which may be necessary to coordinate benefits. The covered employee on his/her own behalf and on behalf of their dependent(s) may be required to furnish information and to take such other action as is necessary to assure the rights of CHI.

MEDICARE

When a covered person is eligible for Medicare, that person must sign and deliver an election card to the Company, stating whom that covered person wants to be his primary insurer. If the covered person elects Medicare as his or her primary source of coverage and belongs to a group covered by the Policy covering twenty (20) persons or more, all Policy benefits otherwise payable to that covered person shall discontinue. If belonging to a covered group of less than twenty (20) persons, all Policy benefits otherwise payable with respect to the covered person will be reduced by any service or supply provided, or any benefits paid or payable, under Part A and Part B of Medicare.

For the purposes of this Section, benefits will be paid on the basis that the covered person is covered by both Part A and Part B of Medicare. If the covered person should not receive benefits under either Part A or Part B because of:

(a) failure to enroll when required;

(b) failure to pay any premiums that may be required for full coverage of the person under Medicare; or

(c) failure to file any written request or claim required for payment of Medicare benefits;

the Company will make determination of the total benefits that would have been payable under Medicare in the absence of this failure.

"Part A" means the "Hospital Insurance Benefits for the Aged" portion of Medicare.

"Part B" means the "Supplementary Medical Insurance for the Aged" portion of Medicare.

TERMINATION OF COVERAGE

Subject to certain exceptions:

- Your coverage under the Policy ends immediately when you leave the employment of the Policyholder. It also ends if such employee is no longer eligible under the Policy, the Policy is discontinued or, after a grace period, premiums are not paid.

- Coverage for your dependents end when they no longer meet the definition of dependents under the Policy or your coverage under the Policy terminates.

- If coverage under the Policy terminates and you want to continue your medical coverage and that of your eligible dependents, you may apply for continued coverage under COBRA or convert your coverage into an individual policy, as explained in Article IX of the Policy.

CLAIMS APPEAL PROCEDURE -

If your claim has been denied in whole or in part, you will be notified by CHI. This notice will set forth the reasons for such denial. If you wish to appeal this decision, you may write to the address which appears on the notice (to the attention of the person who signed the letter, if any).

It is important for you to understand the reasons for the denial of benefits in order to decide whether you want to appeal and request that the claim be reviewed again. You should examine this Summary of Benefits and the Policy, which are on file with your employer. The Policy is a legal document setting forth the full terms and conditions of your hospital and professional coverages and excluded services. You may also request a fuller explanation of the rejection decision by calling CHI.

You may appeal a denial of benefits within 30 days of the date of the rejection by sending a letter stating why you think your claim should not have been denied, including a copy of the denial letter and with any additional claim. Be

sure to include in your letter your Policy number, your Policyholder number, claim number, if any, your employer's name and the date of services for which benefits were denied. If you do not appeal within thirty (30) days, the denial will become final and incontestable.

Upon receipt of your letter and any additional information you provide, your records will be reviewed; and the results of this review will be sent to you promptly. In unusual cases, as when review of your claim requires examination by medical personnel, including consulting physicians, the review may be extended.

No legal action at law or equity may be brought to recover any benefits under the Policy unless and until the appeal process set forth above has been exhausted, and in no event prior to the expiration of 60 days after notice of claim has been furnished to CHI in accordance with the requirements of the Policy.

UNITED STATES HEALTH CARE SYSTEMS OF PENNSYLVANIA, INC.,
d/b/a THE HEALTH MAINTENANCE ORGANIZATION OF
PENNSYLVANIA d/b/a
U.S. HEALTHCARE

FLEX OPTION PLAN
DURABLE MEDICAL EQUIPMENT RIDER

United States Health Care Systems, Inc. d/b/a The Health Maintenance Organization of Pennsylvania, Inc. d.b.a. U.S. Healthcare ("HMO") and Contract Holder agree to offer to the HMO Members the following benefit subject to the provisions listed hereunder:

Durable medical equipment will be provided when medically necessary and required for therapeutic use as determined by HMO. The wide variety and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the HMO Medical Director must approve requests on a case-by-case basis. HMO reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.

Instruction and appropriate services required for the Member to properly use the item, such as attachment or insertion, is also covered. Replacement, repairs and maintenance not provided for under a manufacturer's warranty or purchase agreement coverage will be a covered benefit when it is functionally necessary and appropriate.

General guidelines considered are:

1. The device must be medically reasonable and necessary for the improvement of the patient's condition or must improve or supplement a bodily function.

2. If the equipment is other than standard (electric, motorized) the extra features of the equipment must be medically necessary.

3. The duration of medically necessary usage must be established, especially in those situations where the purchase of the item is relevant.

4. Item, device or equipment is primarily and customarily used to serve a medical purpose and generally considered to be safe and effective for the intended purpose.

5. Items generally not useful to a person in the absence of illness or injury.

Exclusions:

Air conditioners; Whirlpools; Portable Whirlpool Pump; Chair Lifts; Communication Aids; Elevators; False Teeth; Massage Devices; Overbed Tables; Sauna Bath; Telephone Alert Systems; Wigs (except where required by law). Experimental or investigational devices, items or equipment; Items that are not primary medical in nature.

Member is responsible for the following copayment, per item $0.

Maximum annual out-of-pocket limit $0.

UNITED STATES HEALTH CARE SYSTEMS OF PENNSYLVANIA, INC.,
dba THE HEALTH MAINTENANCE ORGANIZATION OF
PENNSYLVANIA dba
U.S. HEALTHCARE

FLEX OPTION PLAN
PRESCRIPTION PLAN RIDER

United States Health Care Systems of Pennsylvania, Inc., d/b/a The Health Maintenance Organization of Pennsylvania d/b/a U.S. Healthcare ("HMO") and Contract Holder agree to offer to the HMO Members the HMO Prescription Plan, subject to the following provisions:

SECTION I - DEFINITIONS is amended to include the following definitions:

Participating Pharmacy - a Pharmacy which has contracted with HMO to provide prescription services to Members.

Average Wholesale Price (AWP) - The published, average price of drugs, available through wholesale distributors per the Blue Book.

SECTION II - BENEFITS is amended to add the following provision:

I. Prescription drugs and medications, including insulin, when prescribed by a licensed Physician. Each prescription is limited to a maximum 34-day supply, with up to five (5) refills when authorized by a licensed Physician. Prescriptions must be filled at the Participating Pharmacy chosen by the Subscriber, in writing, on forms provided by HMO, in advance of enrollment in the HMO Prescription Plan. Except for under Option II.C.3. Generic pharmaceuticals may be substituted for brand name products, as provided by law, for prescriptions filled under this rider. There is a $10.00 Copayment, payable directly to the Participating Pharmacy for each prescription. This Copayment is not subject to the copayment limitation set forth in the Contract.

ADDITIONAL OPTIONAL BENEFITS

The following benefits/prescriptions are additionally covered as described above when the corresponding line is appropriately marked:

1. Oral Contraceptives

Exclusion IlI(a) is hereby deleted in its entirety.

2. Diabetic SuppIies

Diabetic Needles and Syringes.
Diabetic test agents, devices and ravage preparations.

Exclusions IlI(c) and (f) are hereby deleted as they relate to diabetic supplies only

3. Generic/Brand Name Prescriptions

When a generic alternative is available, Member will pay the higher copayment based on Member's decision to purchase a brand name prescription according to the following checked option. Member will not be subject to the higher copayment when a generic brand is not available.

___$2.50/$7.50; ___$5.00/$10.00; ___$10.00/$15.00;

___$15.00/$20.00.

SECTION II.G, EMERGENCY SERVICES is amended to add:

Emergency prescriptions out of area - If an emergency prescription is needed when the Member is located beyond a reasonable distance from his or her Participating Pharmacy, HMO will reimburse, subject to professional review, 75% of the cost of the prescription, less the Copayment.

SECTION III - EXCLUSIONS is amended to include the following provision:

32.(a) Oral contraceptives when used for the purpose of birth control;
(b) injectable except for insulin;
(c) needles and syringes including but not limited to diabetic needles and syringes;
(d) drugs which do not require a prescription even if a prescription is written;
(e) medical supplies, devices and equipment;
(f) test agents and devices including but not limited to diabetic tests agents and ravage preparations;
(g) drugs used for cosmetic purposes, including but not limited to Loniten (Minoxidil) compounded for hair growth;
(h) experimental and/or investigational drugs;
(i) drugs prescribed for uses other then uses approved by the FDA or other appropriate regulatory agency; and
(j) smoking cessation aids.

SECTION VIII - CONVERSION is amended to read:

Prescription Plan - The conversion privilege does not apply to the HMO Prescription Plan.

UNITED STATES HEALTH CARE SYSTEMS OF PENNSYLVANIA, INC.,
dba THE HEALTH MAINTENANCE ORGANIZATION OF
PENNSYLVANIA, INC. dba
U.S. HEALTHCARE

FLEX OPTION PLAN
LENS REIMBURSEMENT RIDER

Schedule lI.A.3.f. of this Contract is hereby amended to read:

United States Health Care Systems of Pennsylvania, Inc., d/b/a The Health

Maintenance Organization of Pennsylvania, Inc. dba U.S. Healthcare. ("HMO") and Contract Holder agree to offer to the HMO Members the following benefit subject to the following provisions:

f. Routine eye examinations and referral to Member's Participating Specialist Physician for appropriate vision care when necessary. Additionally, HMO will reimburse Member up to $35.00 for the purchase of prescription lenses and frames (including contact lenses). This allowance is payable once in a twenty-four (24) month period which commences with the Member's initial use date of this benefit.

CORPORATE HEALTH INSURANCE COMPANY
(A Minneapolis, Minnesota Domiciled Company)
Principal Executive Offices:
980 Jolly Road
Blue Bell, Pennsylvania 19422

COMPREHENSIVE MAJOR MEDICAL
GROUP HEALTH INSURANCE POLICY

NON-PARTICIPATING

This Comprehensive Major Medical Group Health Insurance Policy (the "Policy") is a legal contract between Corporate Health Insurance Company ("CHI" or the "Company") and the policyholder indicated on the Schedule of Benefits (the "Policyholder"), which is set forth in the Summary of Benefits distributed to each eligible employee of the Policyholder and incorporated herein by reference.

In consideration of a signed application and payment of the required premiums, the Company agrees to provide insurance for eligible employees of the Policyholder and their eligible dependents while such persons are covered under this Policy and arc insured for the applicable coverage. Benefits are subject to the terms, conditions, exclusions and limitations of this Policy. Certain identified benefits are subject to pre-certification requirements, which if not followed will result in reduced benefits.

This Policy takes effect 12 01 a.m. Eastern Standard Time on the Effective Date at the Policyholder's address.

Corporate Health Insurance Company has caused its President and Secretary to execute and witness this Policy.

/s/ /s/

Secretary President

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I. GENERAL INFORMATION

1. POLICY NUMBER: PA01-018927-001, PA05-018927-013, PA03-018927-028, PA09-018927-009, GN02-018927-002, NJ01-018927-025, GN01 -018927-003, GN03 -018927-004, NE01 -018927-005, NH01 -018927-007, MD01 -018927-008, MD02-018927-012, DC01-018927-009, RI01-018927-010, GA01-018927-011, VA01-018927-026

2. POLICYHOLDER NUMBER: As listed above

3. NAME AND ADDRESS OF POLICYHOLDER

STV Group
11 Robinson Street
P.O. Box 459
Pottstown, PA 19464

4. EMPLOYER IDENTIFICATION NUMBER (E.I.N.) ASSIGNED BY INTERNAL REVENUE SERVICE: NOT AVAILABLE

5. TYPE OF POLICY: Group Health Insurance Policy - Liberty Flex

6. THE NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE COMPANY:

CORPORATE HEALTH INSURANCE COMPANY
980 Jolly Road
P.O. Box 1109
Blue Bell, Pennsylvania 19422
1-800-204-2300

7. POLICY EFFECTIVE DATE: December 1, 1995

8. WAITING PERIOD: Full-Time Active Employees Working 30 Hours or More Per Week; Eligible for Benefits first of the - month following Date of Hire

II. ELIGIBILITY_

1. Covered Persons

This Policy will cover the following Covered Persons:

(i) all Eligible Employees of the Policyholder and its subsidiaries and affiliates specifically identified in writing by the Policyholder to the Company; and

(ii) their eligible Dependents.

2. Eligibility Date

The "Eligibility Date" for each Covered Person will be:

(i) if the Covered Person is an Eligible Employee, the later of the date of hire by the Policyholder (or, if applicable, the date on which the waiting period imposed by the Policyholder ends) and the Effective Date of this Policy; or

(ii) if the Covered Person is an Eligible Dependent, the later of the date of hire (or, if applicable, the date on which the waiting period imposed by the Policyholder ends) of the Eligible Employee to whom such Covered Person is a Dependent and the Effective Date of this Policy.

3. When Coverage Begins

(a) If an Eligible Employee enrolls on or before the Effective Date of

this Policy, coverage will begin under this Policy on the Effective Date for such Eligible Employee and any Eligible Dependents of such Employee identified as Covered Persons in the Policy Enrollment Form.

(b) If an Eligible Employee enrolls after the Effective Date of this Policy, coverage will begin on the first day of the calendar month after the Eligible Employee enrolls under this Policy.

(c) An Eligible Employee will be deemed to have enrolled under this Policy when the Eligible Employee has completed, signed and delivered a Policy Enrollment Form, identifying any Eligible Dependents as Covered Persons, to the Company and such Policy Enrollment Form has been accepted by the Company at its sole discretion.

(d) Should the Eligible Employee not be working full-time on the day he or she would ordinarily become covered under this Policy, the coverage for such Employee and any Eligible Dependents will be delayed until he or she returns to full-time work.

(e) Limitation: Each Eligible Employee will have 31 days from his or her Eligibility Date to enroll for coverage. No Evidence of Good Health will be required for any Eligible Employee enrolling within such 31 days. All Eligible Employees enrolling after such 31 days will be required to submit Evidence of Good Health for his or herself and for each Eligible Dependent. If such Employee fails to provide Evidence of Good Health satisfactory to the Company, the Company may reject the Employee's enrollment application for insurance under this Policy. Coverage under this Policy for enrollees after such 31 days who provides satisfactory Evidence of Good Health will begin no earlier than the first day of the calendar month after CHl's approval of Evidence of Good Health.

(f) For purpose of this Article only, each Eligible Employee who enrolls under this Policy during any designated open enrollment period of the Policyholder shall be deemed and treated as a new employee of the Policyholder.

4. Return to Work After Voluntary Termination of Employment

If an Eligible Employee returns to active full-time employment with the Policyholder at any time following voluntary termination of employment with the Policyholder, the waiting period described herein for new Employees will apply, unless the Eligible Employee returns within 12 months after the date of the voluntary termination.

5. Dependent Coverage

(a) A Covered Employee's spouse and a Covered Person's dependent children can also be covered under the Policy pursuant to the terms hereof.

(b) The Covered Employee's spouse is eligible for dependent coverage unless:

(i) The Covered Employee and his or her spouse are legally separated or divorced or have obtained an annulment;

(ii) Both the Covered Employee and his or her spouse are employees of the Policyholder. The Covered Employee and his or her spouse may choose to be covered as individual employees of the Policyholder, or one may cover the other as a Dependent, but both of them may not cover the other as a Dependent;

(iii) Such spouse is in active Military Service;

(iv) Such spouse is of the same sex; or

(v) Such spouse is not a legal spouse, under the laws of the Commonwealth of Pennsylvania.

(c) The Covered Person's natural or legally adopted child is eligible from birth so long as the child is:

(i) Less than age 23, or if a full-time student, less than age 23;

(ii) Not married; and

(iii) Not on active duty in any of the armed forces.

(d) Child/children under legal guardianship (including foster children) or children under court order will be included under this Policy under the same conditions and restrictions applicable to a Covered Person's natural or legally adopted children.

(e) The Covered Employee's spouse and child/rep meeting the requirements described above are referred to in this Policy as "Eligible Dependents."

6. Enrolling the Eligible Employee's Eligible Dependents

(a) The Eligible Employee can enroll for family coverage at the same time he or she becomes eligible for his or her individual coverage.

(b) If the Eligible Employee has no Dependents when the Eligible Employee first enrolls but later gains one, the Eligible Employee may enroll for family coverage within 31 days of the date the Eligible Employee gains the Dependent. This includes Dependents gained by marriage, birth adoption, legal guardianship or court order. During the first 31 days after the birth of a child, the child will be automatically covered for all eligible benefits. For coverage of a child beyond the first 31 days after birth and for coverage of a spouse during and beyond the first 31 days after marriage, enrollment must be made and the first premium charge for that Dependent must be paid within that 31 day period.

(c) Note: Except for newborn child's coverage during the first 31 days after birth. if the Eligible Employee does not enroll his or her Dependents within 31 days after the Dependent becomes eligible, satisfactory Evidence of Good Health for each Dependent will be required. If satisfactory Evidence of Good Health is not provided for such Dependent, the Company may reject the enrollment application for insurance of such Dependent under this Policy. Coverage for such Dependent providing satisfactory Evidence of Good Health will then begin no earlier than the first day of the calendar month following CHI's approval of the Evidence of Good Health. However, no Evidence of Good Health will be required for any Dependent who enrolls within such 31 days.

(d) If a Dependent, except a child covered at birth, is confined for medical care or treatment in any institution or at home when coverage would normally start, the Dependent will not be covered until given a final release by a Physician from all such confinement.

7. When Dependent Coverage Stops

Except as otherwise specifically provided in this Policy, coverage for Dependents shall end when the dependent relationship with the Eligible Employee ends or when coverage for the Eligible Employee of whom such person is a Dependent ends. When coverage for a Dependent ends, the Dependent will have an opportunity to obtain continuation of medical coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA). For more information on COBRA and the right to continued medical coverage, see Section 1 of Article IX of this Policy.

8. Extension of Coverage for Dependents

(a) Under certain circumstances described below, coverage could continue for an Eligible Dependent after the time coverage would normally stop under this Policy.

(b) A child who is otherwise eligible hereunder and is physically or mentally incapable of self support upon attaining the limiting age may be continued under the coverage provided hereunder so long as he or she remains incapacitated and unmarried at that time, subject to the coverage of the Covered Employee to whom such child is dependent is continuing in effect.

(c) To be eligible for the continued coverage described in this Section of a Dependent child beyond the time coverage would normally end, proof of his or her incapacity must be submitted to CHI within 31 days after such Dependent's attainment of the limiting age. Proof of the incapacity will be required from time to time to keep this coverage in effect. Each time CHI asks for proof that a Covered Dependent is incapacitated, CHI may require the Covered Dependent to have a Physician's examination at the Covered Person's expense. CHI may specify the Physician.

(d) The continued coverage of a dependent child under this Section shall terminate on the earliest of the following dates:

(i) the date such child is no longer incapacitated according to the Policy;

(ii) the date proof of the child's incapacity is not provided when asked; or

(iii) the date his or her Dependent's coverage terminates pursuant to Article II, Section 7 or Article XIII of this Policy.

III. ENROLLMENT CHANGES

Enrollment and benefit coverage under this Policy may be changed only upon a change in family status of the Covered Employee.

A "change of family status" occurs when:

1. A Covered Employee gets married or divorced;

2. A Covered Employee's child is born or legally adopted;

3. A Covered Employee's spouse or child dies; or

4. A Covered Employee's spouse has a loss of group insurance coverage.

Unless otherwise permitted under Article II, a Covered Employee may change his or her benefit coverage or enroll new Dependents only if Evidence of Good Health

has been submitted and approved by CHI for each individual involved.

Furthermore, if a Dependent of a Covered Employee, other than a newborn child, is confined in a Hospital, Skilled Nursing Facility, at home or any other institution on the date coverage would become effective, then such coverage will be postponed until the day after the Dependent is no longer so confined and a final release from such confinement is provided by the Physician.

IV. POLICY BENEFITS AND PAYMENTS

If, as a result of an illness or injury, a Covered Person incurs eligible medical expenses which exceed the Deductible Amount set forth in the Schedule of Benefits during a calendar year, the Company will pay for such excess in accordance with the co-payment and co-insurance provisions of the Schedule of Benefits, subject to all other terms and conditions set forth in this Policy.

1. Deductible Amount

The Deductible Amount is the specified amount of eligible expenses which a Covered Person or a Family Unit (as the case may be) is required to pay before CHI pays any benefits under this Policy. Covered expenses which are used in satisfying the Deductible Amount must be incurred and applied to such deductible within the applicable calendar year.

The Deductible Amount applies to each Covered Person, subject to any family Deductible Amount set forth in the Schedule of Benefits, if applicable. The Deductible Amount must be satisfied once each calendar year, except for:

(a) the Common Accident Provision: if the Deductible Amount applies to accident expenses and if two or more members of one family incur covered expenses because of disabilities resulting from injuries

sustained in any one accident, the Deductible Amount will be applied only once with respect to all covered expenses incurred as a result of the accident; and

(b) the Carryover Provision: if any part or all of the Deductible Amount has been satisfied during the last three months of such calendar year, the Deductible Amount for the next calendar year will be reduced by the amount applied.

The Deductible Amount is not applicable to certain eligible medical expenses noted in the Schedule of Benefits, for which you or your family member need to pay any Deductible Amount prior to being paid benefits under the Policy.

2. Co-Payment and Co-Insurance

After the applicable Deductible Amount has been paid by the Covered Person or the Family Unit (as the case may be), the eligible expenses for Covered Medical Services will be paid by CHI and the Covered Persons in accordance with the co-payment and co-insurance provisions set forth in the Schedule of Benefits. Certain Covered Medical Services will be subject to co-insurance provisions, which require the payment obligations in excess of the Deductible Amount to be shared between CHI and the Covered Person in accordance with percentages of Reasonable and Customary Charges set forth in the Schedule of Benefits. Certain other Covered Medical Services will be subject to co-payment provisions, which require an initial sum specified in the Schedule of Benefits to be paid by the Covered Person and the balance of Reasonable and Customary Charges to be paid by CHI.

Certain Covered Medical Services specified in the Schedule of Benefits may not be subject to co-insurance or copayment requirements.

3. Out-of-Pocket Maximum

During any calendar year, the Covered Person or the Family Unit (as the case may be) will not be required to pay an aggregate amount in excess of the out-of-pocket maximum amount specified in the Schedule of Benefits (the "Out-of-Pocket Amount"). If during any calendar year the Covered Person or the Family Unit (as the case may be) has paid pursuant to the above co-insurance or co-payment provision an aggregate amount greater than the Out-of-Pocket Amount, CHI will pay for 100% of the balance of the eligible expenses, up to the amount of the maximum benefit amounts set forth in the Schedule of Benefits.

The co-insurance and co-payments paid by the Covered Person or the Family Unit will be included in the Out-of-Pocket Amount. However, the Deductible Amount paid by the Covered Person or the Family Unit will not be included in the Out-of-Pocket Amount.

4. Maximum Benefits

The benefits payable under this Policy for all eligible medical expenses incurred by any Covered Person shall not exceed the applicable maximum benefits specified in the Schedule of Benefits. Such maximum benefits may be in the form of a maximum amount payable during lifetime or a specified period or in the form of a maximum number of days or visits for which benefits are payable under the Policy. Different Covered Medical Services may be subject to one or more different maximum benefits.

5. Restoration and Reinstatement

If a Covered Person has received his or her maximum benefits under the Policy,

then on the first day of each calendar year $1,000 shall be reinstated, but in no event shall the reinstated amount exceed the applicable maximum benefits set forth in the Schedule of Benefits. However, any Covered Person who wishes immediate reinstatement of the full Policy maximum shall again be entitled to receive full benefits by submitting Evidence of Good Health at his or her own expense. The new maximum benefits will take effect on the first day of the month

following CHI's approval at its sole discretion of Evidence of Good Health. This restoration and reinstatement provision will not apply to certain Covered Medical Services, as specified in the Schedule of Benefits.

6. Re-Entry Into Policy

Any person who was formerly covered under the Policy, either as an Eligible Employee or as a Dependent, and who again becomes covered hereunder within a one-year period from the termination date of his or her previous coverage, either as an employee or as a Dependent, shall not have his or her full maximum benefits restored solely by reason of the fact that s/he has become covered for a second or subsequent time. The maximum benefits with respect to such person, as set forth in the Schedule of Benefits, shall be reduced by any benefits previously paid under this Policy.

V. PRE-CERTIFICATION

When a Physician recommends that a Covered Person be hospitalized or receive certain other medical services or supplies specified in the Schedule of Benefits, there are certain procedures that must be followed.

The Covered Person, a member of his or her family, a hospital staff member, or the attending Physician, must notify CHI to pre-certify the admission or treatment, as the case may be, prior to receiving any of the services or supplies that require pre-certification pursuant to the Schedule of Benefits or this Policy.

The Company will reduce the benefits payable under this Policy by the percentage set forth in the Schedule of Benefits if the procedures for pre-certification set forth herein are not followed. Each Covered Person will be responsible to pay the unpaid balance of the benefits.

To obtain pre-certification, call CHI at 1-800-541-3149. This call must be made:

1. Prior to any planned admission into Hospital and prior to receiving such other eligible services or supplies that require

pre-certification according to the Schedule of Benefits or this Policy;

2. Within 24 hours after the time of an emergency admission or as soon thereafter as reasonably possible; and

3. As soon as the attending Physician confirms that a Covered Person is pregnant and again within 24 hours of the birth or as soon thereafter as reasonably possible.

When calling CHI, the caller must provide:

1. The Covered Person's name and the Covered Person's social security number;

2. The treating Physician's name, address and phone number;

3. The name of the Hospital or treatment facility and the anticipated admission or treatment date; and

4. The Policyholder's name and Policyholder Policy Number.

There is no requirement to call in advance before seeking treatment for an emergency.

Large Case Management

Certain medical conditions for which a claim is made under the Policy may be referred to Large Case Management (LCM).

Only those conditions for which Covered Medical Expenses are expected to exceed a certain dollar amount, and for which there is a potential lower cost treatment alternative, will be referred to LCM.

LCM is a program which provides a case-by-case analysis and medical treatment plan suggestions that address the need of catastrophically ill or injured individuals. It concentrates on severe injuries and illnesses, such as spinal cord injuries or head trauma, when early intervention and individual case management will prove effective to a patient's recovery.

The decision to refer any case to LCM will remain with CHI, who will rely on the criteria established by the LCM service provider to determine which claims are recommended for LCM, except that no alternative treatment will be provided to the Covered Person under LCM without prior consent of the Covered Person and the

attending Physician.

In certain instances a recommendation to use alternative treatment not normally covered by the Policy may be made when such treatment endorses quality care, Medical Necessity and cost effectiveness. Under these circumstances, any such alternative treatment will be covered by the Policy.

VI. COVERED MEDICAL SERVICES

Subject to the terms, conditions, exclusions and limitations set forth in the Schedule of Benefits (including the copayment, co-insurance and maximum benefit amounts set forth therein) and in this Policy, the Company will pay and provide to each Covered Person the benefits described below.

This Policy does not cover charges in excess of Reasonable and Customary Charges (as defined herein) and does not provide benefits for service" or supplies other than those Medically Necessary (as defined herein). Therefore, the term "charges" used below shall refer only to Reasonable and Customary Charges for Medically Necessary services or supplies. The coverage under this Policy is also subject to other exclusions set forth in Article VII of this Policy.

Acupuncture

The charges for the administration of acupuncture when provided for pain management in lieu of anesthesia.

Alcoholism and Drug Addiction Treatment

For alcoholism and drug addiction treatment, please refer to "Substance Abuse Treatment" below.

Ambulance Transportation

The charges for ambulance service. Coverage is limited to transportation to and from the nearest facility that can give necessary care and treatment.

Ambulatory Surgery

The charges for services and supplies furnished in connection with performance of a surgical procedure at an Ambulatory Surgical Facility or the outpatient department of a Hospital.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-541-3149 prior to treatment. The Company will reduce the benefits under this Policy by the percentage or dollars (as the cage may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Limitations/Exceptions

Coverage is limited to charges for the following:

1. Services and supplies furnished by the Ambulatory Surgical Facility or Hospital on the date of the procedure;

2. Services of the operating Physician for performing the procedure and for:

   a. Related pre- and post-operative care; and

   b. The administering of an anesthetic; and

3. Services of any other Physician for the administering of a general anesthetic.

This Policy does not cover Ambulatory Surgery charges incurred:

(a) For the services of a Physician who renders technical assistance: to the operating Physician, unless required in connection with the procedure; or

(b) While the Covered Person is confined as a full-time Inpatient in a Hospital.

Anesthesia

The charges for the administration of anesthetics by a Physician (other than the surgeon, assistant surgeon or the attending Physician) or registered nurse anesthetist (R.N.A.).

Assistant Surgeon

The charges for the professional services of a legally qualified Physician to render technical assistance to the operating surgeon when Medically Necessary in connection with a surgical procedure performed. However, no benefits are payable for surgical assistance rendered in hospitals where it is routinely available as a service provided by a hospital intern, resident or house officer. The assistant surgeon's charges are determined by using the surgeon's Reasonable and Customary Charges.

Birthing Center

The charges for services and supplies furnished by a Birthing Center for:

1. Prenatal care;

2. Delivery of a child or children; and

3. Post-partum care rendered within twenty-four (24) hours after the delivery.

Also included are charges for the services shown below if received in connection with the above services and supplies furnished by the Birthing Center:

1. Charges by the operating Physician or certified nurse midwife for:

   a. Performing an obstetrical procedure;

   b. Related pre- and post-operative care; and

   c. Administering an anesthetic.

2. Charges by any other Physician for the administering of a general anesthetic.

Limitations/Exclusions

This Policy does not cover Birthing Center charges incurred:

1. For the services of a Physician or certified nurse midwife who renders technical assistance to the operating Physician; or

2. For which pregnancy-related expenses are not covered under this Policy.

Blood and Blood Plasma

The charges for blood and blood plasma, and blood plasma expanders when not replaced on behalf of the Covered Person.

Cardiac Rehabilitation Services

The charges for cardiac rehabilitation therapy rendered by a licensed therapist, when prescribed by and provided under the supervision of the attending Physician.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-541-3149 prior to receiving services. The Company will reduce the benefits under this Policy by

the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Chemotherapy

The charges for the treatment of malignant disease by chemical or biological antineoplastic agents for cancer chemotherapy and cancer hormone treatments and for services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer, whether performed in a Physician's office, as an Inpatient or Out-Patient at a Hospital, or in any other medically appropriate treatment setting.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-541-3149 prior to treatment. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Chiropractic Care

The charges for detection and correction by manual means of structural imbalance or subluxation resulting from or related to distortion, misalignment or subluxation of or in the vertical column.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-541-3149 prior to treatment. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Consultation

The charges for consultation services by a Professional Provider, provided that the consultation services are given to the Covered Person at the request of the attending Physician while confined as an Inpatient in a Hospital, a Skilled Nursing Facility or a Substance Abuse Treatment Facility.

Consultation consists of an examination of the Covered Person and a review of his or her x-ray and laboratory examinations and medical history, but not staff consultations required by hospital rules and regulations.

Diagnostic Services

The charges for Diagnostic Services.

Durable Medical Equipment

The charges for rental or initial purchase (or necessary repair) of Durable Medical Equipment prescribed by a Physician for the treatment of an Illness or Injury. It does not include any changes made to the Covered Person's home, automobile, or personal property, such as air conditioning or remodeling. Rental coverage is limited to the purchase price of the Durable Medical Equipment.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-541-3149 prior to leasing or purchasing any equipment in excess of $1,500. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Emergency Services

The charges for Emergency Services received within 48 hours after the onset of a Medical Emergency. Surgery (e.g., suturing, burn care, fracture care, etc.) payment will be made as a surgical benefit.

After being admitted into a facility for Emergence Services, CHI must be notified at 1-800-541-3149 within 24 hours of the admission or as soon as reasonably possible. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for such notification are not followed.

Hemodialysis

The charges for hemodialysis treatment.

Home Health Services

The charges for Home Health Services provided by a licensed Home Health Agency pursuant to a Home Health Plan.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-541-3149, and CHI must approve the Home Health Plan, prior receiving Home Health Services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Limitations/Exclusions
Coverage is limited to one visit per day. Each period of up to four (4) hours or less will be considered one visit, and each visit by a Home Health Agency is counted as one visit.

Hospice Care

The charges for Hospice Services if the attending Physician certifies that the Covered Person is a Terminally Ill Person and recommends admission into a Hospice Care Program.

To qualify for payment under the Policy, Hospice Services must be:

1. Provided while the Terminally Ill Person is a Covered Person;

2. Provided within six (6) months of the Terminally Ill Person's entry or re-entry (after a remission period) in the Hospice Care Program; and

3. Furnished or arranged by a Hospice.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1-800-541-3149, and CHI must approve the Hospice Care Program, prior receiving Hospice Services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Limitations/Exclusions
Coverage is limited to one or more of the following charges:

1. For the confinement of a Terminally Ill Person as an Inpatient in a Hospice facility;

2. For Home Health Services furnished to the Terminally Ill Person in the person's home;

3. For social services furnished to the Terminally Ill Person or to the Family Unit by a Social Worker;

4. For palliative care (medication/treatment directed toward relief); or

5. For respite care.

Hospital

The charges for Out-Patient services and supplies, and the following Inpatient charges when a Covered Person is confined in a Hospital:

1. Room and board and general nursing care charges for semi-private accommodations (designated as such by the Hospital) or, if the Covered

Person utilizes private accommodations because the Covered Person's medical condition requires isolation for his or her health and the attending Physician orders such private accommodations, charges for private accommodations; and

2. Charges for all other hospital services and supplies, including special meals and dietary services, medicines, laboratory tests, use of operating rooms and special equipment, anesthetics and x-rays, provided and billed by hospital.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-541-3149 prior to hospital admission as an Inpatient. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Limitations/Exclusions
The Policy does not cover hospital charges for any day that the Covered Person does not receive any medical treatment after being admitted to a Hospital.

Immunization for Children

The charges for child immunization, up to the minimum benefits mandated by the Pennsylvania Department of Health.

Coverage will be provided for those child immunizations, including the immunizing agents, which as determined by the Department of Health, conform to the standards of the U.S. Department of Health and Human Services. These benefits will be exempt from Deductible Amounts and other dollar limits.

Infertility Services

The charges for services to diagnose infertility. Services to treat infertility are not covered by this Policy.

Inpatient Physician Services

The charges for medical treatment given by the attending Physician to a Covered Person while confined as an Inpatient in a Hospital or Skilled Nursing Facility.

Limitations/Exclusions

Inpatient Physician services coverage does not include charges for:

1. Surgical services;
2. Diagnostic Services;
3. Maternity services;
4. Any therapy;
5. For psychiatric treatment; or
6. Treatment rendered to a Covered Person who has exceeded the maximum number of days of confinement or the maximum benefit amount for Inpatient Physician services, as set forth in the Schedule of Benefits.

Mammography

The charges for female Covered Person's expenses for mammography services, up to one routine mammography every calendar year if the Covered Person is age 40 or older. In addition, any mammography recommended by a Physician.

Maternity-Related Care

The charges for female Covered Person's expenses incurred as a result of pregnancy, miscarriages and Medically Necessary and elective abortions. Life threatening abortions will be covered as any other surgery.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must notify CHI at 1 800-541-3149 as soon as pregnancy is confirmed and within 24 hours after birth of a child or as soon thereafter as reasonably possible.

Mental or Nervous Disorders

For coverage of mental or nervous disorder, please refer to "Psychiatric Treatment" below.

Newborn Baby Care

The charges for care of newborn children, including Hospital charges for nursery room and board and miscellaneous expenses.

Occupational Therapy

The charges for occupational therapy rendered by a licensed therapist for Illnesses and Injuries of the Covered Person.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-541-3149 prior to treatment. The Company will reduce the benefit under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Limitations/Exclusions
Coverage is limited only to treatment for up to such number of days per incident of Illness or Injury set forth in the Schedule of Benefits, beginning with the first day of treatment.

Office Visits

The charges for diagnosis or treatment of any Injury or Illness at a Physician's office.

Organ Transplants

The charges for services which are directly and specifically related to organ transplant when performed at a Hospital. Where the Covered Person is the recipient, coverage hereunder includes the hospitalization of donors, and for those hospital services directly and specifically related to the transplantation of the organ to the Covered Person, to the extent that the Covered Person (recipient) would be entitled to such benefits and the donor is not otherwise insured or covered by another health care plan.

The purchase price of the organ is not covered under this Policy. Coverage under this Policy is limited to organ transplants meeting the following requirements:

1. The attending Physician certifies that the organ transplant is Medically Necessary;

2. The covered Person must be the recipient; and

3. The transplant is accepted by the general medical community at the time of the procedure as appropriate treatment for the specific conditions of the Covered Person.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-541-3149 prior to treatment. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Oxygen

The charges for oxygen and the rental equipment for its administration when prescribed by the attending Physician.

Papanicolaou Smear (Pap Smear)

The charges for a female Covered Person's expenses for a routine pap smear in accordance with the recommendations of the American College of Obstetricians and

Gynecologists.

Physical Therapy

The charges for physical therapy rendered by a licensed therapist for Illnesses and Injuries of the Covered Person.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-541-3149 prior to receiving services The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Preventive Care

The charges for an annual gynecological examination, including a pelvic examination and clinical breast examination by a Physician.

The charges for immunizations (other than immunization for children covered elsewhere in this Policy) and physical examinations (other than papanicolaou smears and mammography covered elsewhere in this Policy) by a Physician, subject to the limitations set forth in the Schedule of Benefits.

Private Duty Nursing

The charges for private duty professional nursing services from a L.P.N. or R.N. for a Covered Person's non-hospitalized acute-illness or injury

Private duty nursing care furnished for Custodial Care is not covered.

The Covered Person, a member of his or her family, a hospital member; but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-541-3149 prior to receiving services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Psychiatric Treatment

The charges for the following Inpatient and Out-Patient services for a Covered Person for the treatment of a Mental Illness.

Inpatient: The hospital services and supplies provided to a Covered Person for

the treatment of a Mental Illness while confined as an Inpatient at a Hospital or a Psychiatric Hospital.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1 800-541-3149 prior to admission. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Out-Patient: The following Out-Patient services for the treatment of a Mental Illness rendered by a licensed psychiatrist, psychologist, psychotherapist or psychiatric Social Worker at a Mental Health Treatment Facility:

1. Oral and written diagnostic tests;

2. Consultation visits;

3. Diagnostic visits;

4. Physician's personal treatment visits; and

5. Group therapy.

Radiation Therapy

The charges for the treatment of any Illness or Injury by x-ray (but not dental x-rays, unless directly related to a Covered Medical Service), gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes, including the cost of radioactive materials.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-541-3149 prior to receiving services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Reconstructive/Corrective Surgery

The charges for reconstructive surgery if such surgery is required to:

1. To restore normal functions of a body part (other than a tooth or structure that supports the teeth) which is malformed as a result of a birth defect or as a direct result of Illness or Injury or surgery performed to treat an Illness; or

2. Repair an Injury which occurs while the person is covered under this Policy. Surgery must be performed in the calendar year of the accident which causes the Injury or in the next calendar year.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-541-3149 prior to receiving surgery. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Reconstructive surgery coverage does not include Cosmetic Surgery.

Respiratory Therapy

The charges for respiratory therapy rendered by a licensed therapist for Illnesses and injuries of the Covered Person.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1 800-541-3149 prior to receiving services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Skilled Nursing Facility

The charges listed below when a Covered Person is confined as an Inpatient in a Skilled Nursing Facility while recovering from an Illness or Injury. Coverage is limited to services and supplies furnished while the Covered Person is under continuous care of his or her Physician, requires 24-hour nursing care and the confinement in a Skilled Nursing Facility is required by his or her Physician:

1. Room and board and general nursing care charges for semi-private accommodations (designated as such by the Hospital) or, if the Covered Person utilizes private accommodations because the Covered Person's medical condition requires isolation for his or her health and the attending Physician orders such private accommodations, charges for private accommodations; and

2. Charges for all other skilled nursing services and supplies, including special meals and dietary services and medicines.

Skilled Nursing Facility care coverage does not include Custodial Care.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must obtain pre-certification by CHI at 1-800-541-3149 prior to admission. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

The charges for speech therapy rendered by a qualified speech therapist to restore or rehabilitate any speech loss or impairment caused by Injury or Illness, a previous speech therapeutic process, or as a result of surgery for an Injury or Illness.

The Covered Person, a member of his or her family, a hospital staff member, but preferably the attending physician, must obtain pre-certification by CHI at 1-800-541-3149 prior to receiving services. The Company will reduce the benefits under this Policy by the percentage or dollars (as the case may be) set forth in the Schedule of Benefits if the procedures for pre-certification are not followed.

Substance Abuse Treatment (including Alcoholism and Drug Addition)

The charges for the following Inpatient and Out-Patient services to treat Substance Abuse or Dependency, subject to the limitations set forth below and any additional limitations set forth in the Schedule of Benefits:

1. Out-Patient Care: Covered Medical Services include the following Out-Patient services in a Substance Abuse Treatment Facility for treatment for medical conditions resulting from the Substance Abuse or Dependency: (1) Physician, psychologist, nurse, certified addictions counselor and trained staff services; (2) rehabilitation therapy and counseling; (3) family counseling and intervention; (4) psychiatric, psychological and medical laboratory tests; and (5) drugs, medicines, equipment use and supplies.

   Each Covered Person is eligible for thirty (30) Out-Patient full visits per calendar year. Each Covered Person is also eligible for thirty (30) additional Out-Patient full visits or equivalent partial visits per calendar year at a Substance Abuse Treatment Facility, which may be exchanged on a two-for-one basis for up to fifteen (15) non-hospital, residential alcohol or drug treatment days described in Paragraph 3 below. Treatment for Substance Abuse or Dependency shall be provided according to an individualized treatment plan, subject to a lifetime limit of one hundred and twenty (120) Out-Patient full visits or equivalent partial visits.

2. Inpatient Detoxification: Covered Medical Services include the following Inpatient services at a Hospital or a Substance Abuse

Treatment Facility for detoxification and treatment for medical conditions resulting from the Substance Abuse or Dependency: (1) lodging and dietary services; (2) Physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

Each Covered Person is eligible for seven (7) Inpatient days of per calendar year, subject to a lifetime limit of four (4) separate such admissions. Inpatient rehabilitation beyond detoxification in the Hospital is not covered hereunder.

3. Inpatient Rehabilitation: Covered Medical Services include the following Non-Hospital Substance Abuse Residential Facility care: (1) lodging and dietary services; (2) Physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) rehabilitation therapy and counseling; (4) family counseling and intervention; (5) psychiatric, psychological and medical laboratory tests; and (6) drugs, medicines, equipment use and supplies.

   Each Covered Person is eligible for thirty (30) days per calendar year for such residential treatment in a Non-Hospital Substance Abuse Residential Facility, subject to a lifetime limit of ninety (90) days of such services.

4. Court-ordered chemical dependency admissions are covered but only to the extent of the covered benefits described above.

In the case of Paragraph 2 or 3 above, the Covered Person, a member of his or her family, a hospital staff member, but preferably the attending Physician, must submit to CHI prior to treatment a certificate from a Physician that the Covered Person is suffering from Substance Abuse or Dependency and needs treatment.

Voluntary Sterilization

The charges for male or female voluntary sterilization procedures. The Policy will not cover reversal procedures.

VII GENERAL EXCLUSIONS

This Policy Does Not Cover Charges, Expenses or Costs:

1. For services or supplies not Medically Necessary for the diagnosis or treatment of an Illness or Injury.

2. Which exceeds the Reasonable and Customary Charges or exceeds the maximum benefit amounts set forth in the Schedule of Benefits.

3. Caused by war (declared or undeclared) or any act of war.

4. Suffered while on full-time active duty in the armed forces of any country or international authority.

5. Incurred in connection with any injury or illness which is compensable under any workers' compensation or occupational disease act or law or the federal Longshoreman's and Harbor Worker's Compensation Act.

6. For services received in a veteran's administration hospital, a public health service hospital, or any facility operated by the U.S. government or any of its agencies, except to the extent that there is an unconditional requirement to pay those charges.

7. For medical and dental care received by retirees from armed forces or their dependents pursuant to and covered by programs established under federal law.

8. For the treatment of or care for mental retardation, defects and deficiency, except that this exclusion does not apply to Mental Illnesses specifically covered in Article VI.

9. For dental services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth and gums, including but not limited to apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, and dental implants, except for accidental injuries to sound natural teeth.

10. For optical services: The Policy does not cover charges for examinations to determine the need for (or change of) eyeglasses or lenses of any type except initial replacements for loss of the natural lens, eye surgery such as radial keratotomy when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), or exams for the correction of vision and radial keratotomy eye surgery to improve visual acuity.

11. For services rendered by the Covered Person or his or her Close Relative.

12. For medical services or supplies not prescribed or rendered by a Physician.

13. Directly related to attempted suicide or an intentionally self-inflicted injury (whether sane or insane).

14. For provision or replacement of the following items arch supports; elastic hose; birth control devices including, but not limited, to IUDs, diaphragms and condoms; false teeth; braces; traction apparatus; canes; walkers; corrective shoes; corsets; wigs or cranial prosthesis; diapers; special appliances, supplies or equipment. This exclusion does not apply to Durable Medical Equipment specifically covered by Article VI.

15. For Custodial Care.

16. For Cosmetic Surgery, except reconstructive surgery specifically covered by Article VI.

17. Resulting from the commission of or attempt to commit a felony by the Covered Person.

18. For personal convenience items or services such as telephones, barber services, meals, formulas, radio and television rentals, homemaker services and other like items and services.

19. Applied toward satisfaction of the Deductible Amount or the co-payment or co-insurance amount payable by the Covered Person.

20. For blood, blood plasma and blood products that are replaced on behalf of the Covered Person.

21. For actual or attempted impregnation or fertilization which involves either a Covered Person or a surrogate as a donor or a recipient.

22. For examinations, adjustment of, or purchase of a hearing aid.

23. For career and pastoral counseling.

24. For services or supplies of an Educational, Experimental or Investigative nature.
This exclusion includes, but is not limited to:
- All phases of clinical trials.
- All treatment protocols based upon or similar to those used in clinical trials.
- Drugs approved by the Federal Food and Drug Administration under its
- Treatment Investigatory New Drug regulation or equivalent.

- Federally approved drugs used for treatment indications not generally recognized by the medical community.

25. For the reversal of any sterilization procedure or any related care.

26. For sex transformations or other transsexual surgery or related services not necessitated by an Injury or Illness covered by this Policy.

27. For services rendered for academic reasons.

28. For orthoptic therapy (vision exercises).

29. For Prescription Drugs, except that this exclusion does not apply to Prescription Drugs provided during treatment of an Illness or Injury while confined as an Inpatient.

30. For weight reduction programs and gastric stapling for treatment of obesity.

31. Infertility services, including but not limited to, In-Vitro fertilization procedures, Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian transfer (ZIFT) and other similar or related services; and infertility injectables or other infertility-related supplies.

32. For bereavement counseling services, except as specifically provided for under the Hospice Services in Article Vl.

33. For treatment of temporomandibular joint dysfunction with/intra oral devices or any other method to alter vertical dimension.

34. For hypnosis not used as an integral part of a Covered Medical Service covered under Article VI.

35. For telephone consultations, failure to keep a scheduled visit, or completion of a claim form.

36. For any services or supplies not specifically described herein.

37. For services or supplies covered by any automobile insurance policy up to the amount of coverage limitation under such policy.

38. For orthotic devices.

The Company shall determine whether a service or supply is covered under this Policy or excluded from coverage under this Policy.

VIII. GENERAL PROVISIONS

1. Notice of Claim

Written notice of claim must be furnished to the Company within 90 days after Covered Medical Services have been rendered to the Covered Person. A notice of claim form may be obtained from CHI or the Policyholder. However, in case of a claim for which the Policy provides any periodic payment contingent upon continued provision of Covered Medical Services, this notice may be furnished within 90 days after termination of each period for which the Company is liable. Failure to furnish the notice of claim within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give the notice of claim within 90 days, provided the notice of claim is furnished as soon as reasonably possible. However, except in the absence of legal capacity of the claimant, the notice of claim may not be furnished later than one year from the date when the notice of claim was originally required.

2. Time for Payment of Claim

Benefits payable under the Policy will be paid promptly upon receipt by CHI of satisfactory notice of claim, unless the Policy provides for periodic payment. Where the Policy provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory notice of claim.

3. Payment of Claims

All or any portion of any indemnities provided by the Policy on account of hospital, nursing, medical or surgical services may, at the Company's option, be paid directly to the hospital or other persons rendering such services; but it is not required that the service be rendered by a particular hospital or person. Any payment made by the Company in good faith pursuant to this provision will fully discharge the Company's obligation to the extent of the payment. The Covered Person may request that payments not be made pursuant to this provision. The request must be made in writing and must be given to the Company not later than the time of filing notice of claim. Payment made prior to receipt of the Covered Person's written request at the Company's principal executive office will be deemed to be payment made in good faith.

The Covered Person shall be responsible for the payment of all charges for any service or supply in excess of the Reasonable and Customary Charges or otherwise not covered by this Policy.

4. Renew and Appeal Procedures

If a Covered Person is denied coverage for a procedure during the pre-certification process described in Article V, the Covered Person will be advised of the reason(s) for the denial and of his or her right to a prompt review by a person who did not participate in the denial decision.

If a review is requested, in addition to reviewing the reasons for the denial, CHI may discuss the case with the treating Physician in an effort to agree on care that would be covered under the Policy.

If the review does not result in a satisfactory resolution, the Covered Person will receive a written notice explaining the reason(s) for the denial.

Appeals of Denied Claims or Other Denials

If a Covered Person is denied coverage for a claim or denied coverage for a procedure during pre-certification process, the Covered Person will be advised in writing of the reason(s) for the denial. This notice will set forth the reasons for such denial. If the Covered Person wishes to appeal this decision, the Covered Person may write to the address which appears on the notice (to the attention of the person who signed the letter, if any).

The Covered Person may appeal a denial of benefits within 30 days of the date of the rejection by sending a letter stating why the Covered Person thinks the claim should not have been denied, including a copy of the denial letter and with any additional claim. The Policyholder number, claim number, if any, and the date of service for which benefits were denied must be included will become final and incontestable.

Upon receipt of the letter and any additional information the Covered Person provides, the Covered Person's records will be reviewed; and the results of this review will be sent to the Covered Person promptly. In unusual cases, as when review of the claim or denial of coverage requires examination by medical personnel, including consulting physicians, the review may be extended.

5. Choice of Physician

Each Covered Person has free choice of any Physician, Hospital or other provider.

6. Time Limit on Certain Defenses

No claim for loss incurred after one year from commencement of the individual Covered Person's insurance will be reduced or denied on the grounds that the disease or physical condition existed prior to the commencement of the Covered Person's insurance.

7. Contract

The entire contract between the Company and the Policyholder consists of the Policy, the Summary of Benefits and the applications of the Policyholder and each Covered Employee. All statement contained in the applications will, in the absence of fraud, be deemed representations and not warranties. No statement made by an applicant for insurance will be used to void the insurance or reduce the benefits, unless contained in a written application and signed by the applicant. No agent has the authority to make or modify the Policy, or to extend the time for payment of premiums, or to waive any of the Company's rights or requirements.

No modification of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by an executive officer of the Company and delivered to the Policyholder.

8. Incontestability

The validity of a Covered Person's insurance will not be contested, except for non-payment of premium, after his or her insurance under the Policy has been continuously in force for one year during his or her lifetime. No statement

made by a Covered Employee relating to his or her insurability or that of his or her Dependents will be used in defense to a claim under the Policy unless: (a) it is contained in a written application signed by the Covered Employee; and (b) a copy of the application has been furnished to the Covered Employee or to his or her beneficiary.

9. Misstatements of Age

If the age of any Covered Person has been misstated, an equitable adjustment will be made in the premiums or, at the Company's discretion, the amount of insurance payable. Any premium adjustment will be based on the premium that would have been charged for the same coverage on a Covered Person of the same age and similar circumstances.

10. Physical Examination and Autopsy

The Company, at its own expense, will have the right and opportunity to examine

a Covered Person, when and as often as may reasonably be required during the pendency of a claim under the Policy and to make an autopsy in case of death, where it is not forbidden by law.

11. Legal Action

No action at law or in equity may be brought to recover on the Policy unless and until the expiration of 60 days after notice of claim has been furnished to CHI in accordance with the requirements of this Policy. No such action may be brought after the expiration of three (3) years after the time notice of claim is required to be furnished.

12. Conformity With State Statutes

Any provision of the Policy which, on its Effective Date, is in conflict with the statutes of the state in which it is issued, is hereby amended to conform to the minimum requirements of those statutes.

13. Assignment

No assignment of the Policy, or any part of it, will be binding on the Company unless approved in writing by the President or Executive Vice President of the Company. The Company does not assume any responsibility for the validity of any assignment.

14. Rights of Employees

This Policy does not provide any benefit not specifically described herein. This Policy does not constitute a contract of employment and does not affect the right of the employer to discharge any Employee.

15. Facility of Payment

If, in the opinion of the Company, a Covered Person is not competent to execute a valid release for payment of any benefit to which he is entitled under this Policy, the Company may, but shall not be required to, make payment to such individual(s) or institution(s) as have assumed the care and support of such Covered Person. In the event the Covered Person dies before payment is made to him of all benefits to which he is entitled under the Policy, the Company may, but shall not be required to, make payment to such individual(s) or institution(s) as may be, in the opinion of the Company, equitably entitled thereto, including without limitation, individual(s) or institution(s) to which the Covered Person may have assigned such benefits prior to his death. Any payment made in accordance with the foregoing provisions shall fully discharge the Company to the extent of such payments.

16. Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of the provisions of the Policy, the Company may release to, or obtain from, any other plan or policy administrator, insurance company, or other organization or individual any information, concerning any individual, which the Company consider to be necessary for those purposes. Any individual claiming benefits under this Policy will furnish the information that may be necessary to implement the provisions.

17. Deductible Amounts

For each Covered Medical Expense, the individual Deductible Amount stated in the Schedule of Benefits must be incurred with respect to a Covered Person before benefits become payable. If, during a calendar year, such deductibles are equal to the family Deductible Amount shown in the Schedule of Benefits, no further deductible amount shall apply with respect to any remaining expenses incurred by members of that Family Unit during the remainder of that calendar year.

18. Incorporation of Summary of Benefits

The Summary of Benefits is hereby incorporated in and made a part of this Policy.

IX. CONTINUATION OF COVERAGE

1. Consolidated Omnibus Budget Reconciliation Act of 1985, As Amended ("COBRA")

Upon timely notice from the Employer, CHI will make available continuation coverage, as required by COBRA, for all Covered Persons determined to be qualified beneficiaries, as defined in Subsection 162(k)(7)(B) of the Internal Revenue Code, as amended from time to time, and Subsection 607(3) of the Employee Retirement Income Security Act (ERISA), as amended from time to time. The Employer shall retain full responsibility for notifying Covered Persons of their rights to continuation coverage and administering the exercise of continuation rights, as required by COBRA. CHI shall have no obligation to ensure that any notices received from the Employer comply with the requirements of COBRA. For purposes of COBRA, CHI is not the plan administrator.

A. Each Covered Employee has a right to continue coverage if:

1. Employment with the Employer ends for a reason other than gross misconduct; or

2. Work hours are reduced which result in a loss of coverage.

B. Each Covered Dependent has a right to continue coverage if:

1. The Covered Employee's employment with the Employer ends for a reason other that gross misconduct;

2. The Covered Employee's work hours are reduced;

3. The Covered Employee dies;

4. In the case of the Covered Employee's spouse, when such spouse ceases to be an Eligible Dependent as a result of divorce or legal separation;

5. The Covered Employee becomes entitled to Medicare; or

6. In the case of a Dependent child, when such child no longer satisfies the eligibility requirements for coverage as an Eligible Dependent under this Agreement.

Similar rights may apply to certain retirees and their dependents if the employer commences certain bankruptcy proceedings and these individuals lose coverage.

Under COBRA, the Covered Employee or a family member has the responsibility to inform the Employer of a divorce, legal separation, or a child losing dependent status under the Employer's health plan within 60 days of the later of the date of the event or the date on which coverage would end under the plan because of the event. The Employer has the responsibility to notify the Employer of the Covered Employee's death, termination of employment, reduction in hours or Medicare entitlement.

When the Employer is notified that one of these events has happened, the Employer will in turn notify the qualified beneficiary within 14 days of the notification that he/she has the right to choose continuation coverage. The qualified beneficiary has at least 60 days from such notification or the qualifying event, whichever date is later, to inform the Employer of his or her decision to elect continued coverage. The qualified beneficiary will then have

45 days after notifying the Employer of his or her decision to pay the retroactive premium.

In the case of the Covered Employee's termination of employment or reduction in work hours, the coverage may be continued for up to 18 months. The 18 months of coverage may be extended to 36 months if one of the other events described in Part B above occurs to a dependent within the initial 18 months of coverage. The qualifying events listed in Part B, other than B(1) and B(2), will entitle the dependents for up to 36 months of continuation coverage. The 18 months may also be extended to 29 months if an individual is determined to have been disabled for Social Security disability purposes at the time of the initial qualifying event and the Employer is notified of the disability of the Social Security Administrator determination within 60 days of its disability determination. The affected individual must also notify the Employer within 30 days of any final determination that the individual is no longer disabled.

However, coverage will cease earlier if one of the following events occurs:

1. The Employer ceases to provide any group health insurance to any of its employees;

2. The qualified beneficiary fails to make timely payments of any premium required;

3. The qualified beneficiary is covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition that the qualified beneficiary may have.

4. The qualified beneficiary is entitled to benefits under Medicare; or

5. The qualified beneficiary extended coverage for up to 29 months due to a disability and there has been a final determination that the qualified beneficiary is no longer disabled.

2. Employee Conversion Option

When a Covered Employee's coverage under this Policy terminates for reasons other than failure to make the required premium contributions, the benefits may be converted to an individual policy (the "Converted Policy.) issued by the Company.

This conversion privilege is available:

(a) to an Eligible Employee if s/he has been continuously insured under this Policy for at last three (3) months immediately prior to the termination;

(b) to an Eligible Dependent spouse if the coverage terminates because of his or her spouse/Employee's death, or because of divorce or annulment of marriage; and

(c) to an Eligible Dependent child if the coverage terminates because of the Eligible Dependent's age or because of the death of his or her parent/Covered Employee.

The conversion privilege is not available to any Covered Person if:

(i) if the Covered Person is, or is eligible to be, within 31 days of termination of coverage under this Policy, covered for similar benefits by: (1) another group plan, medical service subscriber contract, medical practice or other prepayment plan, or (2) any governmental program;

(ii) if issuing the Converted Policy to the Covered Person would result in over-insurance, as determined by CHI; or

(iii) if coverage under the Policy terminated because any required premium contribution was not paid when due.

Application and payment of the first premium under the Converted Policy must be made to the Company within 31 days immediately following termination of coverage under this Policy.

If continuation of coverage as described above is elected, this conversion option will apply at the end of the maximum continuation period under this Policy.

The Converted Policy will be issued as follows:

(A) The Covered Policy will in the form CHI has them available for conversion which is most similar to the coverage being converted. The coverage under the Converted Policy may be different from the coverage provided under this Policy;

(B) The Converted Policy may exclude any condition for which the Covered Person was not covered under this Policy, provided a 12-month period has not elapsed from the original Effective Date of this Policy; and

(C) The premium payable for the Converted Policy will be based on the CHI's rate then applicable to the class of risk to which the Covered Person belongs, the age of the Covered Person, and the form and amount of coverage provided, on the effective date of the Converted Policy.

If the Covered Employee and one or more of his Dependents were covered by the Policy, the Converted Policy must cover all previously insured Covered Persons who are eligible for conversion coverage. The Company may, at its option, issue a separate Covered Policy to cover any Dependent.

3. Extension of Benefits Upon Termination of Policy

Except as set forth below, if the Covered Person is an Inpatient on the day coverage under this Policy terminates, the benefits of coverage under this Policy shall be provided until the earlier of:

A. the date on which the maximum amount of benefits under this Policy has been paid; or

B. the date on which the Inpatient stay ends; or

C. the 90th day after the date of termination.

If this Policy is terminated because the Employer participates in or obtains medical coverage under a health benefit plan or arrangement made available by another organization, the liability of CHI shall cease as of the date of such termination, and no benefits will be provided for any services or supplies provided after such date.

X. COORDINATION OF BENEFITS

All benefits provided under this Policy are subject to this Article, and will not be increased by virtue of this Article.

1. Definitions

In addition to the Definitions set forth in Article XV of this Policy, the following definitions only apply to this Article:

a. "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:

(1) group, blanket or franchise insurance coverage;
(2) service plan contracts, group practice, individual practice and other prepayment coverage;
(3) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; or
(4) any coverage under governmental programs, and any coverage required or provided by any statute.

The term "Plan" shall exclude any school accident-type coverages or group or

group-type hospital indemnity benefits of S100 per day or less.

b. "Dependent" means, for any Plan, any person who qualifies as a Dependent under that Plan.

c. "Allowable Benefits" means the eligible charges for Covered Medical Services under this Policy.

d. "Benefits Paid or Payable" means the amounts actually paid for Covered Medical Services.

2. Effect on Benefits

a. This Article shall apply in determining the benefits of this Policy if, for Covered Medical Services received, the sum of the Benefits Payable under this Policy and the Benefits Payable under other Plans would exceed the Allowable Benefits.

b. Except as provided in Subsection c. of this Section 2, the Benefits Payable under this Policy for Covered Medical Services will be reduced so that the sum of the reduced benefits and the Benefits Payable for Covered Medical Services under other Plans does not exceed the total of Allowable Benefits.

c. If: (1) the other Plan contains a provision coordinating its benefits with those of this Policy and its rules require the benefits of this Policy to be determined first, and (2) the rules set forth in Subsection e. of this Section 2 require the benefits of this Policy to be determined first, then the benefits of the other Plan will be ignored in determining the benefits under this Policy.

d. If the other Plan does not include a coordination of benefits provision, such Plan will be primary.

e. If the other Plan does include a coordination of benefits provision:

(1) The Plan covering the patient other than as a Dependent will be primary.

(2) Where both Plans cover the patient as a dependent child, the Plan covering the patient as a dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in a calendar year shall be the primary Plan. But, if both parents have the same birthday,

the Plan which covered the parent longer will be the primary Plan. If the parents are separated or divorced, the following will apply:

(a) The Plan which covers the child as a Dependent of the parent with custody will be the primary Plan.

(b) If the parent with custody has remarried, the Plan which covers the child as a Dependent of the stepparent with custody will determine its benefits before the Plan covering the child as a Dependent of the parent without custody.

(c) Where there is a court decree which establishes financial responsibility for the health care expenses of the dependent child, the Plan which covers the child as a Dependent of the parent with such financial responsibility will be the primary Plan as long as the Plan of that parent has actual knowledge-of the court decree.

(d) If the specific terms of the court decree state that the parents shall 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 shall follow the order of benefit determination rules outlined in the first paragraph of 2. e. 2).

In the event CHI is coordinating with a Plan that uses the male/female rule regarding dependent children, the introductory paragraph of this clause (2) shall be replaced with to the following introductory paragraph:

Where both Plans cover the patient as a dependent child, the Plan covering the patient as a dependent child of a male will be the primary Plan, except that if the parents are separated or divorced, the following will apply:

(3) Where the determination cannot be made in accordance with. clause (1) or (2) above, the Plan which has covered the patient for the longer period of time will be the primary Plan; provided that,

(a) the benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the Dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee as a Dependent of such person; and

(b) if either Plan does not have a provision regarding laid-off or retired employees, and, as a result, the benefits of each plan are determined after the other, then the provisions of

clause (3)(a) above shall not apply.

f. Services provided under any governmental program for which any periodic payment of rate is made by the Covered Person shall always be the primary Plan, except when prohibited by law, or when the Covered Person has elected Medicare secondary.

3. Facility of Payment

Whenever payments should have been made under this Policy in accordance with this Article, but the payments have been made under any other Plan, CHI has the right to pay to any organization that has made such payment any amount it determines to be warranted to satisfy the intent of this Article. Amounts so paid shall be deemed to be Benefits Paid under this Policy and to the extent of the payments for Covered Medical Services, CHI shall be fully discharged from liability under this Policy.

4. Right of Recovery

a. Whenever payments have been made by CHI for Covered Medical Services in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, irrespective of to whom paid, CHI shall have the right to recover the excess from among the following, as CHI shall determine: any person to or for whom such payments were made, any insurance company, or any other organization.

b. The Covered Employee, personally and on behalf of his or her Covered Dependents shall, upon request, execute and deliver such documents as may be required and do whatever else is reasonably necessary to secure CHI's rights to recover the excess payments.

5. CHI shall not be required to determine the existence of any Plan or amount of Benefits Payable under any Plan except this Policy, and the payment of benefits under this Policy shall be affected by the Benefits Payable under any and all other Plans only to the extent that CHI is furnished with information relative to such other Plans by the Employer or Covered Person or any other insurance company or organization or person.

6. When the benefits are reduced under the primary Plan because a Covered Person does not comply with the Plan articles, or does not maximize benefits available under the primary Plan, the amount of such reduction will not be considered an Allowable Benefit. Examples of such provisions are those related to second surgical opinions and pre-certification of admissions and services.

7. CHI may, without the consent or notice to any person, release to or obtain from any other insurance company, or other organization or person, any information, with respect to any Covered Person which CHI deems necessary to determine the applicability of, and implement the terms of, this Article, or any similar provision of any other Plan. Any person claiming benefits under this Policy will furnish to CHI any information necessary to implement this Article.

XI. MEDICARE

When a Covered Person is eligible for Medicare, that person must sign and deliver an election card to the Company, stating whom that Covered Person wants to be his primary insurer. If the Covered Person elects Medicare as his primary source of coverage and belongs to a group covered by the Policy covering twenty (20) persons or more, all Policy benefits otherwise payable to that Covered Person shall discontinue. If belonging to a covered group of less than twenty (20) persons, all Policy benefits otherwise payable with respect to the Covered Person will be reduced by any service or supply provided, or any benefits paid or payable, under Part A and Part B of Medicare.

For the purposes of this Article, benefits will be paid on the basis that the Covered Person is covered by both Part A and Part B of Medicare. If the Covered Person should not receive benefits under either Part A or Part B because of:

(a) failure to enroll when required;

(b) failure to pay any premiums that may be required for full coverage of the person under Medicare; or

(c) failure to file any written request or claim required for payment of Medicare benefits;

the Company will make determination of the total benefits that would have been payable under Medicare in the absence of this failure.

"Part A" means the "Hospital Insurance Benefits for the Aged" portion of Medicare.

"Part B" means the "Supplementary Medical Insurance for the Aged" portion of Medicare.

XII. SUBROGATION

In the event of any payment under the Policy, the Company will, to the extent of the payment under the Policy, be subrogated to all the rights of recovery of the Covered Person arising out of the acts or omissions of any person or organization. The Covered Person hereby agrees to reimburse the Company for any benefits paid hereunder, out of any moneys recovered from any person or organization as the result of judgment, settlement or otherwise. After any benefits under this Policy are paid by the Company, the Covered Person also agrees to execute and deliver all necessary instruments and to furnish such information and such reasonable assistance as may be required to facilitate enforcement of its rights hereunder. In the event the Company recovers an amount greater than the benefit paid, the excess, will be paid to the Covered Person. The Covered Person shall do nothing after loss to prejudice these rights. This Article will not apply, however, to a recovery obtained by any Covered Person from any insurance company on a policy under which the Covered Person is entitled to indemnity as a named insured person or an insured Dependent of a named person. For purposes of this Article only, "Covered Person" will include anyone receiving payment under the Policy, either directly or indirectly.

This Article does not pertain to medical malpractice insurance pursuant to Pennsylvania Law, Chapter 4, Article VI, Section 602 (40 P.S. Section 1301.602), and is limited for Pennsylvania No-Fault Insurance pursuant to Pennsylvania Law Chapter 4, Article VI(J), Section III(4) (40 P.S. Section 1009. 111), as now constituted or later amended.

The Subrogation rights under this Article shall be enforced only to the extent and at those times permitted by law and shall not be enforceable to the extent prohibited by any Pennsylvania statute or regulation.

XII. POLICYHOLDER/EMPLOYER PROVISIONS

Premiums

1. The premiums for this Policy shall be based upon the administrative requirements of CHI and the cost of Covered Medical Services and shall be payable in advance according to the mode of payment agreed upon. At the end of the first calendar year or at any time thereafter, the premiums for this Policy may be readjusted by CHI based upon the experience under the Policy.

2. The Employer is solely responsible for the payment of premiums with respect to its Covered Employees and their Covered Dependents. Payment shall be made directly to CHI.

3. The first premium will be the sum of the individual premiums determined by applying the premium rates, shown in the initial schedule of premium rates, to the amount of insurance then in force at the respective ages of the Covered Persons insured on the Effective Date of the Policy. The premium for each successive month will be the sum of the individual premiums determined by applying the premium rates then in effect to the amount of insurance then in force at the respective ages of the Covered Persons insured on the premium due date.

4. The premium rates will be guaranteed for the first twelve (12) months following the issuance of the Policy. CHI reserves the right to change, after such guaranteed period, the premium rates by written notice to the Policyholder at least thirty (30) days prior to the date of the change.

5. Any change in premium rates necessitated by an amendment of the Policy will be effective on the effective date of the amendment. If the effective date of the amendment is any day other than the premium due date, then a pro rata premium adjustment will be made to the applicable month.

6. There will be no premium adjustment for Covered Person who may be added or terminated between premium due dates. If notice of a Covered Person's termination received by CHI more than thirty (30) days after their termination, any unearned premium will be credited only from the first premium due date prior to the receipt of such notice. This provision will not extend the Covered Person's insurance beyond the termination date.

Grace Period

If the Policyholder has not previously given written notice to CHI that the Policy is to be discontinued, the grace period of thirty one (31) days will be granted to the Policyholder for payment of every premium after the first premium. During the grace period, the Policy will continue in force, unless prior to the date payment was due the Policyholder gave timely written notice to CHI that the Agreement is to be canceled. If the premiums are not paid within the grace period, the Policy will be discontinued, but the Policyholder will still be liable to CHI for all unpaid premiums, including the premiums for the grace period. If during the grace period CHI receives written notice from the Policyholder that the Policy is to be discontinued, the Policy will be discontinued on the date notice is received, but the Policyholder will still be liable to CHI for the payment of all premiums then unpaid, together

with a pro rata premium for the period commencing with the date on which the last premium became due and ending with the date of receipt of written notice by CHI.

Term of Policy and Right to Terminate

This Policy is issued for an indefinite term, commencing on the Effective Date shown on the face page. The Policy continues in force, so long as premiums are paid when due, until terminated in accordance with the terms of this Policy.

The Policyholder may terminate the Policy by giving written notice to CHI. Termination by the Policyholder will be effective on the latter of: (a) the day specified in the notice; or (b) the day the notice is received by CHI. CHI may terminate any or all insurance under the Policy, as of any premium due date, by giving written notice to the Policyholder at least thirty (30) days prior to

that date.

Notice

Written notice to the Policyholder will be deemed to be effective on the date it is placed in the United States mail, postage prepaid and properly addressed to the principal place of business of the Policyholder. Notice will be deemed to be properly addressed if it reflects the last address provided to CHI by the Policyholder.

Individual Certificates

CHI will issue a Summary of Benefits, describing the insurance protection to which each Covered Person is entitled and to whom payable. Copies of the Summary of Benefits will be issued to the Policyholder for delivery to each Covered Employee.

Registry

The Policyholder shall furnish CHI with:

(a) the names of all individuals initially eligible for insurance or who later become eligible for insurance under the Policy, even if they do not become insured;

(b) the names of all Covered Persons who become insured or whose insurance terminates, together with the respective date; and

(c) any information required to initiate, maintain or terminate coverage on each Eligible Person.

CHI will have the right, at reasonable times, to inspect all books and records of the Policyholder which relate to the insurance under the Policy.

XIV. DEFINITIONS

For the purposes of this Policy, unless the context clearly indicates otherwise, the following words and phrases have the following meanings. The following words and phrases are not intended to imply that coverage for them is provided under this Policy.

Ambulatory Surgical Facility - A specialized facility licensed, where required, to render surgical procedures on an Out-Patient basis, which has an organized staff of Physicians, has been approved by the Joint

Commission on Accreditation of Health Care Organizations, the Accreditation Association for Ambulatory Healthcare, Inc., or CHI, and which:

1. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Out-Patient basis;

2. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;

3. does not provide Inpatient accommodations;

4. provides the full-time services of one or more RNs for patient care in the operating rooms and in the post-anesthesia recovery room; and

5. provides at least one operating room and at least one post-anesthesia recovery room; is equipped to perform diagnostic x-ray and laboratory examinations; and has available trained personnel and necessary equipment to handle foreseeable emergencies;

6. maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require post-operative confinement; and

7. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

Birthing Center - A free-standing facility licensed, where required, to provide maternity care, which:

1. Is organized and staffed to provide prenatal care, delivery and immediate post-partum care;

2. Is directed by at least one Physician who is a specialist in obstetrics and gynecology;

3. Has a Physician or certified nurse midwife present at all births and during the immediate post-partum period;

4. Has at least two (2) beds or two (2) birthing rooms for use by patients while in labor and during delivery;

5. Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear;

6. Accepts only patients with low risk pregnancies; and

7. Has a written agreement with a Hospital in the area for emergency transfer of a patient or a child.

CloseRelative - The Covered Person, his or her spouse, a child, brother,

sister, or parent of the Covered Person or his or her spouse.

Company - Corporate Health Insurance Company, a Minnesota corporation, and its successor, if any.

Co-payment - The flat, fixed-dollar amount which shall be payable by a Covered Person pursuant to this Policy to a provider of services or supplies, regardless of, but not in excess of, the charge for such services or supplies, such amount to be set forth in the Schedule of Benefits with respect to applicable Covered Medical Service.

Cosmetic Surgery - Any surgery not Medically Necessary, including, without limitation, ear piercing, rhinoplasty or lipectomy, except cosmetic surgery resulting from the complication of such Cosmetic Surgery.

Covered Dependent - Any Eligible Dependent whose coverage became effective and has not terminated.

Covered Employee - Any Eligible Employee whose coverage became effective and has not terminated.

Covered Person - Any Eligible Employee or Eligible Dependent whose coverage became effective and has not terminated.

Covered Medical Services - Those services and supplies which are Medically Necessary and are otherwise covered by this Policy and for which charges are Reasonable and Customary.

Custodial Care - Any type of care that does not require the skills of technical or professional personnel or are not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility Care. Custodial Care includes, but is not limited to:

- Help in walking, getting into or out of bed, bathing, dressing, eating and other functions of daily living of a similar nature;
- General supervision of exercise programs including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services;
- Bowel training and management;
- General safety/health precautions and preventive procedures such as turning to prevent bedsores; and

o Providing patient recreation and/or companionship.

Deductible Amount - The amount of charges for Covered Medical Services a Covered Person must incur and pay during the calendar year under this Policy. The Deductible Amount will differ depending upon whether the Covered Person is covered under an individual coverage or a family coverage. If covered under an individual coverage, the Covered Person must pay the Deductible Amount for "individual," as set forth in the Schedule of Benefits, before becoming entitled to benefits under the Policy. If covered under a family coverage, the Covered Person and his or her Family Unit must pay the Deductible Amount for "family," as set forth in the Schedule of Benefits, before becoming entitled to benefits under the Policy.

Dentist - Licensed Doctor of Dental Surgery or Doctor of Dental Medicine.

Dependent - Includes a spouse or child, whether by birth or adoption, of an Eligible Employee.

Detoxification - The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in

combination with drugs, as determined by a licensed Physician, while keeping the physiological risk to the patient at a reasonable minimum.

Diagnostic Services - the following procedures prescribed by a Professional Provider because of specific symptoms to determine a definite condition or disease. Diagnostic Services include, but are not limited to:

A. diagnostic radiology, consisting of x-ray, ultrasound and nuclear medicine;

B. diagnostic pathology, consisting of laboratory and pathology tests;

C. diagnostic medical procedures, consisting of ECG, EEG, and other diagnostic medical procedures; and

D. allergy testing consisting of percutaneous, intracutaneous and patch tests.

Durable Medical Equipment - Equipment prescribed by the attending Physician which is:

- Not primarily and customarily used for non-medical purposes;
- Designed for prolonged use; and

- For a specific therapeutic purpose in the treatment of an Illness or Injury.

Durable Medical Equipment includes, but are not limited to, prosthetic appliances and orthopedic braces.

Educational - a service or supply the primary purpose of which is to provide the Covered Person with any of the following training in the activities of daily living: instruction in scholastic skills such as reading and writing; preparation for occupation; or treatment for learning disabilities.

Eligible Dependent - Any Eligible Employee's Dependent who satisfies the eligibility requirements of Article I.

Eligible Employee - Any active employee full-time of the Policyholder who regularly works at least 30 hours per week and otherwise satisfies the eligibility requirements of Article I.

Emergency Services - Medical services required for the initial treatment of a Medical Emergency. These services shall not include treatment for occupational injury for which benefits are covered under workers' compensation law or similar occupational disease law. The condition of the Covered Person must be of sufficient severity to warrant immediate attention.

Employer - The Policyholder.

Evidence of Good Health - A statement from an Eligible Employee or an Eligible Dependent attesting to the "good health" of such person or his or her Eligible Dependents. A standard form available from the Policyholder's human resources department will be provided for this purpose. The Eligible Employee or the Eligible Dependent is responsible for any and all related costs.

Experimental or Investigative - the use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the general medical community does not accept as standard medical treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which approval has not been granted at the time the services were rendered.

Family Unit - A Covered Employee and his or her Covered Dependents.

Home Health Agency - Any organization certified as a home health agency under the Medicare law or otherwise approved by CHI for the delivery of non-Physician patient care in the home of a Covered Person.

Home Health Plan - A program for care and treatment of a Covered Person established and approved in writing by such Covered Person's attending Physician, together with such Physician's certification that the proper treatment of the Injury or Illness would require confinement as a resident Inpatient in a Hospital or confinement in a Skilled Nursing Facility the absence of services and supplies provided as part of the Home Health Plan.

Home Health Services - Those items and services defined as "home health services" in the Medicare law and set forth in 42 CFR Part 417.101 et seq.

Hospice - A facility which is licensed as such, where required, and provides short periods of stay for a Terminally Ill Person in a home-like setting for either direct care or respite care. This facility may be either free-standing or affiliated with a Hospital. It must operate as an integral pan of the Hospice Care Program.

Hospice Care Program - A formal program directed by a Physician to help care for a Terminally Ill Person. This may be through either:

o A centrally-administrated, medically directed and nurse coordinated program which

  - Provides a coherent system primarily of home care; and
  - Is available 24 hours a day, seven (7) days a week; or

o Confinement in a Hospice.

The program must meet standards set by the National Hospice Organization and approved by CHI. If such a program is required by a state to be licensed, certified, or registered, it must also satisfy such requirement.

Hospice Services - Services and supplies furnished or arranged by a Hospice to a Terminally Ill Person.

Hospital - An institution accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association or under Medicare Law, or as otherwise determined by CHI as meeting reasonable standards, which:

1. is a duly licensed, where required, and

2. is primarily engaged in providing Inpatient-diagnostic and surgical and therapeutic services for the diagnosis, treatment and care of injured or ill persons by or under the supervision of Physicians, and

3. provides 24-hour nursing service by or under the supervision of Registered Nurses; and

4. is not a Skilled Nursing Facility, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the treatment of Mental Illness,

place for the treatment of Substance Abuse or Dependency, Hospice, rehabilitation center, or place for the treatment of pulmonary tuberculosis.

Illness - Sickness or disease which requires medical service or supply covered by this Policy.

Injury - Bodily harm which results from an accident and which requires medical service or supply covered by the Policy.

Inpatient - A person who is admitted to a Hospital, a Psychiatric Hospital, a Skilled Nursing Facility or a Substance Abuse Treatment Facility and incurs room and board charges.

L.P.N. - A full-time licensed practical nurse, other than a Close Relative, who is recognized by the state in which care is given as qualified to perform limited nursing functions.

Medical Emergency - a sudden, unexpected onset of a medical condition manifesting itself by acute symptoms or a traumatic bodily injury resulting from an accident, which is of sufficient severity that the absence of immediate medical attention could reasonably result in:

1. Death of the Covered Person;
2. Serious harm the Covered Person's health; or
3. Serious or permanent impairment to bodily functions or any bodily organ or part.

The non-availability of a private Physician or the fact that the Physician may refer the Covered Person to the emergency room does not, by itself, constitute a Medical Emergency. Medical Emergencies include, but are not limited to:.

(a) uncontrolled or excessive bleeding;
(b) suspected heart attack;
(c) inability to breath;
(d) appendicitis;
(e) serious burns;
(f) poisoning;
(g) severe pain and suffering; and
(h) convulsion or unconsciousness

Medically Necessary - Medical service or supply which is provided by a Professional Provider for the diagnosis or the direct care and treatment of a Covered Person's Injury or Illness and which is:

1. Appropriate for the symptoms and diagnosis or treatment of the Covered Person's Injury or Illness; and

2. In accordance with current standards of good medical practice.

Confinement as an Inpatient in a Hospital or other facility is considered Medically Necessary when the Covered Person needs to be confined because of the nature of the services being delivered the Covered Person or when treatment for his or her condition cannot be given safely and adequately if performed on an Out-Patient basis.

Medicare - The programs health care for the aged and the disabled established by Title XVIII of the Social Security Act, as first enacted by the Social Security Amendment of 1965 or as later amended.

Mental Illness - An emotional, nervous or mental disorder means a neurosis, psychoneurosis, psychopathy or psychosis and mental, emotional or nervous disorder without demonstrable organic origin.

Mental Health Treatment Facility - A facility, licensed by the Department of Health, for the care or treatment of person with a Mental Illness and in which services are provided by or under the supervisions of a Physician.

Military Service - Service in any Army, Navy, Air Force, Marines, Coast Guard, or other branch of the military.

Non-Hospital Substance Abuse Residential Care - The provision of medical, nursing, counseling or therapeutic services to patients suffering from alcohol or drug abuse or dependency in a residential environment, according to individualized treatment plans.

Out-Patient - A patient who receives diagnosis or treatment at a facility, but does not incur room and board charges.

Physician - A person, other than a Close Relative of the Covered Person, who is duly licensed member of a medical profession and is practicing within the scope of his or her license.

Policy - this Comprehensive Major Medical Group Health Insurance Policy issued by the Company to the Policyholder.

Policy Enrollment Form - A printed form approved by CHI that an Eligible Employee must complete, execute and deliver to CHI to be eligible for coverage

under this Policy.

Policy Year - The twelve (12) month period commencing on a date agreed to between the Policyholder and CHI or, if no such agreement exists, the twelve (12) month period of January l through December 31 inclusive.

Pre-Certification - A certification that a Covered Person must obtain prior to receiving any of the services or supplies that are identified by the Schedule of Benefits or this Policy as needing a Pre-Certification, which certifies the proposed Hospital admission and length of stay as Medically Necessary.

Prescription Drugs - Drugs and medicines which require a prescription by a Physician to dispense and are approved by the U.S. Food and Drug Administration for general use in treating the illness or injury for which they are prescribed. Prescriptions Drugs include oral contraceptives and vitamins.

Professional Provider - a person or practitioner licensed, where required, and performing services within the scope of such licensure. The Professional Providers include:

- R.N.
- chiropractor
- clinical laboratory
- Dentist
- nurse midwife
- optometrist
- physical therapist
- Physician
- podiatrist
- psychologist

Psychiatric Hospital - An institution which is primarily engaged in providing diagnosis and therapeutic services for the Inpatient treatment of Mental Illnesses and meets all of the following requirements:

1. Services are provided by or under the supervision of a Physician;

2. Provides continuous nursing services under the supervision of an RN.; and

3. Is not a Skilled Nursing Facility, Custodial Care home, health resort, place for rest, place for the treatment of Substance Abuse or Dependency, Hospice, rehabilitation center, or place for the treatment of pulmonary tuberculosis.

R.N. - A registered nurse, other than a Close Relative, who is licensed in the state in which care is given to perform all nursing functions.

Reasonable and Customary Charge - Any charge which, as determined by CHI, does not exceed (i) the usual or customary fee for comparable service or supply charged by other providers of similar services or supplies in the area where the service or supply is provided and who have training, experience and professional standing comparable to those of the actual provider of the service or supply or (ii) if no comparison exists, the reasonable fee (which may differ from the usual or customary fee) determined by CHI after considering unusual clinical circumstances and/or the actual cost of equipment and facilities involved in the treatment. When determining whether a charge is Reasonable and Customary, CHI

may consider the severity of the condition being treated and any complications and unusual circumstances that may be involved.

Schedule of Benefits - The Schedule of Benefits set forth in the Summary of Benefits, which summarizes the benefits payable under the Policy. The terms of the Schedule of Benefits will be individually tailored to each Policyholder.

Semi-Private - A two (2) bed room in a Hospital. If the facility has no such rooms, the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Facility - An institution or a distinct part of an institution which is licensed, where required, or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services (on an Inpatient basis to patients requiring 24-hour skilled nursing but not requiring confinement in an acute care Hospital) as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as a certified skilled nursing facility under Medicare law, or as otherwise determined by CHI to meet the reasonable standards applied by any of the aforesaid authorities.

A Skilled Nursing Facility does not include a rest home, a home for the aged, a place for Custodial Care or educational care, or a treatment facility for alcoholism, drug addiction, or mental illness.

Social Worker - A duly licensed or certified social worker with at least two (2) years or three thousand (3,000) hours of post-masters clinical social work practice in a clinical program established by the state regulatory board or agency.

Substance Abuse or Dependency - Any use of alcohol or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Substance Abuse Treatment Facility - A Hospital or non-Hospital facility, licensed by the Department of Health, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.

Terminally Ill Person - A Covered Person who life expectancy is six (6) months or less, as certified by the attending Physician.

TotalDisability or Totally Disabled - A Covered Employee shall be considered

totally disabled if, as a result of an illness or injury, he or she is unable to engage in any gainful occupation for which s/he is reasonably fitted by education, training, or experience, and is not performing work of any kind for wage or profit. A Covered Dependent will be considered totally disabled if, because of an illness or injury, he or she is prevented from engaging in all the normal activities of a person of like age and sex.

EXHIBIT 11

Statement Re: Computation of Per-Share Earnings

<TABLE>
<CAPTION>

	Year ended September 30		
	1996	1995	1994
<S>	<C>	<C>	<C>
Primary			
Average shares outstanding	1,821,000	1,812,000	1,743,000
Net effect of dilutive stock options - based on the treasury stock method using average market price	52,000	20,000	11,000
Total	1,873,000	1,832,000	1,754,000
Net income	$ 595,000	$ 394,000	$ 563,000
Per-share amount	$ .32	$ .22	$ .32

</TABLE>

EXHIBIT 13.1

Common Stock Market Prices

The common stock of STV Group, Inc., is traded in the over-the-counter market under the symbol STVI. The following table sets forth the reported high and low bid prices for the periods indicated. Such quotations, supplied by NASDAQ, represent interdealer prices without retail mark-up, mark-down or commission.

1996	High Ask	Low Bid
4th Quarter	7 3/4	7
3rd Quarter	7 1/2	6
2nd Quarter	7	5 3/4
1st Quarter	6 1/4	5

1995	High Ask	Low Bid
4th Quarter	5 7/8	5
3rd Quarter	5 1/2	5
2nd Quarter	5 1/4	4 3/4
1st Quarter	5 1/2	4 3/8

EXHIBIT 13.2

FINANCIAL HIGHLIGHTS FOR THE FISCAL YEAR ENDED
September 30

<TABLE>
<CAPTION>

	1996	1995	1994	1993	1992
<S>	<C>	<C>	<C>	<C>	<C>
Total Revenues	$94,073,000	$89,232,000	$89,465,000	$87,361,000	$75,789,000
Operating Revenues	71,271,000	69,397,000	65,746,000	62,692,000	55,231,000
Net Income (Loss)	595,000	394,000	563,000	529,000	(576,000)
Net Income (Loss) per Common Share	.32	.22	.32	.33	(.37)
Working Capital	8,721,000	8,570,000	7,184,000	6,630,000	6,355,000
Stockholders' Equity	10,342,000	9,872,000	9,078,000	8,515,000	7,486,000
Total Assets	39,995,000	41,626,000	43,960,000	40,719,000	37,184,000
Long-Term Obligations	1,795,000	2,021,000	1,939,000	1,875,000	1,790,000

</TABLE>

[GRAPHICS OMITTED]

EXHIBIT 21.1

Subsidiaries:

STV Incorporated
STV Architects, Inc.
STV Construction Services, Inc.
STV Environmental, Inc.
STV International, Inc.
STV/Silver & Ziskind, Inc.

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Transmitting STV Group's Form 10-K. Period ending 09/30/96.
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