MASTER PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

OF

ROBERTS OXYGEN COMPANY, INC.
HEALTH CARE PLAN

Effective April 1, 2016

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Section I:

Introduction

Roberts Oxygen Company, Inc., the Plan Sponsor, has established the Roberts Oxygen Company, Inc. Health Care Plan (the "Plan") in order to provide comprehensive healthcare benefits for Eligible Employees and their Dependents. The Roberts Oxygen Company, Inc. Health Care Plan is amended and restated in its entirety effective April 1, 2016.

> **Note:** Words and phrases appearing in initial capital letters are defined terms. The complete definitions can be found in the *Definitions section* that appears at the end of this document.

Written Document and SPD

This document serves as both the written Plan Document required under ERISA, and the Summary Plan Description (SPD) required under ERISA. It is very important to review this document carefully to confirm a complete understanding of the benefits available, as well as responsibilities, under this Plan. The document should be read in its entirety because many of its provisions are interrelated.

Grandfathered Status

Statement of Grandfathered Status Under Health Care Reform. This Plan is NOT a "grandfathered health plan" under Health Care Reform. Questions regarding the Plan's status can be directed to the Plan Administrator at Roberts Oxygen Company, Inc., P.O. Box 5507, Rockville, Maryland, 20855. The Covered Individual may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Note: For information regarding ERISA Rights under this Plan, please refer to Section XVIII – ERISA – Statement of Rights.

Nature of the Plan

This Plan is an employee welfare benefit plan within the meaning of the ERISA. This Plan is a self-insured medical plan intended to meet the requirements under Sections 105(b), 105(h) and 106 of the Code so the portion of the cost for coverage paid by the Employer may not be taxable income to the Covered Individual and any benefits received through this Plan may not be taxable income to the Covered Individual.

This Plan is "self-insured" which means benefits are paid from the Employer's general assets. The Plan Sponsor and the Plan Administrator have contracted with the Claims Administrator to perform certain consultative and management services related to this Plan. Roberts Oxygen Company, Inc. is the Plan Administrator and Named Fiduciary of this Plan and thereby retains ultimate authority for this Plan.

HealthSmart Benefit Solutions, Inc. is the Claims Administrator and will process Claims and answer benefit and Claim questions. HealthSmart Benefit Solutions, Inc. will be referred to as the Claims Administrator throughout this document. Contact information for HealthSmart Benefit Solutions, Inc. appears at the end of this section.

- This Plan is a group health plan for purposes of HIPAA and shall be administered in a manner consistent with HIPAA.
- This Plan is not a grandfathered plan under the Health Care Reform.

Scope of Coverage and Maximizing Coverage

This Plan does not pay all medical expenses. It pays certain expenses under certain circumstances.

Note: Although a Healthcare Provider may recommend or prescribe a course of treatment, it does not mean the cost of such treatment will be paid by this Plan.

For an expense to be "covered" under this Plan, a number of requirements must be met, Including:

1. The person must be a Covered Individual;
2. The service which results in an expense must be a Covered Service;
3. The expense for the Covered Service must meet the requirements of a Covered Charge; and
4. Any applicable Cost Sharing Amounts must be met (e.g., Deductible, Copayment, Coinsurance, etc.).

This Plan Document provides a Covered Individual with the information necessary to determine whether and to what degree a particular expense is "covered" under this Plan and, therefore, the financial responsibility of this Plan.

Network Healthcare Providers

If a Covered Individual receives a service that results in an expense, he is responsible for following Plan requirements to maximize his level of coverage. In addition, the Covered Individual is financially responsible for any portion of the expense that is not "covered" under this Plan. Taking care of that responsibility is between a Covered Individual and the Healthcare Provider. Under this Plan, Covered Individuals may receive different levels of benefits depending on where Covered Services are received and depending upon whether Precertification, if required, was obtained. Generally, when care is received at an In-Network Healthcare Provider, the Covered Individual will receive the highest level of benefits at the lowest cost. When care is received from an Out-of-Network Healthcare Provider, the Covered Individual will be responsible for any charges above the Reasonable and Customary Charge. In addition, benefits for certain Covered Services may be reduced if the Covered Individual does not receive Precertification for the specific Covered Service. See the Care Management section for a list of services that require Precertification and details on how to obtain Precertification.

The Plan reserves the right to negotiate In-Network Claims below the stated savings in any preferred Healthcare Provider organization agreement. Any such negotiation and subsequent savings must be used for the benefit of the Plan in its entirety and may be used by the Plan to pay benefits and defray reasonable administrative expenses of the Plan.

Membership ID Card

The Membership ID Card issued by the Claims Administrator to a Covered Individual pursuant to this Plan is for identification purposes only. Possession of a Membership ID Card confers no right to services or benefits under this Plan and misuse of such Membership ID Card may be grounds for termination of a Covered Individual's coverage under this Plan. To be eligible for services or benefits under this Plan, the holder of the Membership ID Card must be a Covered Individual and must present the Membership ID Card to the Healthcare Provider. Any person receiving services or benefits which he is not entitled to receive pursuant to the provisions of this Plan will be charged for such services or benefits at prevailing rates. If any Covered Individual permits the use of his Membership ID Card by any other person, such card may be retained by this Plan, and all rights of such Covered Individual pursuant to this Plan may be terminated.

Questions

The Claims Administrator's customer service representatives are available to answer any questions or concerns regarding this Plan.

HealthSmart Benefit Solutions, Inc.
PO Box 3262
Charleston, West Virginia 25332
1 (800) 624-8605

Section II:

Benefits Schedule

The *Benefits Schedule* is a snapshot of the terms and conditions of the Medical Benefits portion of the Plan. It is not intended to be comprehensive. Details regarding each of these items are in the later text.

The Covered Charges for certain Covered Services may be reduced or entirely excluded if the Covered Individual does not receive Precertification for the specific Covered Service. Precertification is always the Covered Individual's responsibility.

MEDICAL BENEFITS SCHEDULE – PLAN MAXIMUMS AND LIMITATIONS	
Benefits under the Medical Plan will be available for those Covered Individuals who have elected, and are eligible for, this coverage.	
Please refer to the Medical Benefits Coverage Descriptions on pages 13 through 27 for further information regarding Plan benefits. *See the Care Management/Precertification Programs section appearing later in this document for a list of services that require Precertification and details on how to obtain Precertification. For further information, please contact the Claims Administrator at 1 (800) 624-8605.*	
Lifetime	Unlimited
Calendar Year	Unlimited
Skilled Nursing Facility	100 days per period of disability (1)
Medical Rehabilitation Admission	100 days per period of disability (1)
Hospice Care	6 months lifetime
Bereavement Counseling	$500 per family
Home Health Care	8 hours per day; 90 visits per Calendar Year (2)
Transportation, Lodging and Meals *(in connection with Human Organ Transplant)*	$10,000 per transplant
Acupuncture Treatment	$2,500 per Calendar Year
Inpatient Cardiac Rehabilitation Services	100 days per condition
Outpatient Speech Therapy	30 visits per Calendar Year
Treatment of Temporomandibular Joint Syndrome (TMJ)	$10,000 lifetime
Diabetic Educational Training	Once per lifetime
Preventive Care	*Please refer to the Medical Benefits Descriptions for further information*
(1) Certain benefits may be subject to precertification requirements – please see the Care Management/Precertification Programs section appearing later in this document for a list of services that require Precertification and details regarding how Precertification may be obtained. *(2) Four (4) hours of home health aide service will be counted as one (1) home health care visit.*	

CALENDAR YEAR DEDUCTIBLE	In-Network	Out-of-Network
• Individual	$200	$200
• Family *(cumulative)*	$400	$400
The Calendar Year Deductible will apply to all services unless otherwise indicated. *Amounts applied to the Calendar Year Deductible for In-Network Providers will apply on a reciprocal basis towards satisfaction of Out-of-Network Deductible requirements, and vice versa.*		

BENEFIT PERCENTAGES	In-Network	Out-of-Network
Inpatient Hospital Facility Expenses	100% (1) (3) (4)	80%* (1) (3) (4)
Inpatient Hospital Physician Expenses	100% (1) (4)	80%* (1) (4)
Newborn Nursery Expenses *(facility fee, Physician visits and circumcision)*	100% (3)	80%* (3)
Outpatient Hospital Expenses *(facility and Physician fees)*	100%	80%*
Outpatient Treatment of Mental Disorders and/or Substance Abuse *(including, but not limited to, partial day psychiatric services and partial Hospitalizations)*	100% (1)	100% (1)
Outpatient Surgical Expenses *(facility and Physician fees)*	100% (1)	80%* (1)
Human Organ Transplant Expenses *(surgical fee/donor procurement)*	100% (1) (3)	80%* (1) (3)
Transportation, Lodging and Meals *(in connection with Human Organ Transplant)*	100% (1) (3) (4)	80%* (1) (3) (4)
(1) Certain benefits may be subject to precertification requirements – please see the Care Management/Precertification Programs section appearing later in this document or contact the Claims Administrator for further information regarding Precertification requirements. *(3) Calendar Year Deductible waived.* *(4) Please refer to page 4 for information regarding Plan maximums that may affect certain benefits.* **Until the Out-of-Pocket Maximum has been reached, then covered expenses are payable at 100% for the remainder of the Calendar Year.*		

BENEFIT PERCENTAGES	In-Network	Out-of-Network
Emergency Room Expenses *(facility fees)*	100%	100%
Emergency Room Expenses *(Physician fees)*	100%	80%*
Urgent Care Expenses *(facility and professional fees)*	100%	80%*
Ambulance Expenses	100%	80%*
Skilled Nursing Expenses	100% (1) (3) (4)	80%* (1) (3) (4)
Medical Rehabilitation Admission Expenses	100% (1) (3) (4)	80%* (1) (3) (4)
Birthing Center Expenses	100%	80%*
Hospice/Bereavement Care Expenses	100% (3) (4)	80%* (3) (4)
Home Health Care Expenses	100% (4)	80%* (4)
Physician Office Expenses	100%	80%*
Allergy Testing/Treatment Expenses	100%	80%*
Outpatient Therapy, Radiation and Chemotherapy Expenses	100% (4)	80%* (4)
Pain Management for Chronic Condition Expenses	100% (1)	80%* (1)
Pre-Admission/Pre-Operative Testing Expenses	100% (3)	80%* (3)
Second/Third Surgical Opinion Expenses	100% (3)	80%* (3)
Oral Surgical Procedure Expenses	100%	80%*
Sleep Disorder Tests and Treatment Expenses	100%	80%*
Treatment of Temporomandibular Joint Syndrome (TMJ) Expenses	100% (4)	80%* (4)
Chiropractic Expenses	100%	80%*
Acupuncture Treatment Expenses	100% (4)	80%* (4)

(1) Certain benefits may be subject to precertification requirements – please see the Care Management/Precertification Programs section appearing later in this document or contact the Claims Administrator for further information regarding Precertification requirements.

(3) Calendar Year Deductible waived.

(4) Please refer to page 4 for information regarding Plan maximums that may affect certain benefits.

**Until the Out-of-Pocket Maximum has been reached, then covered expenses are payable at 100% for the remainder of the Calendar Year.*

BENEFIT PERCENTAGES	In-Network	Out-of-Network
Diabetic Education Training Expenses	100% (4)	80%* (4)
Independent Facility Diagnostic, X-ray and Lab Expenses	100%	80%*
Durable Medical Equipment and Supply Expenses	100%	80%*
Synagis Injection Expenses	$20 copay per injection; 100% (5)	$20 copay per injection; 80%* (5)
Preventive Care Expenses		
Well Care Services – Adult and Child	100% (3) (4) (6)	100% (3) (4) (6)
Screening Services/Immunizations	100% (3) (6)	100% (3) (6)
All Other Covered Expenses	100%	80%*

(3) Calendar Year Deductible waived.

(4) Please refer to page 4 for information regarding Plan maximums that may affect certain benefits.

(5) Copays apply to the Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been reached, no further copays will apply for the remainder of the Calendar Year.

(6) Please refer to the Medical Benefits Coverage Descriptions for additional information regarding specific services covered under this benefit.

**Until the Out-of-Pocket Maximum has been reached, then covered expenses are payable at 100% for the remainder of the Calendar Year.*

OUT-OF-POCKET MAXIMUM	In-Network	Out-of-Network
• Individual	$200	$200
• Family *(cumulative)*	$400	$400

The Out-of-Pocket Maximums include the Calendar Year Deductible.

Amounts applied to the Out-of-Pocket Maximum for In-Network Providers will apply on a reciprocal basis towards satisfaction of the Out-of-Network Out-of-Pocket Maximum, and vice versa.

PRESCRIPTION DRUG PROGRAM	
Benefits under the prescription drug program will be available for those Covered Individuals who have elected, and are eligible for, this coverage.	
Prescription Drug Out-of-Pocket	
Individual	$6,400
Family	$12,800
Retail Benefit - participating pharmacies only	
(Benefits are limited to a 30-day supply per prescription copay.)	
Per prescription copay:	
Generic	$5
Formulary Brand Name	$25
Non-Formulary Brand Name	$50
Specialty	$20% up to $100 maximum
Flu vaccine	$0
Mail Order Benefit	
(Benefits are limited to a 90-day supply per prescription copay.)	
Per prescription copay:	
Generic	$10
Formulary Brand Name	$55
Non-Formulary Brand Name	$125
Important Notes: *The copays listed above apply to the prescription drug Out-of-Pocket Maximum. Once the prescription drug Out-of-Pocket Maximum has been reached, the covered expenses are payable at 100% for the remainder of the Calendar Year.* *For the retail and mail order benefit, if a Covered Individual purchases a Brand Name medication when a Generic is available and allowed by the Physician, in addition to the Brand Name copay, the Covered Individual will also have to pay the difference in cost between the Brand Name and Generic medication.* *Use of the specialty pharmacy vendor will be mandatory in order to receive benefits for certain injectable medications through the prescription drug program. In addition, benefits for such medication may be subject to prior authorization.*	

Section III:

Selecting a Healthcare Provider

<u>In-Network/Out-of-Network Plan</u>

This Plan recognizes two (2) categories of Healthcare Providers, based on the Healthcare Provider's relationship with this Plan:

- In-Network; and
- Out-of-Network.

Please refer to the Medical Benefits Schedule for detailed information on coverage levels for In-Network and Out-of-Network Healthcare Providers under this Plan.

The benefits paid under this Plan for In-Network Healthcare Providers are usually greater than for Out-of-Network Healthcare Providers. It is the Covered Individual's choice as to which Healthcare Provider to use. In addition to a greater Deductible when Out-of-Network Healthcare Providers are used, the Covered Individual may have substantial additional costs for which they are responsible because the Plan pays Out-of-Network Healthcare Providers based on the Reasonable and Customary Charge. In addition to Cost Sharing Amounts, the Covered Individual will also be responsible for any charges above the Reasonable and Customary Charge when receiving Covered Services Out-of-Network. Therefore, the percentage of payment actually paid by this Plan may be lower than the stated percentage, and the percentage of payment paid by the Covered Individual may be higher than the stated percentage.

Under the following circumstances, the higher In-Network benefit level may be available for certain Out-of-Network Healthcare Provider's services:

- Professional services of an emergency room Physician, radiologist, pathologist or anesthesiologist when services are rendered in an In-Network.
- Services not available by an In-Network Provider.

Additional information, including a list of In-Network Healthcare Providers, will be provided to Covered Individuals, at no cost, and updated as needed. Because the In-Network Healthcare Providers are continuously being updated, a current list of In-Network Healthcare Providers is available, without charge, through the Claims Administrator's website.

Enrolling in this Plan does not guarantee that a particular In-Network Healthcare Provider will remain an In-Network Healthcare Provider or that a particular Healthcare Provider will provide Covered Individuals under this Plan only with Covered Services. Covered Individuals should verify a Healthcare Provider's status as an In-Network Healthcare Provider each time services are received from the Healthcare Provider.

Each Covered Individual has a free choice of any Healthcare Provider, and the Physician-patient relationship shall be maintained. The Covered Individual, together with his Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The In-Network Healthcare Providers are merely independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any In-Network Healthcare Provider.

Each Covered Individual has free choice of any Healthcare Provider, and the Physician-patient relationship shall be maintained. The Covered Individual, together with his Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The Plan will not have any liability for any acts, omissions, or conduct of any provider. The Plan's only obligation is to make payments according to the terms of this Plan Document.

Section IV:

Medical Costs

Medical Benefit Cost Sharing Amounts

"Medical Benefit Cost Sharing Amounts" refers to the portion of the cost of a Covered Charge for a Medical Benefit that a Covered Individual is responsible for paying out-of-pocket.

Medical Benefits Deductible

In general, Deductible refers to the annual aggregate amount of Covered Charges for which the Covered Individual is financially responsible for each Calendar Year before the Plan has a financial responsibility. Medical Benefits Deductible is the amount of Covered Charges which must be paid each Calendar Year by the Covered Individual or the covered family before benefits are payable. The Benefits Schedule shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies. Copayments do not apply towards satisfaction of the Deductible and Copayments continue to apply after the Deductible has been met.

Each Calendar Year, a new Deductible must be satisfied. Any charges incurred by an individual during the last three months of a year and applied toward such individual's Deductible for that year will be applied also toward such individual's Deductible for the next year.

Note: With respect to satisfying the In-Network Deductible and the Out-of-Network Deductible, amounts are counted without distinction. In other words, amounts required to be paid by the Covered Individual because the applicable Deductible has not been met, count towards the satisfaction of the In-Network Deductible and the Out-of-Network Deductible.

Medical Benefits Copayment

In general, Copayment (also referred to as "copay") refers to the flat dollar per occurrence amount for which the Covered Individual is financially responsible. Medical Benefits Copayment is the amount a Covered Individual must pay each time certain Covered Services are provided, as outlined in the Benefits Schedule. Copayments do not apply towards satisfaction of the Deductible and Copayments continue to apply after the Deductible has been met.

Medical Benefits Coinsurance

Coinsurance is the portion of the Covered Charge, after any applicable Deductible or Copayment, for which the Covered Individual is financially responsible.

Note: Coinsurance applies until the applicable Out-of-Pocket Maximum has been met, unless otherwise specified.

Out-of-Pocket Maximum

In general, the Out-of-Pocket Maximum is the annual aggregate amount of Copayments for which a Covered Individual will be financially responsible before the Plan pays one hundred (100%) percent of the charges for the remainder of that Calendar Year.

Penalties do not apply to the Out-of-Pocket Maximum, nor do prescription copayments or expenses not covered by the Plan.

Amounts in Excess of the Reasonable and Customary Charge

This Plan pays no more than the Reasonable and Customary Charge for a Covered Service. However, Reasonable and Customary limitations will not apply to In-Network repriced Claims. If the Healthcare Provider charges more than the Reasonable and Customary Charge, the Covered Individual is responsible for the amount in excess of the Reasonable and Customary Charge. This excess amount is considered outside the scope of the Plan and is not counted towards satisfaction of the Deductible and is not paid by the Plan upon satisfaction of the Deductible.*

**See page 110 for a definition of Reasonable and Customary Charge.*

Employee Contribution

The employee shall be responsible for paying the Employee Contribution specified by the Human Resources Department, at the time an employee becomes a Covered Individual and as announced in writing at such other times as changes are made to the employee.

Contribution Rates

Subject to the requirements of the Family and Medical Leave Act or the COBRA continuation coverage provisions, the employee shall pay his or her portion of the Employee Contribution, including the coverage of his Spouse and/or Dependent Children, if applicable, by payroll deduction.

Section V:

Medical Benefit Coverage Descriptions

Medical benefits are available under this Plan when Covered Charges are incurred by a Covered Individual for care while the person is covered for these benefits under the Plan. This section is intended to be read in conjunction with the Medical Benefits Schedule.

Some Covered Services are subject to Precertification requirements, as indicated in the Care Management section. Please refer to the Care Management section for information regarding Precertification.

Covered Charges are those incurred for the following items of services and supplies when (1) Medically Necessary to diagnose or treat a Covered Individual, or (2) specifically for Preventive Care. These charges are subject to the benefit limits, exclusions and other provisions of this Plan.

For information regarding Medical Plan Exclusions, please refer to pages 28 through 33.

Abortion

Induced termination of a Pregnancy by any acceptable means. Benefits will be available for services received by all covered females.

Acupuncture Treatment

Benefits will be payable up to the maximum amount indicted in the Medical Benefits Schedule for acupuncture treatment when performed by a Physician, by needle, for emergency relief of pain or any other medical conditions. The medical condition must be identified by the Physician, and treatment must be for a condition for which acupuncture is a prescribed therapy.

Allergy Treatment

Charges for allergy treatment; including injections, testing and serum.

Ambulance Service

Local professional ambulance service for necessary transportation due to an Accident or life-threatening emergency of for treatment which cannot be performed at the Hospital in which the patient is confined. Benefits will also be provided for air ambulance, if determined to be Medically Necessary, to the nearest facility where care can be provided.

Ambulatory Surgical Center

Facility charges for procedures performed in an Ambulatory Surgical Center and associated services and supplies.

Birthing Centers
Facility charges for procedures performed in a Birthing Center and associated services and supplies.

Note: For further information regarding benefits for Newborn Care and Pregnancy please refer to pages 18 and 21.

Cardiac Rehabilitation Services
Cardiac rehabilitation services as determined to be Medically Necessary, provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and (d) in a medical care facility as defined by this Plan. Benefits for Inpatient cardiac rehabilitation treatment will be limited to the maximum amount indicated in the Medical Benefits Schedule.

Chemotherapy
A regimen comprised of a single agent or a combination of anti-cancer agents clinically recognized for treatment of a specific type of cancer, including modifications and combinations appropriate to the history of the cancer or according to protocol specifying the combination of drugs, doses, and schedules for administration of the drugs.

Drug Requirements:

- Use that is included as an indication on the drug's label as approved by the FDA.
- Use of an FDA-approved drug for an off-label purpose that is medically accepted for an anti-cancer therapeutic regimen as evidenced by major drug compendia, medical literature, and/or accepted standards of medical practice.
- Use of drugs to treat toxicities or side effects of the cancer treatment regimen when the drug is administered in relation to chemotherapy, including off-label uses supported by medical literature.

Chiropractic Treatment
Examinations, diagnostic evaluations, and treatments by manipulation and other modalities.

Contraceptives
Services and supplies related to administration, insertion and removal of contraceptive implants, and intra-uterine devices (IUD's), contraceptive injections, oral contraceptives, and diaphragms.

Note: Certain Covered Services may be provided under the Preventive Care benefit as described in this Medical Benefit Coverage Descriptions.

Dental Care for Accidental Injury
Treatment of Accidental Injuries to the jaw, mouth, or sound natural tooth (a tooth which is free of decay but may be restored by fillings, has a live root, and does not have a cap or crown), provided treatment is for an Injury which has occurred while covered under the Plan.

Note: For further information regarding benefits for Oral Surgery eligible under this Plan, please refer to page 19.

Diagnostic Services
Services performed for the express purpose of determining the cause of definite symptoms experienced by the patient, not in connection with routine physical examinations except as specified in this Plan Document. Covered expenses include:

- Pathology
- Radiology
- Physician's Interpretation

Emergency Room Services and Supplies

a) Life-Threatening/Sudden & Serious Illness
Immediate care required for a life-threatening Medical Emergency or Accidental bodily Injury which untreated could result in death or serious bodily impairment.

b) Non-Emergency Use
Care received for Illness or Injury which does not qualify as life-threatening.

Growth Hormones
Services and supplies related to the administration of Medically Necessary growth hormones. Furthermore, benefits for growth hormone medication will be available through the prescription drug program.

Home Health Care Services and Supplies
Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. Benefits will be payable up to the maximum amount indicated on page 4 of the Medical Benefits Schedule for the following:

a) Services
Part-time or intermittent nursing care provided or supervised by a Registered Nurse (R.N.); part-time or intermittent home health aide services, primarily for the patient's medical care; physical, occupational, speech, or respiratory therapy by a licensed qualified therapist; nutrition counseling provided by or under the supervision of a registered dietician; or medical supplies, laboratory services, drugs, and medications prescribed by a Physician (does not include the services of a social worker). Benefits will be limited to a maximum of 8 hours per day, and one Home Health Care visit is considered 4 or less hours of nursing care. For example, 8 consecutive hours of nursing care will be considered 2 visits.

b) Requirements
Services must be provided in the patient's home under a written plan of the patient's attending Physician's stating the diagnosis, certifying that the Home Health Care is in lieu of Hospital Confinement or Skilled Nursing Facility care, and further specifying the type and extent of treatment.

Hospice Care Services and Supplies
Benefits will be payable up to the maximum amount indicated on page 4 of the Medical Benefits Schedule for the following:

a) Services

- Hospice room and board while the terminally ill person (diagnosed by the attending Physician as having six months or less to live) is an inpatient in a Hospice;
- Outpatient and other customary Hospice services provided by a Hospice or Hospice team;
- Counseling services provided by a member of the Hospice team; and
- Home Health Care services, including: Part-time nursing care rendered in the Covered Individual's home; Physician's visits to the Covered Individual's home; Physical therapy provided in the Covered Individual's home; the use of medical equipment; rental of wheelchairs and Hospital-type beds; emotional support services of a Physician or social worker, drugs and medications, and homemaker services.

b) Requirements

These services and supplies are eligible only if the Hospice operates as an integral part of a Hospice Care Agency and the Hospice team includes at least a doctor and a registered graduate nurse. Each service or supply must be:

- Provided under a Hospice Care Agency program that meets standards set by the Plan. If such a program is required by federal or state law to be licensed, certified, or registered, it must meet that requirement;
- Provided while the terminally ill person is in a Hospice Care Program; and
- Ordered by the doctor directing the Hospice Care Program.
- Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered under this Plan). Benefits will be subject to the maximum amount indicated on page 4 of the Medical Benefits Schedule, and will cover a period beginning on the date the terminally ill patient enters the Hospice Program and ending ninety (90) days after the date of death.

Hospital Inpatient Services and Supplies

a) Room and Board

Semi-private room accommodations, including general nursing services. Room charges made by a Hospital having only private rooms will be paid as if the room were a semi-private room. Expenses for special care units, including general nursing services. Special care units include intensive care units, cardiac care units, respiratory care units, step down units, emergency care facilities, and other units considered by the Plan to be special care units.

If a private room is Medically Necessary for isolation purposes, the private room charge will be considered as semiprivate.

b) Ancillary

Benefits will be payable for Medically Necessary miscellaneous and ancillary services Including operating rooms, delivery rooms, treatment, equipment and supplies furnished during a covered Hospital Confinement.

Hospital Outpatient Services and Supplies

Coverage Includes services rendered in an Outpatient department of a Hospital, as follows:

- Allergy testing
- Chemotherapy
- Dialysis
- Laboratory Tests and X-rays
- Pre-Admission Testing
- Radiation Therapy
- Respiratory Therapy
- Surgical Services

Infertility Testing

Diagnostic infertility tests for determination of the condition and treatment of the medical condition if it is causing the infertility problem.

Medical Rehabilitation Facility

Benefits will be payable up to the maximum amount indicated in the Medical Benefits Schedule for expenses incurred for stays in a Rehabilitation Facility, Including associated services and supplies. In order to be eligible for benefits, confinement in the facility must follow within twenty-four (24) hours of, and be for the same or related cause(s), as a period of Hospital or Skilled Nursing Facility confinement.

Medical Supplies/Durable Medical Equipment

Coverage includes, but is not limited to, the following:

- Rental or initial purchase (whichever is less expensive, subject to approval by the Plan) of Durable Medical Equipment, Including respiration equipment, hospital beds, and wheelchairs. Replacement of Durable Medical Equipment when Medically Necessary due to a physiological change to the patient, due to normal wear and tear of an item or the existing equipment is damaged and cannot be made serviceable.
- Blood and blood derivatives that are not donated or replaced.
- Artificial limbs, eyes, and larynx (including fitting); heart pacemaker; surgical dressings; casts; splints; trusses; braces; crutches.
- Oxygen and related supplies.
- Initial contact lenses or glasses required following cataract surgery.
- Insulin and diabetic supplies unless covered under the Plan’s prescription drug program.

Mental Disorders

a) Inpatient

Semiprivate room accommodations and Medically Necessary services and supplies furnished by the Hospital or facility for diagnosis or treatment of Mental Disorders.

b) Outpatient

Medical Expenses for Outpatient treatment of Mental Disorders Including the following:

- Medically Necessary services and supplies provided by a Hospital or other duly licensed facility on an Outpatient basis, including laboratory testing.
- Physician office visits or Physician visits on an Outpatient basis at a Hospital or other licensed facility.
- Outpatient shock therapy.
- Partial hospitalization.

Note: Please refer to page 25 for further information regarding benefits for Substance Abuse.

Newborn Care Services and Supplies

Medically Necessary expenses incurred by a well newborn infant during his initial confinement. Covered expenses include services and supplies furnished by the Hospital and services and supplies furnished by the Physician to care for the newborn infant during his initial confinement. Inpatient Physician care for a healthy, full-term newborn includes, but is not limited to, examinations and the circumcision of male infants. Benefits will be payable on the same basis as for any other Illness and will be payable as expenses of the Child.

Covered expenses for a sick newborn Child Incurred for Hospital and Physician services will be made on the same basis as any other Illness. Benefits will be payable as expenses of the Child.

Covered expenses for both well or sick newborn Children will be payable as indicated above, provided the Employee has properly enrolled his Dependents for Dependent benefits within 30 days as specified in the Eligibility, Enrollment and Effective Dates section of this Plan Document.

Note: For further information regarding benefits for Birthing Centers and Pregnancy please refer to pages 14 and 21.

Nutritional Counseling

Nutritional counseling rendered by a licensed nutritionist (if licensing is required by the state) or registered dietician. Benefits will be limited to the following conditions, and will be subject to any applicable maximum amount indicated on page 4 of the Medical Benefits Schedule:

- Diabetes
- Post cardiac surgery

<u>Oral Surgery</u>
Benefits are limited to the following procedures:

- Excision of tumors or cysts from the mouth
- Cutting procedures on the gums and mouth tissues for treatment of disease
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures)
- Treatment of fractures of facial bones
- External incision and drainage of cellulitis
- Incision of accessory sinuses, salivary glands or ducts

Note: For further information regarding additional benefits available under this Plan, please refer to Dental Care for Accidental Injury, page 14.

<u>Organ Transplants</u>

a) Services
Covered Services related to non-experimental human organ transplants which are Medically Necessary. Covered procedures Include:

- Bone Marrow
- Cornea
- Heart
- Heart/lung
- Kidney
- Liver
- Lung
- Pancreas

The Plan will also cover any other types of human organ transplants that become accepted as non-experimental procedures, as determined by the Plan Administrator. Covered Charges include acquisition cost and drugs, even if not otherwise covered under this Plan.

Covered transplant-related expenses incurred by a living donor, provided the recipient is covered under the Plan. Any services and supplies that are required for donor/procurement as a result of a surgical transplant procedure are not provided under this provision if benefits are provided under another group plan or other group or individual contract or any arrangement of coverage for individuals in a group (whether an insured or uninsured basis), including any prepayment coverage.

b) Requirements
Transplants: Any human solid organ or bone marrow/stem cell transplant provided that:

- The condition is life-threatening; and

- Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and
- The patient is a suitable candidate for the transplant approved by the Plan.

c) Transportation, Lodging and Meals

Benefits will be provided in connection with covered transplants (other than cornea transplants) for transportation to accompany the recipient to and from the facility, and for lodging and meals at or near the facility where the recipient is confined. Furthermore, this benefit includes the reasonable costs incurred for the transplant recipient and one companion, or in the event that the recipient is a minor, two companions. The deductible will be waived, and benefits will be payable at 100% to a maximum of $10,000 per transplant.

Orthotics/Foot Care

Covered services include corrective shoes or inserts that eliminate the need for corrective surgery; charges for the examination, prescription or fitting thereof; diagnosis and treatment of weak, strained, or flat feet or instability or imbalance of the feet; and any tarsalgia, metatarsalgia, or bunion.

Pain Management

Pain management for chronic pain must be Medically Necessary and rendered by a covered Physician. Pain is chronic if it has occurred recurrently over months or years or persists longer than expected following an Illness or Injury. Typically, pain is not considered chronic until it has persisted from 3 or more continuous months. Multi-disciplinary pain management assessment and the submission of a treatment plan following the initial evaluation by a pain Physician will be required for pain management services.

Physical/Occupational Therapy

Medically Necessary services, as certified by a Physician, rendered by a certified or licensed physical therapist or registered occupational therapist. Therapy rendered by a licensed therapist to restore the loss or impairment of motor functions resulting from Illness or Injury. Coverage ends once maximum medical recovery has been achieved and further treatment is primarily for maintenance purposes. Only therapy designed to restore motor functions needed for activities of daily living (such as walking, eating, dressing, etc.) is covered.

Physician Services

a) Hospital Inpatient

Inpatient services and Medically Necessary consultations by a Physician to a Hospital inpatient.

b) Physician Home/Office Visits

Services and supplies provided by a Physician in a professional office or in the home of the Covered Individual when Medically Necessary.

c) Other

Reasonable and necessary services of a Physician. Covered Services Include:

- Allergy Injections
- Allergy Testing
- Cardiac Rehabilitation
- Chemotherapy
- Dermatology Testing
- Dialysis
- Emergency Room Services
- Infusion Therapy
- Injections
- Interpretation of Diagnostic Tests
- Radiation Therapy
- Respiratory Therapy

Pregnancy

This Plan shall not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. This Plan shall not require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods, and nothing is to prevent the mother's or newborn's attending health care provider and the mother from agreeing to an earlier discharge. Notwithstanding the above, compliance with this Plan's policy of Precertification for maternity care management shall be required.

Regular Plan benefits (as specified in the applicable sections of this document) are payable for expenses incurred by the Covered Employee, Spouse or Dependent Child.

Services required for the normal management of Pregnancy, including any condition usually associated with the management of a difficult Pregnancy but not considered a complication of Pregnancy. Antepartum and postpartum care of the mother is included.

Services required for the treatment of complication of Pregnancy, including any physical effect directly caused by Pregnancy but considered to be an effect of a normal Pregnancy, conditions related to ectopic Pregnancy or conditions requiring cesarean section.

Care for miscarriage.

Notes: For further information regarding benefits for Birthing Centers and Newborn Care, please refer to pages 14 and 18.

Certain Covered Services may be provided under the Preventive Care benefit as described in this Medical Benefit Coverage Descriptions section.

Prescription Drugs
In addition to the benefits provided by this Plan, the Employer has selected a prescription coverage to provide benefits for retail, and mail order prescription drugs.

a) Retail Benefit

If a Covered Individual incurs expenses for prescription drugs, the prescription coverage plan will pay 100% of the cost of the prescription minus the per-prescription Copayment. Once the prescription drug Out-of-Pocket Maximum has been reached, no further prescription copays will apply for the remainder of the Calendar Year. Please refer to the Medical Benefits Schedule for further information regarding the prescription drug copay amounts.

If a prescription is filled at a participating pharmacy, the Covered Individual will have to pay only the Copayment amount shown in the Medical Benefits Schedule. The pharmacy will submit the claim to the prescription drug plan, which will reimburse the pharmacy.

If a prescription is filled at a nonparticipating pharmacy, no benefits will be available.

b) Mail Order Benefit

This program is particularly beneficial for those individuals who take regular medication over an extended period of time (maintenance medication). Maintenance medication is usually associated with the treatment of such illnesses as anemia, arthritis, diabetes, emotional distress, epilepsy, heart disorders, high blood pressure, thyroid or adrenal conditions, ulcers, etc.

To participate in the mail order drug program, the Covered Individual must send the original prescription, along with the appropriate per prescription Copayment amount, to the mail order drug service. Once the prescription drug Out-of-Pocket Maximum has been reached, no further prescription copays will apply for the remainder of the Calendar Year. The medication will then be mailed by the mail order drug service along with reordering instructions.

Preventive Care
Preventive benefits will be payable as specified in the Medical Benefits Schedule and will include Physician expenses, facility charges, outpatient Hospital charges, and expenses incurred for outside laboratory/x-ray services for the following:

a) Well Care Services (Adult and Child)

- Exam, and related labs and x-rays *(except as specified below)*
- Routine/screening CA125 lab *(even if not billed with a routine physical)*
- Exams in connection with prostate screening, gynecological exam, immunizations, or mammogram are allowed in addition to the routine physical exam, but would be subject to the deductible

b) Screening Services/Immunizations

- Pap smear, limited to once per Calendar Year
- Mammograms, limited to once per Calendar Year
- Prostate specific antigen (PSA) test, limited to once per Calendar Year

- Colonoscopy, for Employee and Spouse age 50 and over, limited to once every five years
- Fecal occult testing, limited to once per Calendar Year
- Immunizations *(regardless of age)*
- H1N1 *(including office visit)*

c) Preventive Care For Women, Including Pregnant Women

As adopted under the Health Resources and Services Administration (HRSA) guidelines for women's preventive services based on recommendations developed by the Institute of Medicine at the request of Health and Human Services and in addition to any Covered Services provided under the Adult and Child Preventive Care benefit listed above, the following items will also be included as a Covered Service for any female Covered Individual under this Plan: Services marked with an asterisk (*) are provided with no Cost Sharing (such as Copayments, Coinsurance or Deductibles. If the Plan does not have an In-Network provider that can provide a particular Preventive Care Service, the Plan will cover the Preventive Care Service without Cost-Sharing if performed by an Out-of-Network provider.

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for woman at higher risk
- **Breast Cancer Mammography** screenings.
- **Breast Cancer Chemoprevention** counseling for woman at higher risk
- **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women*
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Contraception** Food and Drug Administration-approved women's contraceptive methods, sterilization procedures for women, and patient education and counseling for women, not including abortifacient drugs or male based contraceptive methods*
- **Domestic and interpersonal violence** screening and counseling for all women*
- **Folic Acid** supplements for women who may become pregnant
- **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes*
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B screening** for pregnant women at their first prenatal visit
- **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women*
- **Human Papillomavirus (HPV) DNA Test** high risk HPV DNA testing every 3 years for women with normal cytology results who are 30 or older*
- **Osteoporosis** screening for women over age 60 depending on risk factors
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk

- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Sexually Transmitted Infections (STI)** counseling for sexually active women*
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Well-woman visits** to obtain recommended preventive services for woman under 65*

Note: This Plan will at all times comply with the Patient Protection and Affordable Care Act (PPACA), as amended by the Reconciliation Act and related regulatory guidance. To the extent required by PPACA and the regulatory guidance, the Plan will provide benefits for all Healthcare Services and supplies rendered solely for the purpose of health maintenance and not for the treatment of an Illness or Injury without any Cost-Sharing (such as Copayments, Coinsurance or Deductibles). If the Plan does not have an In-Network provider that can provide a particular Preventive Care Service, the Plan will cover the Preventive Care Services without Cost-Sharing if performed by an Out-of-Network provider.

Private Duty Nursing

Services certified as Medically Necessary by a Physician and provided by a nurse. The nursing services provided must require the special skill and training of a Registered Nurse, Licensed Practical Nurse or Professional Nurse.

Radiation Therapy

Radiation therapy by X-ray, radon, radium and radioactive isotopes.

Routine Patient Costs for Approved Clinical Trials

Charges for Routine Patient Costs for items and services furnished in connection with a Qualified Individual's participation in an Approved Clinical Trial. Subject to the provisions of this paragraph, this Plan will provide coverage of Routine Patient Costs for a Qualified Individual in connection with an Approved Clinical Trial. If one or more In-Network Healthcare Providers are participating in an Approved Clinical Trial, this Plan may require that a Qualified Individual participate in the Approved Clinical Trial through such In-Network Healthcare Provider if the In-Network Provider will accept the Qualified Individual as a participant in the Approved Clinical Trial. If one or more In-Network Healthcare Providers are participating in an Approved Clinical Trial and one such In-Network Provider will accept the Qualified Individual as a participant in the Approved Clinical Trial, this Plan will not provide coverage for Routine Patient Costs for items and services furnished in connection with an Approved Clinical Trial rendered by an Out-of-Network Healthcare Provider.

Skilled Nursing Facility

Benefits will be payable up to the maximum amount indicated in the Medical Benefits Schedule for the following:

a) Services

Services and supplies (other than personal items and professional services) provided while the patient is under continuous medical care and requires 24-hour nursing care, and room and board.

b) Requirements

Confinement must be ordered by the Physician as Medically Necessary for convalescence from the Illness or Injury that caused the Hospital Confinement.

The Covered Individual must be first confined to a Hospital for at least three (3) days or the stay must be determined to be Medically Necessary rather than for custodial care, in addition, the Covered Individual must begin his stay in the Skilled Nursing Facility within fourteen (14) days following discharge from the Hospital.

The attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the facility.

Sleep Disorders/Sleep Apnea

Charges for Medically Necessary diagnosis, testing, treatment or any charges related to sleep disorder or sleep apnea.

Smoking Cessation

Physician office visits to assist a Covered Individual to quit smoking and medication specifically prescribed to aid in smoking cessation, as well as over-the-counter smoking cessation aids. However, benefits do not include services rendered in conjunction with smoking cessation treatment related to electronic cigarettes ("e-cigarettes").*

**Notes: Benefits for over-the counter smoking cessation aids (prescription needed) will be limited to a lifetime benefit of $500.*

Certain Covered Services may be provided under the Preventive Care benefit as described in this Medical Benefit Coverage Descriptions section.

Speech Therapy

Therapy rendered by a certified speech therapist/pathologist on the recommendation and evaluation of a Physician to restore already established speech loss due to an Illness or Injury or to correct an impairment due to congenital defect for which corrective surgery has been performed. Benefits will be payable up to the maximum amount indicated in the Medical Benefits Schedule.

Sterilization

Procedures to bring about, but not reverse, sterilization, regardless of Medical Necessity

Note: Certain Covered Services may be provided under the Preventive Care benefit as described in this Medical Benefit Coverage Descriptions section.

Substance Abuse

a) Inpatient

Semiprivate room accommodations and Medically Necessary services and supplies furnished by the Hospital or facility for diagnosis or treatment of Substance Abuse.

b) Outpatient

Medical Expenses for Outpatient treatment of Substance Abuse Including the following:

- Medically Necessary services and supplies provided by a Hospital or other duly licensed facility on an Outpatient basis.
- Physician office visits or Physician visits on an Outpatient basis at a Hospital or other licensed facility.
- Partial hospitalization.

Note: See also page 18 for information regarding benefits for Mental Disorders.

Surgery

a) Surgeon

Charges for multiple surgical procedures will be a Covered Charge subject to the following provisions:

- If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Reasonable and Customary Charge that is allowed for the primary procedures. Then a portion of the Reasonable and Customary Charge will be allowed for each additional procedure performed through the same incision, as well as for each additional procedure performed through a separate incision. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures.
- If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Reasonable and Customary Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Reasonable and Customary percentage allowed for that procedure; and
- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 25% of the surgeon's Reasonable and Customary allowance.

b) Anesthesiologist

Services of a qualified anesthesiologist (not the services of an operating surgeon or a surgical assistant) in administering regional or general anesthesia in connection with a covered surgical service, except by local infiltration. Additional benefits are not provided for preoperative anesthesia consultation.

c) Cosmetic/Reconstructive Surgery

Correction of abnormal congenital conditions and reconstructive surgery performed as a result of Illness or Injury.

d) Reconstructive Surgery Following Mastectomy

This Plan shall provide, in a case of a Covered Individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction with such mastectomy, coverage for:

- reconstruction of the breast on which the mastectomy has been performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications for all stages of mastectomy, Including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient. Such coverage may be subject to annual Deductibles and Coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan.

e) Dental Surgery

Dental services for the treatment of a fractured jaw or an Injury to sound natural teeth. Benefits are payable for the services of a Physician, Dentist or dental surgeon, provided the services are rendered for treatment of an Accidental Injury which occurred while covered under the Plan.

Temporomandibular Joint Dysfunction

Benefits will be payable up to the maximum amount indicated in the Medical Benefits Schedule for covered Services and supplies recognized as effective and appropriate by the medical or dental profession as necessary to treat TMJ.

Wigs

Charges associated with the purchase of a wig for hair loss due to chemotherapy.

For information regarding Medical Plan Exclusions, please refer to pages 28 through 33.

Section VI:

Medical Plan Exclusions

The following exclusions apply to this Plan except that if any exclusion is contrary to any law to which this Plan is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

Arch Supports. Arch supports and orthopedic shoes; (except those forming an integral part of a corrective brace) or those prescribed to eliminate the need for the corrective surgery.

Biofeedback. Services and supplies related to treatment by biofeedback therapy.

Charges Billed by Both Physician and Hospital for the Same Service. Exclusion does not apply to charges for anesthesia which shall be paid to the Hospital and to the Physician based upon any other negotiated rates.

Contraceptives. Contraceptives and medications used for contraceptive purposes, except as specified as a Covered Service under this Plan.

Note: In addition to the coverage that is provided under the Medical Plan, benefits are available for other forms of contraception as allowable through the Plan's Prescription Drug Plan. Benefits may be obtained from the Medical Plan, or Prescription Drug Plan, but not both. For any contraceptive that is obtained through the Plan's prescription drug program, any Physician's fee associated with dispensing such contraception will be eligible for payment under the Medical Plan.

This exclusion does not apply to any service or supply required by the Patient Protection and Affordable Care ACT (PPACA), as amended by the Reconciliation Act and related regulatory guidance, to be included as a Covered Service under the Preventive Care benefit.

Cosmetic Surgery. Expenses incurred in connection with the care and/or treatment of surgical procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

Custodial Care. Charges for custodial care, domiciliary care, rest cures, services that are primarily educational in nature (except as specified), or any maintenance-type care which is not reasonably expected to improve the patient's condition (except Hospice Care as specified).

Dental Treatment. Any dental treatment or services, except specified services and Medically Necessary Hospital expenses.

Diagnostic Testing. With respect to diagnostic testing, tests performed more frequently than is necessary according to the diagnosis and accepted medical practice, or duplicate testing by different Physicians unless necessary in relation to a second opinion.

Drugs Requiring a Written Prescription. (except those taken or administered in whole or in part during confinement in a licensed facility or those administered in a Physician's office) are not covered by this Plan. They are provided under a separate plan provided by the Employer through the pharmacy benefits manager.

Educational or Vocational Testing. Services for natural childbirth classes, or any other educational or vocational testing or training, natural except as specified or diabetes training.

Exercise Programs. Exercise programs for treatment of any condition, except for Physician supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

Experimental and/or Investigational. Treatments, drugs and devices which have demonstrated promise in the laboratory, but whose efficacy has not been established through controlled scientific studies designed to assess the effectiveness of procedures, drugs and devices, typically performed after a treatment shows promise during limited testing.

Eye Care. Glasses, contact lenses, or eye examinations and/or treatment (surgical or nonsurgical) of refractive error for the correction of vision or the fitting of glasses, except as specified. *(See also, Orthoptics and/or Visual Therapy, page 31).*

Family Covered Individual. Services, supplies, care, treatment or referrals rendered by a person who is related to the Covered Individual as a spouse, parent, grandparent, grandchild, aunt, uncle, cousin, Child, brother or sister, or any person who resides with the Covered Individual.

Foot Care. Treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral vascular disease), or any other service, treatment or supply except as otherwise specified or as deemed to be Medically Necessary.

Foreign Travel. Charges for services incurred outside the continental United States unless charges were incurred while traveling on business or for pleasure, or in the case of a student, while studying abroad.

Functional Therapy. Charges made for functional therapy for learning or vocational disabilities or for speech, hearing and/or occupational therapy, unless specifically covered under another provision of this Plan.

Genetic Testing. Genetic testing unless family history necessitates.

Note: This exclusion does not apply to any service or supply required by the Patient Protection

and Affordable Care ACT (PPACA), as amended by the Reconciliation Act and related regulatory guidance, to be included as a Covered Service under the Preventive Care benefit.

Government Coverage. Charges for services or supplies provided by the Veterans Administration or in any Hospital or institution owned, operated, or maintained by the United States Government for a service-related Illness or Injury.

Hair Loss. Care and treatment for hair loss including wigs, cranial prostheses, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs for hair loss due to chemotherapy.

Hearing Aids and Exams. Hearing aids, implants, routine hearing testing or services necessary due to degenerative hearing loss not specifically caused by Illness, congenital defect or trauma.

Hospital Employees. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Hypnotherapy. Care, services and supplies related to treatment by hypnosis.

Illegal Acts. Services, supplies, care or treatment of an Illness or Injury sustained during the commission, or attempted commission, of an assault or felony; or Injuries sustained while engaging in an illegal occupation. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Illegal Drugs or Medications. Services, supplies, care or treatment to a Covered Individual for illness or Injury resulting from that Covered Individual's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Incurred by Other Persons. Services, supplies, care or treatment expenses actually Incurred by other persons, except as specified.

Infertility. With respect to infertility, invitro or invivo fertilization, artificial insemination, or any other impregnation procedure, fertility drugs, any treatment other than that which treats a medical condition, diagnostic tests unless necessary to diagnose a medical condition, and fertility supplies, treatment and counseling.

Marital or Pre-Marital Counseling. Care and treatment for marital or pre-marital counseling.

Massage Therapy. Services and supplies related to treatment by massage therapy.

Music Therapy. Music therapy, or remedial reading therapy or treatment for learning disabilities. (However diagnosis and treatment are covered for ADD and ADHD).

Negligence. For Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

Negotiated Rates. Expenses incurred in excess of negotiated rates.

No Charge. Care and treatment for which there would not have been a charge if no coverage had been in force.

Non-Emergency Hospital Admissions. Care and treatment billed by a Hospital for non-Medical Emergency Admissions on a Friday or a Saturday. This does not apply if surgery is performed within twenty-four (24) hours of Admission.

No Obligation to Pay. Charges Incurred for which the Plan has no legal obligation to pay.

No Physician Recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Individual is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Illness or Injury.

Not Medical Necessity. Services, supplies, care or treatment that are not Medically Necessary.

Obesity. Care and treatment of any type of obesity (Including Morbid Obesity), weight loss programs, exercise programs, medications and/or dietary consultations. This exclusion is applicable whether or not it is solely for the treatment of obesity or if it is a part of the treatment plan for another Illness. Counseling services related to eating disorders (ex. anorexia, bulimia) will be provided under benefits for the treatment of Mental Disorders.

Occupational Injury or Illness. Services rendered for treatment of any Illness or Injury for which benefits are available under any worker's compensation employer liability law or services for any Occupational Illness or Injury. Occupational Illness or Injury includes those as a result of any work for wage or profit.

Orthoptics and/or Visual Therapy. Services, and supplies related to treatment by orthoptic and/or visual therapy. *(See also, Eye Care, page 29).*

Orthotics. Orthotics, unless deemed Medically Necessary by the Claims Administrator, orthopedic shoes or other supportive devices for the feet.

Penile Implants. Penile implants and/or any related expenses unless having organic origin.

Personal Comfort Items. Personal comfort items or other equipment, includes but is not limited to; air conditioners, air purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first aid supplies and non-Hospital adjustable beds.

Physician Visits. Charges made by a doctor for phone calls or interviews when the Physician does not see the patient for treatment. This also includes charges for failure to keep a scheduled visit or charges for completion of a claim form.

Plan Limitation. Any costs for treatment that exceed Plan limitation detailed in the Benefits Schedule or elsewhere in the document.

Reasonable and Customary Charges. The part of an expense for care and treatment of an Illness or Injury that is in excess of the Reasonable and Customary Charge.

Removal of Excess Skin. Expenses incurred for the removal of excess skin, unless Medically Necessary.

Replacement Braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Individual's physical condition to make the original device no longer functional or the age of the brace makes it no longer functional.

Replacement of Prosthetic Devices. Replacement of prosthetic devices, except when required because of growth or other physiologic changes or a change in the Covered Individual's condition.

Rolfing. Expenses incurred for services and supplies when used in conjunction with manipulation of the body by Rolf therapy.

Self-Inflicted Injury. Any loss due to an intentionally self-inflicted Injury, while sane or insane. This exclusion does not apply if the Injury resulted from an act of domestic violence. (Under HIPAA, benefits for injuries generally covered under a plan cannot be excluded merely because they were self-inflicted or were sustained in connection with a suicide or attempted suicide if the injuries resulted from a medical condition such as depression.)

Services Before or After Coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

Sex Change. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery and medical or psychiatric treatment.

Speech Therapy. Speech therapy for remedial or educational purposes or for initial development of natural speech. This would apply to Children who have not established a natural speech pattern for reasons that do not relate to a congenital defect. In these cases, speech therapy would be considered educational in nature and not eligible for coverage. Speech therapy would **not** meet coverage criteria for the following conditions: chronic voice strain, congenital deafness, delayed speech, developmental or learning disorders, environmental or cultural speech habits, hoarseness, infantile articulation, lisping, mental retardation, resonance, stuttering, and voice defects of pitch, loudness, and quality.

Sterilization. Sterilization expenses for Dependent male children.

Sterilization Reversal. Care and treatment for reversal of surgical sterilization.

Surrogate Parenting. Expenses incurred in conjunction with surrogate parenting.

Taxes, Postage, Shipping and Handling. Expenses incurred for taxes, postage, shipping and handling.

Timely Filing. Medical care claims filed more than one year from the date of service.

Travel or Accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for Ambulance charges as defined as a covered expense or organ transplant related charges as defined as a covered expense.

Vitamins. Charges for vitamins, minerals, non-prescription food and/or food supplements and non-prescription dietary drugs, except as required by the Patient Protection and Affordable Care Act (PPACA), as amended by the Reconciliation Act and related regulatory guidance.

War. Any loss that is due to a declared or undeclared act of war, or loss due to an act of terrorism committed by the Covered Individual.

Section VII:

Care Management/Precertification Programs

Note: These programs are not designed to be the practice of medicine or to be a substitute for the medical judgment of the treating Physician.

Introduction

This section describes the care management programs available under this Plan and the Covered Individual's responsibilities under these programs. Care management programs assist the Covered Individual(s) under the Plan to obtain the maximum benefit coverage under this Plan while optimizing clinical outcomes across a continuum of care.

The care management programs are designed to assist this Plan in:

1. Evaluating Covered Individual's Healthcare Services to ensure they are Medically Necessary and appropriate;
2. Evaluating alternative levels of care opportunities;
3. Coordinating care needs;
4. Identifying applicable benefit limitations;
5. Identifying high risk Covered Individuals for proactive case management and/or disease management programs when applicable.

This Plan uses the methods described in this section to coordinate and review care, and identify covered medical service expenses under the Plan.

Medical Necessity Determinations

Covered Individuals will receive benefits under this Plan only for Covered Services that are determined to be Medically Necessary* and not Experimental or Investigational*. The fact that a Physician has prescribed, ordered, recommended, or approved a Healthcare Service, or has informed the Covered Individual of its availability does not in itself make it Medically Necessary. This Plan will make the final determination of whether any service is Medically Necessary or is considered Experimental or Investigational.

**See Definitions, page 99.*

How to Obtain Precertification

The Physician, Covered Individual, or someone on the Covered Individual's behalf (e.g., family member) must call the precertification organization listed on the Plan Membership ID Card to receive Precertification. The following information is needed:

1. The name of the Covered Individual and the relationship to the Covered Employee;
2. The name, employee identification number and address of the Covered Employee;
3. The name of the Employer;
4. The name and telephone number of the treating Physician;
5. The name of the facility, proposed date of Admission, and the proposed length of stay when applicable; and
6. The proposed medical or surgical services when applicable.

Note: Failure to follow this procedure will reduce reimbursement received from the Plan. See below.

Penalty for Not Obtaining Precertification

Each time Precertification is required under this Plan but not obtained in connection with a Covered Service performed by a covered In-Network or Out-of-Network Healthcare Provider, eligible charges related to the Covered Services will be reduced as indicated in this Plan Document. The penalty will be paid outside of the Plan. Any such penalty paid by a Covered Individual does not apply to the Deductible.

Inpatient Hospital Precertification

Inpatient Hospital Confinement Precertification is one type of care management program designed to help Covered Individuals receive necessary and appropriate health care while avoiding unnecessary expenses.

This program consists of the following:

1. Precertification of Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:

   a. Hospitalization.
   b. Rehabilitation Facility stays (includes long-term acute care admissions).
   c. Skilled Nursing Facility stays.
   d. Routine and high risk Pregnancy.
   e. Inpatient detoxification.
   f. Inpatient Mental Disorders and Substance Abuse Hospital treatment.

2. Retrospective review of Medical Necessity of the listed services provided on an emergency basis.
3. Concurrent review, based on the admitting diagnosis, of the listed services requested by the treating Physician;
4. Certification of services and planning for discharge from a Hospital or cessation of medical treatment.

Concurrent review of a course of treatment and discharge planning from a Hospital are types of utilization management programs. The Care Management Organization will monitor the

Covered Individual's Hospital stay and coordinate either the scheduled release or an extension of the Hospital stay.

The Care Management Organization should be notified prior to a non-Emergency Admission. In the event of an Emergency Admission, Precertification must be obtained within 48 hours or as soon as reasonably possible given the facts and circumstances of the Emergency Admission.

Benefits for Covered Charges for Medically Necessary Hospital Confinement which would normally be payable will be reduced to 80% for In-Network Providers and 60% for Out-of-Network Providers if admission and length of stay approval is not obtained as specified above, or in the event of an Inpatient admission for Surgery that could have been performed on an Outpatient basis. Furthermore, if the confinement extends beyond the approved length of stay, additional days must be authorized by the Care Management Organization. The same requirements and reduction penalties will apply to the additional days.

Note: In the event that Medicare is primary, precertification review requirements do not apply. In addition, this Plan will accept another carrier's primary precertification if this Plan is the secondary plan.

Other Services Requiring Precertification

The following services should be precertified for Medical Necessity by the care management organization.

- Gastric bypass
    - Gastrectomy, gastric restrictive procedures, lap sleeve, revision of stomach-bowel fusion
- Home and home infusion therapy (home nursing care) – *Recommended for the management of high-cost specialty drugs*
    - Registered nurse, licensed practical nurse or aid in the home
- Home infusion therapy - *Recommended for the management of high-cost specialty drugs*
    - Home infusion therapy for immunotherapy, continuous medications, hydration, total parenteral nutrition, pain management.
- Injectable medications – *Recommended for the management of high-cost specialty drugs*
    - Immune globulin, drugs for factor deficiencies, interferon, Rituxan, some chemotherapeutic agents, botox
- Oral pharynx procedures
    - Uvulectomy, LAUP procedures, palatopharyngoplasty (PPP), uvulopalatopharyngoplasty (UPP)
- Outpatient procedures (potentially cosmetic) *Does not include all outpatient surgeries*
    - Facial reconstruction, varicose vein treatment and breast reconstruction or reduction, blepharoplasty, rhinoplasty
- Potential Experimental and/or Investigational/unproven procedures – *Recommended for the management of high-cost specialty drugs*

    - Kerotoplasty, total disc arthroplasty, molecular pathology and gene analysis, air ambulance, private duty nursing, arthrodesis, external defibrillator, biologic implant
- Spinal procedures
    - Allograft/osteopromotive material for spine surgery, osteotomy, percutaneous vertebroplasty, arthrodesis, laminectomy, vertebral corpectomy, destruction by neurolytic agent, laminotomy, facet joint nerve destruction, spinal cord decompression
- Transplants – *Required opt in with Cigna Lifesource Transplant Network*
    - Adult or pediatric, living or cadaveric donors for heart, heart/lung, intestinal, liver, pancreas, pancreatic islet cell, multivisceral solid organ transplants, preparation for and including allogeneic/autologous hematopoietic/bone marrow transplants
- Unlisted procedures
    - Vascular surgery, miscellaneous DME, unclassified drugs/biologics including antineoplastics, lower extremity prosthesis.

Authorization must be obtained for services prior to the start of treatment. Covered Charges for professional and/or facility fees for any services for which the required Precertification is not obtained will be reduced to 80% for In-Network Providers and 60% for Out-of-Network Providers if approval is not obtained as specified above.

Further authorization will be required if the duration of treatment is expected to extend beyond the Precertification period. In addition, the penalty indicated above will apply to each date of service for which authorization has not been obtained.

Note: In the event that Medicare is primary, precertification review requirements do not apply. In addition, this Plan will accept another carrier's primary precertification if this Plan is the secondary plan.

Case Management

The Plan may, at its sole discretion and when acting on a basis that precludes individual selection, permit alternative benefits that may otherwise not be payable under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's decision to permit the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Individual, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan. Case Management is a cost management program administered to provide a timely, coordinated referral to alternative care facilities to a Covered Individual who suffers a catastrophic Illness or Injury while covered under this Plan.

The following are examples of diagnoses that might constitute a catastrophic Illness or Injury:

- High Risk Pregnancy
- Neonatal High Risk Infant
- Cerebral Vascular Accident (CVA or Stroke)

- Multiple Sclerosis
- Amyotrophic Lateral Sclerosis (ALS)
- Cancers/Tumor Malignancy
- Severe Cardio/Pulmonary Disease
- Leukemia
- Major Head Trauma and Brain Injury Secondary to Illness
- Spinal Cord Injury
- Amputation
- Multiple Fractures
- Severe Burns
- AIDS
- Transplant
- Any claim expected to exceed $25,000

When the Case Manager is notified of one of the above diagnoses (or any other diagnosis for which Case Management might be appropriate in the Plan's sole discretion), the Case Manager will contact the Covered Individual to discuss current medical treatment and facilitate future medical care. The Case Manager will also consult with the attending Physician to develop a written plan of treatment outlining all medical services and supplies to be utilized, as well as the most appropriate treatment setting. The treatment plan may be modified intermittently as the Covered Individual's condition changes, with the mutual agreement of the Case Manager, the patient, and the attending Physician.

All services and supplies authorized by the treatment plan will be considered Covered Services, whether or not they are otherwise covered under the Plan. The benefit level for alternative treatment settings may be the same as the Hospital benefit level, in the absence of the Case Management program. For all other services and supplies, the benefit level will be the same as the benefit for outpatient medical treatment, in the absence of the program.

Any deviation from the treatment plan without the Case Manager's prior approval will negate the treatment plan, and all charges will be subject to the regular provisions of this Plan.

Section VIII:

Eligibility, Enrollment and Effective Dates

Eligibility

1. Eligible Employee

To be an Eligible Employee, an employee must have met the eligibility requirements for employee coverage (described below).

An employee becomes eligible for coverage on the first day of the month following a Waiting Period of 60 consecutive days of employment, not to exceed 90 days.

Waiting Period: This is the time between the first day of employment as an Eligible Employee and the first day of coverage under the Plan.

However, if an Eligible Employee and/or Dependent enrolls as a Late Enrollee or through either an open enrollment period or a Special Enrollment Period as set forth in this section, any period before such late or Special Enrollment Period is not a Waiting Period. Additionally, periods of employment in an employment classification that is not eligible for coverage under this Plan does not constitute a Waiting Period.

An Eligible Employee includes the following:

An active employee who is directly employed in the regular business of and compensated for services by the Employer and regularly works 24 or more hours per week.

The following persons do not meet the definition of an Eligible Employee:

- Independent contractors;
- Leased employees;
- Part-time employees working less than 24 hours per week;
- Temporary employees; or
- Any person who is on active duty in any military service of any country for longer than two (2) weeks, unless coverage may be extended pursuant to USERRA.

2. Eligible Dependents

A Dependent is any one of the following persons:

a. A Covered Employee's Spouse. The term "Spouse" shall mean the lawful husband or wife of a participating Employee who is not legally separated from such Employee. This does not include a common-law spouse. In addition, the Plan Administrator may require documentation proving a legal marital relationship.

b. A Covered Employee’s Child to the last day of the month in which they attain twenty-six (26) years of age.

c. Any Child of a Covered Employee who is an alternate recipient under a qualified medical Child support order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan.

d. A Covered Employee’s Child who is already covered under the Plan, who is 26 years of age or older from the date his coverage would otherwise terminate under the Plan and who is mentally or physically incapable of sustaining his or her own living. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within thirty (30) days after the date the Child attains the limiting age stated above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan.

To be considered an Eligible Dependent, a Covered Employee’s Child must be one of the following:

- A Covered Employee’s natural Child;
- A Covered Employee’s stepchild;
- A Covered Employee’s legally adopted Child;
- A Child placed in the Covered Employee’s physical custody whom the Covered Employee intends to adopt;
- A Covered Employee’s Foster Child;
- A Child for whom the Covered Employee and/or Spouse has been named Legal Guardian;
- An Eligible Employee’s Child or Children for whom the Eligible Employee has a Qualified Medical Child Support Order (QMCSO).

The following persons do not meet the definition of a Dependent:

- Other individuals living in the Covered Employee’s home but are not eligible pursuant to this Plan;
- The legally separated or divorced former Spouse of the Covered Employee;
- Any person on active military duty, unless coverage may be extended under USERRA;
- Any person covered under this Plan as a Covered Employee;
- Any person covered as a Dependent by another Covered Employee; or
- A Covered Employee’s common law spouse, the Children of common-law spouses, same-sex spouses or partners in civil unions.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all Cost Sharing Amounts.

If both mother and father are Covered Employees, any Children will be covered as Dependents of the mother or father, but not both.

Enrollment

1. Enrollment Requirements for Eligible Employees.

An Eligible Employee must enroll for coverage by completing the Plan's enrollment process, along with authorizing any required contribution.

2. Enrollment Requirements for Dependents.

If an Eligible Employee intends to cover any Dependents, those Dependents must also be affirmatively enrolled at the time of the Employee's enrollment or when a Dependent is acquired by a Covered Employee.

3. Enrollment Requirements for Newborn Children.

A newborn Child of a Covered Employee who does not have Dependent coverage or a newborn Child of a Covered Employee who already has Dependent coverage must be affirmatively enrolled in this Plan as stated below under Timely Enrollment. If the newborn Child is not enrolled on a timely basis, any expenses related to the birth will not be covered by this Plan. In addition, if the newborn Child is not enrolled within 30 days of birth, any subsequent enrollment will be considered a Late Enrollment as stated below.

Effective Date of Coverage

1. Effective Date of Eligible Employee Coverage

Coverage for benefits becomes effective on the date the Employee is eligible for coverage provided the Employee has enrolled and authorized any required contribution within 30 days of the date eligible.

2. Effective Date of Dependent Coverage

When a Covered Employee enrolls his Dependents and authorizes any required contributions for Dependent coverage, Dependent coverage will become effective as follows:
If an Eligible Employee has eligible Dependents at the time he enrolls for coverage, then coverage for those Dependents will be effective on the date the Eligible Employee's coverage begins.

If a Covered Employee does not have eligible Dependents on the effective date of his coverage and later acquires an eligible Dependent(s), and if he enrolls for Dependent coverage within 30

days of the date of acquisition, then coverage for those Dependent(s) will become effective on the first of the month following the date of acquisition. However, coverage will be retroactive to the date of birth, adoption or placement for adoption if the Covered Employee's first eligible Dependent is a newborn, an adopted Child or a Child placed for adoption.

If the Covered Employee is already enrolled for Dependent coverage, any newly acquired Dependents must be enrolled within 30 days of acquisition. Coverage will be effective on the first of the month following the date of acquisition. However, coverage will be retroactive to the date of birth, adoption or placement for adoption if the Covered Employee's first eligible Dependent is a newborn, an adopted Child or a Child placed for adoption.

Timely, Open, or Late Enrollment

Timely Enrollment. The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period. If two employees (husband and wife) are covered under the Plan and the Covered Employee who is covering the Dependent Children terminates coverage, the Dependent coverage may be continued by the other Covered Employee with no Waiting Period as long as coverage has been continuous.

Open Enrollment. This Plan has an open enrollment period. "Open enrollment period" means the period of time during the year in which (1) Eligible Employees who are not covered under this Plan may elect to begin coverage and (2) Covered Employees will be given an opportunity to change their coverage elections. The terms of the open enrollment period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an open enrollment period. Generally, the open enrollment period is held during the month of March. Coverage will be effective on the subsequent April 1st.

Late Enrollment. An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during a subsequent open enrollment period.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to a resumption of employment or due to a resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Special Enrollment Rights

Federal law provides Special Enrollment rights under some circumstances. If an Eligible Employee is declining enrollment for the employee and/or Dependent (including a Spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops

contributing towards the other coverage). However, a request for enrollment under these circumstances must be made within 30 days after the other coverage ends (or after the employer completely stops contributions towards the other coverage).

Special Enrollment Periods

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first day of coverage. Thus, the time between the dates a Special Enrollee first becomes eligible to enroll under the Plan as a Special Enrollee and the first day of coverage under the Plan is not treated as a Waiting Period.

1. Individuals losing other coverage creating a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for other coverage meets all of the following conditions:

   a. The Eligible Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

   b. If required by the Plan Administrator, the Eligible Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

   c. The coverage of the Eligible Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions were terminated.

   d. The Eligible Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above.

   Under these circumstances, coverage will begin on the first of the month following the date of enrollment.

2. For purposes of the above rules, a "loss of eligibility" occurs if one of the following occurs:

   a. The Eligible Employee or Dependent has a loss of eligibility due to the other coverage no longer offering benefits to a class of similarly situated individuals (e.g., ceasing to cover part-time employees).
   b. The Eligible Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

c. The Eligible Employee or Dependent has a loss of eligibility when the other coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

d. The Eligible Employee or Dependent has a loss of eligibility when the other coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

Note: Not a Special Enrollment situation. If the Eligible Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent Claim or an intentional misrepresentation of a material fact in connection with the other coverage), that individual does not have a Special Enrollment right under this Plan.

3. New Dependents Creating a Special Enrollment Right.

   a. The Eligible Employee is a Covered Employee under this Plan (or has met the Waiting Period applicable to becoming a Covered Employee under this Plan and is eligible to be enrolled under this Plan but for failure to enroll during a previous enrollment period), and

   b. A person becomes a Dependent of that Employee through marriage, birth, adoption or placement for adoption,

   then the Dependent (and if not otherwise enrolled, the Eligible Employee) may be enrolled under this Plan. In the case of the birth or adoption of a Child, the Spouse of the Covered Employee may also be enrolled as a Dependent of the Covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Eligible Employee must enroll under this Special Enrollment Period in order for any eligible Dependent to enroll.

Note: The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment Period, the Dependent and/or employee must request enrollment during this 30 day period.

The coverage for Dependent and/or Eligible Employee enrolled in the Special Enrollment Period will be effective:

- in the case of marriage, the first of the month following the date of the marriage;
- in the case of a Dependent's birth, as of the date of birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Medicaid and State Child Health Insurance Programs

An Eligible Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if

1. The Eligible Employee or Dependent covered under a Medicaid plan under Title XIX of the Social Security Act or a State Child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent terminated due to loss of eligibility for such coverage, and the Eligible Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or State Child Health Insurance Program (CHIP) coverage terminated.

2. The Eligible Employee or Dependent becomes eligible for assistance with payment of employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Eligible Employee or Dependent requests enrollment in this Plan within 60 days after the date the Eligible Employee or Dependent is determined to be eligible for such assistance.

Note: If a Dependent becomes eligible to enroll under this provision and the Eligible Employee is not then enrolled, the Eligible Employee must enroll in order for the Dependent to enroll**.**

Coverage will become effective on the first of the month following the date of enrollment.

Section IX:

Certificates of Creditable Coverage

Note: This provision may no longer apply after December 31, 2014.

The Plan shall issue a Certificate of Creditable Coverage, automatically and without charge, under the following circumstances:

- For an individual who is a Qualified Beneficiary entitled to elect COBRA coverage, the Certificate of Creditable Coverage shall be issued with the COBRA notice sent after the Qualifying Event.
- For an individual who loses coverage under the Plan, but is not entitled to COBRA coverage, the Certificate of Creditable Coverage shall be issued as soon as reasonably possible after coverage ceases.
- For an individual who is a Qualified Beneficiary and has elected COBRA coverage, the Certificate of Creditable Coverage shall be issued within a reasonable time after the cessation of COBRA coverage or, if applicable, after the expiration of any grace period for the payment of COBRA premiums.

The Plan shall also issue a Certificate of Creditable Coverage at any time within twenty-four (24) months after coverage ceases, provided that the Plan receives a written request for the Certificate of Creditable Coverage by the former Plan Covered Individual (or by another person authorized by the former Plan Covered Individual).

Also upon written request, the Plan shall provide a copy of the Plan Document and other information as outlined in the model form established by HIPAA to provide additional information on categories of benefits for plans that use the Alternative Method of counting Creditable Coverage. The Plan shall charge the requesting entity or individual a fee to cover the reasonable cost of providing this information.

Section X:

Extensions of Coverage

Family Medical Leave Act Qualified Leave of Absence

Coverage during an FMLA leave of absence will be administered in accordance with the policies established by the Employer and applicable law, including the following: (1) during an FMLA leave of absence, coverage under this Plan shall be maintained on the same terms and conditions as the coverage would have been provided had the Covered Employee not taken the FMLA leave, (2) if Plan coverage lapses during the FMLA leave, coverage will be reinstated upon conclusion of the FMLA leave, and (3) coverage shall be reinstated only if the person(s) had coverage under the Plan when the FMLA leave began.

Extended Medical Leave

If a Covered Employee takes an approved medical leave of absence as determined by the Employer, coverage for the Covered Employee and any Covered Dependents may be continued for a maximum of six months to run concurrently with the FMLA leave of absence. The Covered Employee will be responsible for making any required contributions to the Plan.

COBRA

1. **COBRA Initial Notice of Rights.** Under certain circumstances, a Covered Individual may elect to continue coverage under this Plan in accordance with COBRA.

    a. A Covered Individual whose coverage is ending may be able to elect to continue the coverage. Continued coverage shall be provided as required under COBRA. The Employer shall, within the parameters of the law, establish uniform policies for the purpose of providing such continuation of coverage.

    b. COBRA requires most employers with twenty (20) or more employees to offer employees and their families the opportunity to pay for a temporary extension of coverage (called "continuation coverage") at group rates in certain instances where coverage would otherwise end. This information is provided with respect to this Plan.

    c. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay the entire premium for the continuation coverage.

    d. This notice is intended to inform Covered Individuals under this Plan, in summary fashion, of their rights and obligations under the continuation coverage provision of this law. It does not fully describe the individual's continuation coverage rights. For additional information about rights and obligations under the Plan and under federal law,

the individual should contact the Human Resource Department. It is intended that no greater rights be provided than those required by the law.

e. Each person covered under the Plan should read this notice carefully.

2. **Trigger Events**. Upon the commencement of a "qualifying event" each person that loses coverage has rights as a "qualified beneficiary."

3. **Qualifying Event**. A qualifying event is the occurrence of an enumerated event (described below) that results in a loss of coverage under the terms of this Plan.

4. **Qualified Beneficiary**. A qualified beneficiary is the Employee, Employee's Spouse and/or Employee's Dependent Children who on the day before the qualifying event were covered under this Plan. A Spouse whose coverage was reduced or terminated in anticipation of divorce is also a qualified beneficiary. In addition, a Child born to or placed for adoption with a qualified beneficiary who was the Employee is a qualified beneficiary if he was covered under this Plan on the day before the qualifying event. Furthermore, an individual for whom the Employee must provide coverage under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) is a qualified beneficiary.

5. **Employee Loss**. If covered by this Plan, the Employee has the right to elect continuation coverage if he loses coverage under this Plan due to (1) termination of employment (other than for gross misconduct), or (2) a reduction in hours of employment.

6. **Spouse's Loss**. If covered by this Plan, a Spouse has the right to elect continuation coverage if he loses coverage under this Plan due to any of the following:

   a. The Employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;

   b. The Employee's death;

   c. Divorce or legal separation from the Employee; or

Note: If an Employee eliminates coverage for a Spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier.

   d. The Employee's entitlement to (actual coverage under) Medicare.

7. **Dependent Child's Loss.** If covered by this Plan, a Dependent Child has the right to elect continuation coverage if he loses coverage under this Plan due to any of the following:

a. The Employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;

b. The Employee's death;

c. Divorce or legal separation of the Employee and the Dependent Child's other parent;

d. The Employee's entitlement to (actual coverage under) Medicare; or

e. The Child ceasing to be a "Dependent Child" under the terms of this Plan.

8. **Responsibility to Notify**. In certain circumstances, the Covered Individual is required to provide notification to the Plan in order to protect their rights under COBRA.

9. **Notice of Qualifying Event**. Under the law, the Covered Individual (or a representative acting on behalf of the Covered Individual) has the responsibility to inform the Human Resource Department of a divorce, legal separation, or a Child losing Dependent status under this Plan within sixty (60) days of the latest of:

   a. The date of the qualifying event;

   b. The date coverage would be lost because of the qualifying event; or

   c. The date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so.

   The notice must be provided in writing to the Human Resource Department. Oral notice by telephone is not acceptable. The notice must be postmarked no later than the last of the sixty (60) day notice period described above. The notification must:

   - State the name of the Plan;
   - State the name and address of the Employee or former Employee who is or was covered under the Plan;
   - State the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the qualifying event;
   - Include a detailed description of the event;
   - Identify the effective date of the event; and
   - Be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

   If notification is not received within the required time period, continuation coverage will not be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the Employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing

information is not provided within that time, the notification will be ineffective and no continuation coverage will be provided.

10. **Notice of Second Qualifying Event.** In addition, the Covered Individual (or a representative acting on behalf of the Covered Individual) must notify the Plan of the death of the Employee, divorce or separation from the Employee, or a Dependent Child's ceasing to be eligible for coverage as a Dependent under the Plan, if that event occurs within the eighteen (18) month continuation period (or an extension of that period for disability or for pre-termination Medicare entitlement). The notification must be provided within sixty (60) days after such a second qualifying event occurs in order to be entitled to an extension of the continuation period. The notification must be provided in writing and be mailed to the Plan. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. The notice must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

    - State the name of the Plan;
    - State the name and address of the Employee or former Employee who is or was covered under the Plan;
    - State the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;
    - Identify the nature and date of the initial qualifying event;
    - Include a detailed description of the event;
    - Identify the effective date of the event; and
    - Be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

    If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the Employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

11. **Notice of Disability.** The Covered Individual (or a representative acting on behalf of the Covered Individual) must notify the Human Resource Department when a qualified beneficiary has been determined to be disabled under the Social Security Act within sixty (60) days of the latest of:

    a. The date of the disability determination;

    b. The date of the qualifying event;

    c. The date coverage would be lost because of the qualifying event; or

d. The date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. (Notwithstanding the foregoing, the notice must be provided before the end of the first eighteen (18) months of continuation coverage.)

The notice must be provided in writing and be mailed to the Human Resource Department. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. The notice must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

- State the name of the Plan;
- State the name and address of the Employee or former Employee who is or was covered under the Plan;
- State the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;
- Identify the nature and date of the initial qualifying event;
- State the name of the disabled qualified beneficiary;
- Identify the date upon which the disabled qualified beneficiary became disabled;
- Identify the date upon which the Social Security Administration made its determination of disability; and
- Include a copy of the determination of the Social Security Administration.

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the Employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided with thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the Human Resource Department of that determination within thirty (30) days of the later of: (1) the date of such determination; or (2) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notice must be in writing and be mailed to the Human Resource Department. Regardless of when the notification is provided, continuation coverage will terminate retroactively on the first day of the month that begins thirty (30) days after the date of the determination, or the end of the initial coverage period, if later. If the individual does not provide the notification within the required time, the Plan reserves the right to seek reimbursement of any benefits provided by the Plan between the date coverage terminates and the date the notification is provided.

Note: Failure to provide timely notice ends the right to COBRA continuation coverage.

12. **Election Rights.** When a qualifying event occurs, or when the Human Resource Department is notified that a qualifying event has occurred in the case of those events in which the Employee has an obligation to provide notice, the Human Resource Department must notify the qualified beneficiaries of the right to elect continuation coverage. Because the Employer and the Human Resource Department are the same entity, the Human Resource Department has forty-four (44) days to provide the option to elect COBRA coverage. Qualified beneficiaries have sixty (60) days to elect continuation coverage measured from the later of (1) the date coverage would be lost because of a qualified event, or (2) the date a notice of election rights is provided. An election is considered "made" on the date sent. If continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If continuation coverage is not elected within this period, coverage under this Plan ends.

Note: Each qualified beneficiary has an independent right to elect continuation coverage. Employees and Spouses (if the Spouse is a qualified beneficiary) may elect continuation coverage on behalf of all qualified beneficiaries and parents may elect continuation coverage on behalf of their children. Furthermore, other third persons can elect continuation coverage on behalf of a qualified beneficiary.

Note: Qualified beneficiaries who are entitled to elect COBRA may do so even if they are covered by Medicare effective on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if he or she first becomes covered by Medicare effective after the date on which COBRA is elected.

13. **Duration.** The law requires that qualified beneficiaries be allowed to maintain continuation coverage as follows:

    a. **Eighteen (18) Months**. If the qualifying event is the Employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment, the continuation period is eighteen (18) months measured from the date coverage would otherwise be lost because of the qualifying event.

    b. **Disability Extension**. For qualified beneficiaries receiving continuation coverage because of the Employee's termination or reduction in hours, the continuation period may be extended eleven (11) months, for a total maximum of twenty-nine (29) months where a qualified beneficiary receives a determination under the Social Security Act that at the time of the Employee's termination of employment or reduction of hours, or within sixty (60) days of the start of the eighteen (18) month continuation period, the qualified beneficiary was disabled. The extension is available to all qualified beneficiaries in the family group.

    c. **Pre-Qualifying Event Medicare Extension**. The eighteen (18) month continuation period may be extended if the Employee became entitled to (actually covered under) Medicare prior to the Employee's termination of employment (other than for gross

misconduct) or a reduction in hours. Qualified beneficiaries other than the Employee are entitled to the greater of (1) eighteen (18) months measured from the qualifying event or (2) thirty-six (36) months measured from the date of the Employee's Medicare entitlement.

d. **Thirty-Six (36) Months.** For qualifying events other than termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period is thirty-six (36) months measured from the date coverage would otherwise be lost because of the qualifying event.

e. **Second Qualifying Events.** If during the initial eighteen (18) month continuation period (or during an extension of that period for disability or for pre-termination Medicare entitlement) a second qualifying event occurs (e.g., divorce or legal separation, death of Employee, loss of Dependent status), that would have caused the qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred, the continuation period for the particular qualified beneficiaries affected by the second qualifying event may be extended to thirty-six (36) months.

Note: Under no circumstances may the total continuation period be greater than thirty-six (36) months from the date coverage would otherwise be lost because of the original qualifying event that triggered the continuation coverage.

14. **Type of Coverage**. Initially, the coverage will be the same coverage as immediately preceding the qualifying event. Thereafter, coverage must be identical to the coverage provided to similarly situated employees or family Covered Individuals that have not experienced a qualifying event. Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active Employees to change their coverage options or to add or eliminate coverage for Dependents at open enrollment. In addition, Special Enrollment rights under HIPAA will apply to those who have elected COBRA.

15. **Cost**. Under the law, a person electing continuation coverage may have to pay all or part of the cost of continuation coverage. The individual will receive additional information regarding the cost requirements following the occurrence of a qualifying event. The amount charged cannot exceed 102% of the cost to the Plan of providing the coverage. The amount may be increased to 150% for the months after the eighteenth (18th) month of continuation coverage when the additional months are due to a disability under the Social Security Act. Payment is generally due monthly. Payment is considered "made" on the date sent.

16. **Pre-Mature Ending**. The law provides that continuation coverage shall automatically end for any of the following reasons:

a. The Employer no longer provides group health coverage to any of its Employees;
b. The premium for continuation coverage is not paid on time (including any applicable grace period);

c. After electing COBRA, the qualified beneficiary becomes covered under another group plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that he has. This provision may no longer apply after December 31, 2014.

Note: Under HIPAA, an exclusion or limitation under the other group health plan might not apply at all, depending on the length of the qualified beneficiary's Creditable Coverage prior to enrolling in the other group health plan. If the other group health plan has applicable exclusions or limitations, then COBRA coverage terminates after the exclusion or limitation no longer applies (for example, after a twelve (12) month preexisting condition waiting period expires). This provision may no longer apply after December 31, 2014.

d. After electing COBRA coverage, the qualified beneficiary becomes entitled to (actually covered under) Medicare.

Notice Obligation: The Covered Individual (or a representative acting on behalf of the Covered Individual) must notify the Plan Administrator immediately if any qualified beneficiary actually becomes covered by another group health plan or Medicare. Regardless of when such notification is provided, coverage will terminate retroactively to the date of the coverage under the other group health plan or Medicare. If, for whatever reason, a qualified beneficiary receives any benefits under the Plan after coverage is to cease under these rules, the Plan reserves the right to seek reimbursement from the qualified beneficiary.

e. With respect to disability extension coverage, a final determination that the qualified beneficiary is no longer disabled (this cuts short the coverage for all qualified beneficiaries with extended coverage); or

f. Termination for cause under the generally applicable terms of this Plan (e.g., submission of fraudulent Claims).

17. **Insurability & Conversion.** A qualified beneficiary does not have to demonstrate insurability to elect continuation period. At the conclusion of the available continuation coverage, there must be an opportunity to convert to individual coverage if such coverage is offered under the Plan.

Address Changes: Important information is distributed by mail. In order to protect the Employee's rights and the rights of his family, if a qualified beneficiary's address changes, the qualified beneficiary or someone on his behalf should notify the Plan Administrator's Human Resource Department immediately.

More Information: A person covered under this Plan should contact the Plan Administrator's Human Resource Department with any questions.

For more information about rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, the individual should contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in his area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation Rights Under USERRA

Note: Although USERRA protections look similar to COBRA protections, USERRA rights are separate and independent from COBRA rights.

A Covered Employee may be entitled to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). USERRA requires the Employer to offer Employees and their families (Spouse and/or Dependent Children) the opportunity to pay for a temporary extension of health coverage (called "U-continuation coverage") at group rates where health coverage under Employer-sponsored group health plan(s) would otherwise end because of the Employee's service in the uniformed services.

This notice is intended to inform Covered Individuals, in summary fashion, of their rights and obligations under the continuation coverage provision of USERRA. It is intended that no greater rights be provided than those required by this law. It does not fully describe the individual's U-continuation coverage rights. For additional information about rights and obligations under the Plan and under federal law, the Covered Individual should contact the Human Resource Department.

Each person covered under the Plan(s) should read this notice carefully.

1. **Service Leave Event.** If covered under this Plan, the Employee has the right to elect U-continuation coverage for himself, his Spouse, and his Dependents if they lose coverage under this Plan due to an absence from employment for service in the uniformed services (a "service leave").

2. **Service in the Uniformed Services.** Service in the uniformed services generally means the voluntary or involuntary performance of duties in the uniformed services. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

3. **Election Rights.** The Covered Employee has sixty (60) days to elect U-continuation coverage, measured from the date his absence from employment for the purpose of performing service begins. An election is considered "made" on the date sent. If U-continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If U-continuation coverage is not elected within this period, coverage under the Plan ends. However, if no election is made in a situation in

which he is not required (in accordance with USERRA) to provide advance notice of his service (e.g., because such notice was impossible, unreasonable, or precluded by service necessity), his coverage will be reinstated on a retroactive basis upon his election to continue coverage (regardless of when it is received) and payment of all unpaid amounts due.

Note: A Covered Employee's Spouse and Dependent child(ren) with coverage under the Plan(s) do not have an independent right to elect U-continuation coverage. Their coverage may be continued only if the Covered Employee elects U-continuation coverage.

4. **Duration.** The law requires that a Covered Employee generally be allowed to maintain U-continuation coverage for a twenty-four (24) month period beginning on the date of his absence from employment for the purpose of performing service begins.

5. **Type of Coverage.** Initially, the coverage will be the same coverage as immediately preceding the service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated Employees or Dependent Covered Individuals that are not on service leave.

6. **Cost.** A person electing U-continuation coverage may have to pay all or part of the cost of U-continuation coverage. If the Covered Employee performs service in the uniformed services for fewer than thirty-one (31) days, he will pay the same amount for the coverage that he normally pays. If his service exceeds thirty (30) days, the amount charged cannot exceed 102% of the cost to the Plan of providing the coverage.

   Payment is generally due monthly on the first day of the month. Payment is considered "made" on the date sent. The Covered Employee will be given a grace period within which to make the payment. The length of the grace period will be thirty (30) days.

7. **Termination of the Continuation Coverage**. The U-continuation coverage may be terminated for any of the following reasons:

   a. The Employer no longer provides group health coverage to any of its Employees;

   b. The premium for U-continuation coverage is not paid on time (including the grace period);

   c. The Employee's failure to return from service or apply for a position of employment as required under USERRA; or

   d. Termination for cause under the generally applicable terms of this Plan (e.g., submission of fraudulent benefit Claims).

8. **Insurability**. The Employee does not have to demonstrate "insurability" to elect U-continuation coverage.

Section XI:

Termination and Reinstatement of Coverage

Employee Termination of Coverage

Employee coverage will terminate on the earliest of the following dates. (In certain circumstances, a Covered Employee may be eligible for COBRA or USERRA Continuation of Coverage. See the Extension of Coverage Section in this document.)

- The date this Plan is terminated.
- The last day of the month in which the Covered Employee ceases to be an Eligible Employee. This includes death or termination of employment of the Covered Employee.
- The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- The date the Covered Employee begins active duty in the Armed Forces of any country for longer than two weeks, unless coverage may be extended pursuant to USERRA.
- The date the Covered Employee elects in writing that termination of coverage occurs.
- If a Covered Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under this Plan, then the Plan may either terminate coverage as of a date to be determined at the Plan's discretion, consistent with applicable law, including the rules regarding Rescission.

This Plan will provide a Certificate of Creditable Coverage after the Covered Employee's coverage terminates under the Plan. (See Certificates of Creditable Coverage section.) This provision may no longer apply after December 31, 2014.

Dependent Termination of Coverage

A Dependent's coverage will terminate on the earliest of the following dates. (In certain circumstances, a Covered Dependent may be eligible for COBRA Continuation of Coverage. See the Extension of Coverage section in this document.)

- The date the Plan, or Dependent coverage under this Plan, is terminated.
- The date that the Covered Employee's coverage under this Plan terminates for any reason, including death.
- The date a Dependent Spouse ceases to be a Dependent as defined by this Plan.

- The last day of the month in which a Dependent Child ceases to be a Dependent as defined by this Plan.

- In the case of a Child age 26 or older for whom coverage is being continued due to mental retardation or physical handicap, the earliest to occur of:

    - Cessation of such handicap;

    - Failure to furnish any required proof of the uninterrupted continuance of such handicap or to submit to any required examination;

    - Upon the Child's no longer being dependent upon the Covered Employee for support.

- The end of the period for which the required contribution has been paid if the required contribution for the next period is not paid when due.

- If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Plan may terminate coverage as of a date to be determined at the Plan's discretion, consistent with applicable law including the rules regarding Rescission.

- For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the calendar month as of which coverage is no longer required under the terms of the order of this Plan.

The Plan will provide a Certificate of Creditable Coverage after the Dependent's coverage terminates under the Plan. This provision may no longer apply after December 31, 2014.

Rescission

Coverage under this Plan may be Rescinded under certain circumstances. A determination by the Plan that a Rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Covered Individual whose coverage is being Rescinded will be provided a 30-day notice period as described under Health Care Reform and regulatory guidance. Such notice shall be considered an Adverse Benefit Determination. At the conclusion of the 30-day notice period, coverage shall be terminated retroactive to the date identified in the notification. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid Claims by this Plan.

Reinstatement of Coverage for COBRA Covered Individuals

A qualified beneficiary who has elected COBRA continuation coverage will be considered to have had no lapse of coverage, provided the coverage is in effect on the day before the employee returns to eligible employment.

Reinstatement of Coverage Following a Military Leave

Special Rules apply to those Eligible Employees whose coverage is reinstated following a leave of absence governed by the Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA). Under USERRA, a Covered Individual entitled to have coverage reinstated upon returning to work following a military leave of absence shall be treated as if no break in coverage occurred during the leave. In addition, any Deductible or Out-of-Pocket Maximum satisfied prior to the USERRA leave will be credited if reinstatement takes place during the same Calendar Year in which the expenses were Incurred. For more information regarding USERRA rights, see the Extension of Coverage section of this document

Reinstatement of Coverage Following Termination of Employment

If a Covered Employee terminates his employment with the Employer and is subsequently rehired within 30 days from the date of termination, the Covered Employee and any Dependents will have coverage reinstated on the return-to-work date provided that an enrollment form is submitted. The Waiting Period will only apply to the extent it was in effect on the day of termination. Any Deductible satisfied prior to the termination will be credited if reinstatement takes place during the same Calendar Year in which the expenses were Incurred. If a Covered Employee terminates his employment with the Employer and is subsequently rehired after 30 days from the date of termination, the employee will be treated as a newly hired employee and will be required to satisfy all eligibility and enrollment requirements.

Section XII:

Coordination of Benefits

Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans including Medicare are paying. When a Covered Individual is covered by this Plan and another plan, or the Covered Individual's Spouse is covered by this Plan and by another plan or the couple's Covered Children are covered under two (2) or more plans, the plans will coordinate benefits when a Claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans may pay the balance due up to one hundred (100%) percent of the total Allowable Charge (defined below for purposes of this Section).

Benefit Plan

This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- Group or group type plans, including franchise or blanket benefit plans.
- Blue Cross and Blue Shield group plans.
- Group practice and other group prepayment plans.
- Federal government plans or programs. This includes, but is not limited to, Medicare and TRICARE.
- Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge

For a charge to be "allowable" it must be a Reasonable and Customary Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization): This Plan will not consider any charges in excess of what an HMO has agreed to accept as payment in full. Also, when an HMO plan is primary and the Covered Individual does not use an HMO provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO had the Covered Individual used the services of an HMO provider.

In the case of service-type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Benefit Plan Payment Order

When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

2. Plans with a coordination provision will pay their benefits up to the allowable charge:

   a. The benefits of the plan which covers the person directly (that is, as an employee, Covered Individual or Covered Employee) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B"). However, if the person covered directly is a Medicare beneficiary, and if Medicare is secondary to Plan B and if Medicare is primary to Plan A (for example, if the person is a retiree), then Plan B will pay before Plan A.

   b. The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

   c. The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired or a Dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

   d. When a Child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

      i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

      ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

   e. When a Child's parents are divorced or legally separated, these rules will apply:

      i. This rule applies when the parent with custody of the Child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

ii. This rule applies when the parent with custody of the Child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the Child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

iii. This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the Child. In this case, the benefit plan of that parent will be considered before other plans that cover the Child as a Dependent.

iv. 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 above when a is covered as a Dependent and the parents are not separated or divorced.

v. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

f. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

g. If a Covered Individual is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

h. The Plan will pay primary to TRICARE and a state child health plan to the extent required by federal law.

Coordination with Medicare

A Covered Employee and his Spouse (ages 65 and over) may, at the option of such Covered Employee, elect or reject coverage under this Plan. If such Covered Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

To the extent required by federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor. The Covered Individual will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Covered Individual has enrolled for the full coverage. If the Healthcare Provider accepts assignment with Medicare, covered expenses will not exceed the Medicare-approved expenses.

If any Covered Individual is eligible for Medicare benefits because of End Stage Renal Disease, the benefits of the Plan will be determined before Medicare benefits until the end of the Medicare secondary coordination period.

The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS.

Claims Determination Period

Benefits will be coordinated on a Plan Year basis. This is called the Claims determination period.

Right To Receive or Release Necessary Information

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Individual will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of Payment

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery

Whenever payments have been made by this Plan with respect to Allowable Charges in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Charges, and any future benefits payable to the Covered Individual.

Medicaid Coverage

A Covered Individual's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Individual. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Individual, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

Workers' Compensation

Coverage under this Plan is not in lieu of workers' compensation.

Section XIII:

First and/or Third Party Recovery, Subrogation & Erroneous Payment

Condition of Payment

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Individuals, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Individual(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including No-fault Auto Insurance, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Outside Coverage").

2. Covered Individual(s), his attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred (100%) percent of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Individual(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Individual(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Individual(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Covered Individual(s) settles, recovers, or is reimbursed by any coverage, the Covered Individual(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Individual(s). If the Covered Individual(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Individual(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Individual(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

5. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Individual(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a

subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

6. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Individual(s).

7. This Plan's right of subrogation and reimbursement will continue to apply without regard to coverage status or whether the Covered Individual has terminated coverage under the Plan.

8. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease or disability.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Individual(s) agrees to assign to the Plan the right to subrogate and pursue any and all Claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the Covered Individual(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

2. If a Covered Individual(s) receives or becomes entitled to receive benefits under this Plan, an automatic equitable lien attaches in favor of the Plan to any Claim, which any Covered Individual(s) may have against any coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Individual(s) commence a proceeding or pursue a Claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Covered Individual(s) fails to file a Claim or pursue damages against:

    a. The responsible party, its insurer, or any other source on behalf of that party;

    b. Any first party insurance through medical payment coverage, personal Injury protection, No-fault Auto Insurance coverage, uninsured or underinsured motorist coverage;

    c. Any policy of insurance from any insurance company or guarantor of a third party;

    d. Worker's compensation or other liability insurance company; or

    e. Any other source, including, but not limited to, crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Individual(s) authorizes the Plan to pursue, sue, compromise and/or settle any such Claims in the Covered Individual(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the pursuance of any such Claims. The Covered Individual(s) assigns all rights to the Plan or its assignee to pursue a Claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover one hundred (100%) percent of the benefits paid under this Plan, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Individual(s) is fully compensated by his recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Individual(s)' recovery is less than the benefits paid under this Plan, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

Erroneous Payments

To the extent payments made by this Plan with respect to a Covered Individual are in excess of the maximum amount of payment necessary under the terms of the Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following sources, as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are either responsible for payment or received payment in error, and any future benefits payable to the Covered Individual.

Excess Insurance

Except as otherwise provided under the Plan's *Coordination of Benefits section*, the following rule applies:

1. If at the time of Injury, Illness, disease or disability there is available, or potentially available any coverage (including coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

2. The Plan's benefits shall be excess to:

    a. The responsible party, its insurer, or any other source on behalf of that party;

b. Any first party insurance through medical payment coverage, personal Injury protection, No-fault Auto Insurance coverage, uninsured or underinsured motorist coverage;

c. Any policy of insurance from any insurance company or guarantor of a third party;

d. Workers' compensation or other liability insurance company; or

e. Any other source, including, but not limited to, crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Individual(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Individual(s), such that the death of the Covered Individual(s), or filing of bankruptcy by the Covered Individual(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Covered Individual(s) dies as a result of his Injuries and a wrongful death or survivor claim is asserted against a third party or any outside coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

1. It is the Covered Individual(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

   a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights. The Covered Individual will furthermore agree to cooperate on all occasions, in a timely manner, regardless of whether the right to subrogation or reimbursement is being exercised by the Plan;

   b. To provide the Plan with pertinent information regarding the Illness, disease, disability, or Injury, including Accident reports, settlement information and any other requested additional information;

   c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

   d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

   e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

f. To not settle or release, without the prior consent of the Plan, any Claim to the extent that the Covered Individual may have against any responsible party or outside coverage.

2. If the Covered Individual(s) and/or his attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Individual(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Individual(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Individual(s)' cooperation or adherence to these terms.

These provisions apply even if the Covered Individual has terminated coverage.

Offset

Failure by the Covered Individual(s) and/or his attorney to comply with any of these requirements described in this Section may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Covered Individual(s) may be withheld until the Covered Individual(s) satisfies his obligation.

Minor Status

In the event the Covered Individual(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Severability

In the event that any provision of this section is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this section and Plan. The provision shall be fully severable. The Plan shall be construed and provisions enforced as if such invalid or illegal provision had never been inserted in the Plan.

SECTION XIV:

HIPAA Privacy & Security

Compliance with HIPAA Privacy and Recovery Standards

Certain Covered Individuals of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

1. **General.** The Plan shall not disclose Protected Health Information to any Covered Individual of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy & Security Section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

2. **Permitted Uses and Disclosures**. Protected Health Information disclosed to Covered Individuals of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions.

   The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of Healthcare Providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

3. **Authorized Employees.** The Plan shall disclose Protected Health Information only to Covered Individuals of the Employer's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy & Security Section, "Covered Individuals of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

4. **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the Covered Individuals of its workforce who are authorized to receive Protected Health Information.

5. **Use and Disclosure Restricted.** An authorized Covered Individual of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his duties with respect to the Plan.

6. **Resolution of Issues of Noncompliance.** In the event that any Covered Individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

   a. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

   b. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

   c. Mitigating any harm caused by the breach, to the extent practicable; and

   d. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

Certification of Employer

The Employer must provide certification to the Plan that it agrees to:

1. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan Documents or as required by law;

2. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

4. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

5. Make available Protected Health Information to individual Plan Covered Individuals in accordance with Section 164.524 of the Privacy Standards;

6. Make available Protected Health Information for amendment by individual Plan Covered Individuals and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

7. Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan Covered Individuals in accordance with Section 164.528 of the Privacy Standards;

8. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

9. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

10. Ensure the adequate separation between the Plan and Covered Individual of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

HIPAA Security Rule

The Employer will comply with the Standards for Security of Individually Identifiable Health Information (the "Security Rule") set forth by HHS pursuant to HIPAA. The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, or maintains electronically that is kept in electronic form ("Electronic PHI" or "ePHI") as required under HIPAA.

Definitions

"Electronic Protected Health Information" (ePHI) is defined in Section 160.103 of the Security Standards (45 CFR 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

"Security Incidents" is defined in Section 164.304 of the Security Standards (45 CFR 164.403) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Employer Obligations

To enable the Employer to receive and use ePHI for Plan Administration Functions (as defined in 45 CFR 164.504(a)), the Employer agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan.

2. Ensure that adequate separation between the Plan and the Employer, as required by 45 CFR 164.504 (f)(2)(iii), is supported by reasonable and appropriate security measures.

3. Ensure that any agent, including a subcontractor, to whom the Employer provides ePHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate reports to the Plan of any Security Incident of which it becomes aware.

SECTION XV:

Claim Filing

Making a Claim. In order for a Covered Charge to be paid by the Plan, a Claim must be properly and timely submitted.

Claims should be mailed to the address indicated on the employee's identification card(s). Employees should contact the Human Resource Department for additional information.

This Plan recognizes four (4) categories of Claims:

- Post-Service Claim;
- Pre-Service Claim;
- Urgent Pre-Service Claim;
- Concurrent Care Claim.

These are all defined terms. More detail may be found in the Definitions section that appears at the end of this document.

Very Important – Period Within Which to Make a Claim: A Claim must be made within 12 months from the date the expense was Incurred. It is the Claimant's responsibility to comply with this requirement.

Note: Just because a Healthcare Provider submits a Post-Service Claim on a Claimant's behalf does not mean the Healthcare Provider is an Authorized Representative. To be an Authorized Representative, procedure (described below) must be followed.

1. **Post-Service Claims.** Healthcare Providers may submit Post-Service Claims on a Claimant's behalf.

    a. A Post-Service Claim must be written and submitted electronically or to HealthSmart Benefit Solutions, Inc. at the address indicated on the Plan's Membership ID Card.

    b. A Post-Service Claim for Covered Services should be filed on a universal billing form. The Healthcare Provider may have this type of form and must include the following information:

        i. The name of the Plan;
        ii. The identity of the Claimant, including name, address, and date of birth
        iii. The date(s) of service;
        iv. The name, credentials and tax identification number of the Healthcare Provider;
        v. The place of service;

vi. A specific diagnosis code (current International Classification of Disease, Clinical Modification (ICD, CM) format);
vii. A specific service code for which payment is requested (current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format);
viii. The amount of billed charges;
ix. if the Claimant has already paid for the medical service or supply and is requesting reimbursement, he must also submit proof of payment;

These forms are also available upon request from the Claims Administrator.

2. **Pre-Service Claims (including Urgent Pre-Service Claims).** Typically, a Pre-Service Claim is made on the Claimant's behalf by the Healthcare Provider as an Authorized Representative. However, it is the Claimant's responsibility to ensure that a Pre-Service Claim has been filed. The Claimant can accomplish this by having his Healthcare Provider contact the Claims Administrator to file a Pre-Service Claim on behalf of the Claimant.

   a. A Pre-Service Claim must be written and submitted electronically or to HealthSmart Benefit Solutions, Inc. at the address indicated on the Plan's Membership ID Card.

   b. An Urgent Pre-Service Claim may be submitted orally to Customer Service at the phone number indicated on the Plan's Membership ID Card.

   c. A Pre-Service Claim must include the following information:

      i. The name of this Plan;
      ii. The identity of the Claimant, including name, address, and date of birth;
      iii. The proposed date(s) of service;
      iv. The name and credentials of the Healthcare Provider;
      v. An order or request from the Healthcare Provider for the requested service;
      vi. The proposed place of service;
      vii. A specific diagnosis;
      viii. A specific proposed service code for which approval or payment is requested [current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format];
      ix. Clinical information for this Plan to make a Medical Necessity determination.

3. **Concurrent Care Claims.** Where an extension is requested for benefits beyond the initially approved benefit, a Claimant should follow the instructions (described above) for how to file a Pre-Service Claim.

4. **Timing and Notification of Claims Decisions.** The time frames within which decisions must be made, whether formal notification shall be made, the details of any required formal notification, etc., are all described later in this document.

5. **Appeals and External Review.** If a Claimant does not agree with the initial Claim decision made by the Plan, the Claimant has a right to appeal that decision and have it reviewed. Under certain circumstances, expedited review may be requested. If the Claimant does not agree with the Claim decision on appeal, the Claimant has the right, in most cases, to request an External Review. These procedures are described later in this document.

6. **Authorized Representative.** For purposes of the Plan's Claim procedure (and appeal procedures described later in this document), an Authorized Representative may act on a Claimant's behalf with respect to any aspect of a Claim (or appeal).

Note: Recognition as an Authorized Representative is completely separate from a Healthcare Provider being an assignee of the Claimant. Assignment, and its limitations under this Plan, are described herein.

   a. For Post-Service Claims, a completed Authorized Representative Form must be received by the Plan in order for the Plan to recognize a person as an Authorized Representative. Authorized Representative Forms are available from the Claims Administrator by request.

   b. For Claims other than Post-Service Claims, the Plan will recognize a Healthcare Provider with knowledge of the Claimant's medical condition as the Authorized Representative unless the Claimant provides written direction to the Claims Administrator otherwise.

Special Note Regarding Authorized Representatives: Once an Authorized Representative has been recognized by the Plan, the Plan will direct all information, correspondence, notifications, etc. regarding the Claim to the Authorized Representative, unless and until the Claimant provides written direction to the Claims Administrator otherwise.

Section XVI:

Claim Appeals Procedures

Introduction. All Claims must be submitted to this Plan and all Claims review must comply with the rules and procedures set forth in this Plan.

> **Note:** Information regarding "Making a Claim" appears in the Claim Filing section of this document. That description is to be read together with this section.

Types of Claims

1. This Plan has four (4) categories of Claims:

   - Post-Service Claim;
   - Pre-Service Claim;
   - Urgent Pre-Service Claim; and
   - Concurrent Care Claim.

2. Each category of Claim has its own set of Claim and appeal requirements. The primary difference between the categories of Claims is the timeframe within which Claims must be determined.

3. For the purposes of determining which Claim and appeal procedures to follow, the Claim type is determined initially. However, if the nature of the Claim changes as it proceeds through the Claim and appeal process, the Claim can be re-characterized. For example, a Claim may initially be an Urgent Pre-Service Claim. If the urgency subsides, it may be re-characterized as a Pre-Service Claim. Once the services are rendered and submitted to this Plan for payment, it becomes a Post-Service Claim.

Filing a Claim

Pre-Service Claims (including Urgent Pre-Service Claims).

- **Incorrectly Filed Claim.** Failure to submit a Claim to the proper place and/or in writing, if requested, may result in the Claim being treated as an incorrectly filed Claim. If a Pre-Service Claim has been filed incorrectly, this Plan will notify the Claimant as soon as possible but no later than the timeframes stated below:

  - **Pre-Service Claims (not including Urgent Pre-Service Claims).** No later than five (5) days following receipt of the incorrectly filed Claim.

  - **Urgent Pre-Service Claims.** No later than twenty-four (24) hours following receipt of the incorrectly filed Claim.

Timeframes for Claim and Pre-Determination Decisions

Note: Nothing precludes a Claimant from voluntarily agreeing to extend the timeframes specified below for this Plan to make a decision.

Timeframes. The following timeframes apply unless the Claim is incomplete, as described below.

1. **Post-Service Claims.** This Plan will determine the Claim within thirty (30) days of receipt of the Claim. If this Plan is not able to determine the Claim within this time period due to matters beyond its control, this Plan may take an additional period of up to fifteen (15) days to determine the Claim. If this additional time will be needed, this Plan will notify the Claimant in writing prior to the expiration of the initial thirty (30) day time period for determining the Claim.

2. **Pre-Service Claims.** This Plan will determine the Claim within fifteen (15) days of receipt of the Claim. If this Plan is not able to determine the Claim within the time period due to matters beyond its control, this Plan may take an additional period of up to fifteen (15) days to determine the Claim. If this additional time will be needed, the Plan will notify the Claimant in writing prior to the expiration of the initial fifteen (15) day time period for determining the Claim.

3. **Urgent Pre-Service Claims.** This Plan will determine the Claim as soon as possible but no later than seventy-two (72) hours after receipt of the Claim.

4. **Concurrent Care Claims.**

   a. For a reduction or termination of coverage for a previously approved benefit, this Plan will determine the Claim sufficiently in advance to allow the Claimant to appeal and obtain a determination on review before coverage for the previously approved benefit is reduced or terminated.

   b. Where an extension is requested by the Claimant for coverage beyond the initially approved benefit,

      i. If the request meets the definition of an Urgent Pre-Service Claim and is filed at least twenty-four (24) hours prior to the end of the treatment, this Plan will determine the Claim within twenty-four (24) hours.

      ii. If the request meets the definition of an Urgent Pre-Service Claim and is filed less than twenty-four (24) hours prior to the end of treatment, this Plan will determine the Claim within seventy-two (72) hours.

iii. If the request does not meet the definition of an Urgent Pre-Service Claim, this Plan will determine the Claim within fifteen (15) days. If this Plan is not able to determine the Claim within this time period due to matters beyond its control, this Plan may take an additional period of up to fifteen (15) days to determine the Claim. If this additional time will be needed, this Plan will notify the Claimant in writing prior to the expiration of the initial time period for determining the Claim.

5. **Incomplete Claims.**

   a. **Post-Service Claims and Pre-Service Claims (not including Urgent Pre-Service Claims).** Incomplete Claims can be addressed through the fifteen (15) day extension of time described above. If the reason for the extension is the failure to provide necessary information and the Claimant is appropriately notified, this Plan's period of time to make a decision is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the Claimant responds or should have responded.

      The notification will include a timeframe of at least forty-five (45) days in which the necessary information must be provided. Once the necessary information has been provided, this Plan will decide the Claim within the extension described above. If the requested information is not provided within the time specified, the Claim may be denied.

   b. **Urgent Pre-Service Claims**. This Plan will notify the Claimant of an incomplete Claim as soon as possible, but no later than twenty-four (24) hours following receipt of the incomplete Claim. The notification will describe the information necessary to complete the Claim and specify the timeframe of at least forty-eight (48) hours within which the Claim must be complete.

      Notification may be made orally to the Claimant or the Healthcare Provider, unless the Claimant requests written notice.

      This Plan will make a Claim determination as soon as possible but not later than the earlier of (1) twenty-four (24) hours after receipt of the specified information, or (2) the end of the period of time provided to submit the specified information.

Notification of Claim Decisions

1. **Plan Provided Notification of a Claim Determination.**

   a. **Post-Service Claims and Concurrent Care Claims.** Notification will be provided only if the decision is an Adverse Benefit Determination.

   b. **Pre-Service Claims (including Urgent Pre-Service Claims).** Notification will be provided whether the Claim or request is approved or denied.

2. **Content of Appeal Notification.**

   a. **Adverse Benefit Determination.** Notice of an Adverse Benefit Determination will be provided in written or electronic form. For Urgent Pre-Service Claims, notification will be provided orally to the Claimant within the timeframe described above and written or electronic notification will be furnished not later than three (3) days after the oral notification.

      The notification will include the following:

      i. The specific reason(s) for the determination;

      ii. Reference to the specific Plan provision(s) on which the determination is based;

      iii. A description of any additional material or information necessary to complete the Claim and an explanation of why such information is necessary;

      iv. A description of this Plan procedures and time limits for appeal of the Adverse Benefit Determination and the right to sue in federal court;

      v. Disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination or a statement that such information was relied upon in making the Adverse Benefit Determination and will be provided free of charge upon request;

      vi. If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of this Plan to the Claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request; and

      vii. Disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist Covered Individuals with the internal Claims and appeals and external review process.

   b. **Not Adverse Benefit Decision.** For Pre-Service Claim and Urgent Pre-Service Claim determinations that are not adverse, notice that the request for Precertification has been approved will be provided.

Appeals Process

The following will apply to all types and levels of Adverse Benefit Determinations:

1. **Submission and Consideration of Comments.** The Claimant will have the opportunity to submit documents, written comments, or other information in support of the appeal. The review of the Adverse Benefit Determination will take into account all information, whether or not presented or available for the initial determination. No deference will be given to the prior determination.

2. **Decision.** The review will be made by a person different from the person who made the prior determination and such person will not be a subordinate of the prior decision maker.
3. **Consultation with Independent Medical Expert**. In the case of a Claim denied on the grounds of a medical judgment, a Healthcare Provider with appropriate training and experience will be consulted. The Healthcare Provider who is consulted on appeal will not be the individual who was consulted, if any, during the prior determination or a subordinate of that individual.

Filing an Appeal

If there is an Adverse Benefit Determination, the Claimant may request a review by the Claims Administrator by filing an appeal.

1. An appeal request must be in writing and submitted to:

   HealthSmart Benefit Solutions, Inc.
   Attn: Covered Individual Appeals
   P.O. Box 366
   Charleston, West Virginia 25332

2. **Special rule for expedited review of Urgent Pre-Service Claims.** A Claimant may request an expedited review orally or in writing and all necessary information (including this Plan's benefit determination on review) will be transmitted by telephone, facsimile, or other available expeditious method.

   a. An appeal must include the following information:

      i. The name of this Plan;

      ii. The identity of the Claimant, including name, address, and date of birth;

      iii. Information regarding the Claim or Pre-Determination request being appealed, such as:

         a) For Post-Service Claims, a copy of the Explanation of Benefits or the Claim number listed on the Explanation of Benefits;

b) For other types of Claims, a copy of the Adverse Benefit Determination notice the Claimant received or other information to identify the Claim;

c) For Pre-Determination requests, a copy of the denial letter;

iv. A statement that the Claimant is requesting an appeal;

v. An explanation of why an appeal is being requested, including the particular aspect of the Adverse Benefit Determination the Claimant is disputing; and

vi. Supporting documentation.

b. An appeal of an Adverse Benefit Determination must be submitted to this Plan within one hundred eighty (180) days following receipt of a notification of an Adverse Benefit Determination of a Claim. Submission to the Plan is accomplished by notifying the Claims Administrator, HealthSmart Benefit Solutions, Inc. If a first level appeal is not requested within these one hundred eighty (180) days, the Claimant loses the right to appeal.

Note: Nothing precludes a Claimant from voluntarily agreeing to extend the timeframes specified below for this Plan to make a decision.

Timeframes for Appeals

A Claimant may voluntarily agree to extend the timeframes specified below for this Plan to make a decision.

1. **Post-Service Claims.** This Plan will make a determination no later than sixty (60) days from the date the first level appeal was received.

2. **Pre-Service Claims.** This Plan will make a determination no later than thirty (30) days from the date the first level appeal was received.

3. **Urgent Pre-Service Claims.** This Plan will make a determination no later than seventy-two (72) hours from the date the first level appeal was received.

4. **Concurrent Care Claims.**

   a. For a reduction or termination of coverage for a previously approved benefit, this Plan will make a determination sufficiently in advance to allow the Claimant to file a second level appeal and obtain a determination before the benefit is reduced or terminated.

   b. Where an extension is requested by the Claimant for coverage beyond the initially approved benefit:

i. If the request meets the definition of an Urgent Pre-Service Claim, this Plan will make a determination no later than seventy-two (72) hours from the date the first level appeal was received.

ii. If the request does not meet the definition of an Urgent Pre-Service Claim, this Plan will make a determination no later than thirty (30) days from the date the first level appeal was received.

Notification of Appeal Decision

Written or electronic notification of this Plan's determination will be provided to the Claimant for all appeals.

1. **When Notice Will Be Provided**. Written or electronic notification of this Plan's determination will be provided to the Claimant for all appeals.

2. **Content of Notification.**

   a. **Adverse Benefit Determination.** The notification will include the following:

      i. The specific reason(s) for the Adverse Benefit Determination;

      ii. Reference to the specific Plan provision(s) on which the determination is based;

      iii. A statement indicating entitlement to receive, upon request, and free of charge, reasonable access to or copies of all documents, records and other information relevant to the Claimant's Claim for benefits;

      iv. A statement regarding additional levels of appeal (if any) and the right to sue in federal court;

      v. Disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination (or a statement that such information will be provided free of charge upon request); and

      vi. If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of this Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

   b. **Not Adverse Benefit Decision.** Notice will be provided that informs the Claimant that the decision has been reversed, and the Claim or Pre-Determination request has been approved.

Healthcare Provider Notification

The Plan may notify the Claimant, person on the Claimant's behalf, Authorized Representative, and Healthcare Provider of Claims decisions even where not otherwise required under this Plan provided such notification does not violate applicable law.

Plan Interpretation

This Plan will be administered in accordance with its terms. The Plan Administrator, Claims Administrator and/or a fiduciary acting as a fiduciary with respect to this Plan, to the extent that such individual or entity is acting in its fiduciary capacity, shall have the complete and final authority, responsibility, and control, in its sole discretion, to manage, administer and operate this Plan, to make factual findings, to construe the terms of this Plan, and to determine all questions arising in connection with the administration, interpretation, and application of this Plan, including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. All determinations and decisions will be binding on this Plan, Covered Individuals, Claimants, and all interested parties.

A Covered Individual's Right to Take Legal Action

Unless there are special circumstances, the appeals process outlined above must be completed prior to initiating legal action regarding a Claim for benefits. If a Claimant intends to initiate legal action [under Section 502(a) of ERISA], he must do so within two (2) years after receipt of a notification of an Adverse Benefit Determination. If, due to special circumstances, the Claimant was not required to complete the appeals process outlined above, legal action must be brought within two (2) years of the date the Claimant's Claim for benefits was submitted to this Plan. Claimants may not bring legal action after the expiration of the two-year period.

Note: This is not the same as the period of time within which a Claim must be submitted to the Plan. A Claim must be made within 12 months of the date the expense was incurred.

Questions Regarding Claims and Appeals Procedures

If a Covered Individual has any questions regarding these procedures, the Covered Individual should contact the Claims Administrator.

Claims Administrator's Customer Service Telephone: 1 (800) 624-8605.

Note: A Covered Individual and the Plan may have other voluntary alternative dispute resolution options available to them, such as mediation. Please contact the local U.S. Department of Labor Office for further information.

Payment of Claims

The above claims processing procedures address only the timeframes within which claims must be decided and not the periods within which payments that have been granted must be actually paid.

Amendment of Claims Procedures

The Employer reserves the right to amend these claims and payment procedures at any time in whole or in part in accordance with the amendment procedures set forth in the Plan.

Federal External Review Process

Review by an accredited independent review organization ("IRO"), separate and apart from the Plan, is available for most Adverse Benefit Determinations once guidance has been implemented. The availability of this review is collectively referred to as "the federal external review process." There are two types of external review, "standard" external review and "expedited" external review.

> **Note**: Regulatory guidance in this area is ongoing. Changes may need to be made to this process. The Covered Individual will be promptly notified of such changes.

Standard External Review

1. If a Covered Individual wants to have a Claim that was denied by the Plan reviewed externally, the Covered Individual (or someone on the Covered Individual's behalf) must file a request for an external review within four (4) months after the date of receipt of notice of an Adverse Benefit Determination. The request for an external review must be made in writing on the form made available by the Claims Administrator and submitted to the Claims Administrator.

2. Within five (5) business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether:

    a. The Covered Individual is (or was) covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, the Covered Individual was covered under the Plan at the time the health care item or service was provided;

    b. The Adverse Benefit Determination is not based on the fact that the Covered Individual was not eligible for coverage under the Plan;

    c. The Covered Individual has exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); and

    d. The Covered Individual has provided all the information and forms required to process an external review.

The Covered Individual (or someone on the Covered Individual's behalf) will be notified by the Claims Administrator of the results of the preliminary review of the request within one business day of the Claim Administrator's completion of the preliminary review. If the request is complete but not eligible for external review, the notice will state the reasons for the request not being eligible for external review and will provide other important information. If the request is incomplete, the notice must describe the information, materials, etc. needed to complete the request. The Covered Individual (or someone on the Covered Individual's behalf) will then be provided time to perfect the request; the longer of the initial four month period within which to request an external review or, if later, forty-eight (48) hours (or such longer period specifically identified in the notice) after the receipt of the notice.

3. With respect to a request that is eligible for external review, the Claims Administrator will assign an IRO to conduct the external review. The parameters under which the IRO will operate include the following:

   The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan. The IRO will notify the Covered Individual (or someone on the Covered Individual's behalf) in writing of the request's eligibility and acceptance for external review and that it has been assigned to conduct the external review. The Covered Individual (or someone on the Covered Individual's behalf) may submit additional information in writing to the IRO within ten (10) business days of the IRO's notification that is has been assigned the request for external review. The IRO must consider this additional information when conducting the external review.

   The Claims Administrator will timely provide to the IRO documents and any information considered in making the Adverse Benefit Determination. The IRO will review all of the information and documents timely received. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

   a. The Covered Individual's medical records;

   b. The attending health care professional's recommendation;

   c. Reports from appropriate health care professionals and other documents submitted by the Claims Administrator, the Covered Individual, or the Covered Individual's treating Healthcare Provider;

   d. The terms of the Covered Individual's summary plan description;

   e. Evidence-based practice guidelines;

   f. Any applicable clinical review criteria developed and used by the Claims Administrator; and

g. The opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

In making its decision, the IRO is not bound by the Plan's prior determination.

4. The IRO will provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision. The notice of the final external review decision shall be provided to the Covered Individual (or someone on the Covered Individual's behalf) and the Plan. To the extent the final external review decisions reverses the Plan's decision (as was reflected in the Adverse Benefit Determination), the Plan shall follow the final external review decision of the IRO.

Expedited External Review. Under certain circumstances, an "expedited" external review may be requested.

1. The Covered Individual (or someone on the Covered Individual's behalf) may request an expedited external review when:

   a. An Adverse Benefit Determination involves a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Covered Individual's life, health, or ability to regain maximum function, and a request for an expedited internal appeal has been filed; or

   An Adverse Benefit Determination involves (i) a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Covered Individual's life, health, or ability to regain maximum function, or (ii) an admission, availability of care, continued stay, or health care item or service for which the Covered Individual received emergency services, but have not been discharged from a facility.

   The request for an expedited external review must be made in writing on the form made available by the Claims Administrator and submitted to the Claims Administrator.

2. Immediately upon receipt of the request for an expedited external review, the Claims Administrator will determine whether the request meets the requirements described above for a standard external review and will notify the Covered Individual (or someone on the Covered Individual's behalf) of its eligibility for expedited determination.

3. When the Claims Administrator determines that the Covered Individual's request is eligible for external review, an IRO will be assigned as described above for a standard external review.

4. The Claims Administrator will provide all necessary documents and information considered in making the Adverse Benefit Determination to the IRO by any available expeditious method.

5. In reaching its decision, the IRO must consider the information or documents as described above for a standard external review and the IRO is not bound by the Plan's prior determination.

6. The IRO will provide notice of the final external review decision as expeditiously as the Covered Individual's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the IRO's notice of decision is not in writing, the IRO must provide written confirmation of the decision within forty-eight (48) hours to the Covered Individual (or someone on the Covered Individual's behalf) and the Plan. To the extent the final external review decision reverses the Plan's decision (as was reflected in the Adverse Benefit Determination), the Plan shall follow the final external review decision of the IRO.

SECTION XVII:

Plan Administrator

Appointment of Committee

The plan shall be administered by a Benefit Committee of the Plan Administrator consisting of at least three persons who shall be appointed by and serve at the discretion of the Plan Administrator.

Responsibilities of the Plan Administrator

Roberts Oxygen Company, Inc. Health Care Plan is the benefit plan of Roberts Oxygen Company, Inc. The Plan Administrator is Roberts Oxygen Company, Inc. The Plan must be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Roberts Oxygen Company, Inc. to act on behalf of Roberts Oxygen Company, Inc.as the Plan Administrator. If the Plan Administrator resigns, dies or is otherwise removed from the position, Roberts Oxygen Company, Inc. shall appoint a new Plan Administrator as soon as reasonably possible.

Powers of the Plan Administrator

1. The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures.

   It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Individual's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan.

   The Plan Administrator or any duly authorized representative of the Plan Administrator will have the right to examine any claim for benefits under this Plan, whether assigned or unassigned. The Plan Administrator will, at the Plan's expense, have the right to have the person whose Illness or Injury is the basis for a claim examined as often as reasonably required during the time a claim is pending under the Plan. The Plan Administrator will not discriminate in treatment of individuals in similar situations, and the Claims Administrator is not obligated to inquire into the circumstances.

   To the maximum permitted under applicable law, the decisions of the Plan Administrator will be final and binding on all interested parties.

2. Service of legal process may be made upon the Plan Administrator.

Duties of the Plan Administrator

The Plan Administrator will have the powers and duties of the general administration of this Plan, including the following:

- To administer the Plan in accordance with its terms;
- To determine all questions of eligibility, status, and coverage under the Plan;
- To adopt and implement procedures, including Care Management recommendations, in its sole discretion
- To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a Covered Individual's rights and/or availability of benefits;
- To prescribe procedures for filing a Claim for benefits, to review Claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the plan documents and all other records pertaining to the Plan;
- To appoint and supervise a Claims Administrator to pay Claims;
- To perform all necessary reporting as required by ERISA;
- To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
- To delegate to any person or entity such powers, duties and responsibilities it deems appropriate; and
- To perform each and every function necessary for or related to the Plan's administration.

Plan Administration Compensation

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of Plans assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to Covered Individuals, and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

- By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- In accordance with the Plan documents to the extent that they agree with ERISA.

Named Fiduciary

A "named fiduciary" is the fiduciary named in the Plan. A Named Fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the Named Fiduciary allocates its responsibility to other persons, the Named Fiduciary shall not be liable for any act or omission of such person unless either:

1. the Named Fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
2. the Named Fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Release of Medical Information

The Plan Administrator and Claims Administrator are entitled to receive information reasonably necessary to administer this Plan, subject to all applicable confidentiality requirements as defined in this Plan and as required by law, from any Healthcare Provider of services to a Covered Individual. By accepting coverage under this Plan, Covered Individuals agree to sign the necessary authorization directing any Healthcare Provider that has attended or treated them, to release to the Plan Administrator and Claims Administrator upon request, any and all information, records or copies of records relating to attendance, examination or treatment rendered to Covered Individual. If the Covered Individual fails to sign the necessary authorization or otherwise inhibits the Plan Administrator and/or Claims Administrator from getting necessary information to pay Claims, this Plan has no obligation to pay Claims.

Payment to Healthcare Providers and Assignment of Benefits

When a Covered Individual receives Covered Services from an In-Network Healthcare Provider, this Plan pays the Healthcare Provider. When a Covered Individual receives Covered Services from an Out-of-Network Healthcare Provider, this Plan pays the Healthcare Provider, unless the Covered Individual provides this Plan with satisfactory proof that the Covered Individual has already paid the Healthcare Provider. A Covered Individual's right to receive payment hereunder is personal to that Covered Individual and may not be assigned, or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or be liable for the debts or obligations of a Covered Individual, except for assignment of the right to receive benefits to a Healthcare Provider. With respect to any assignment to a Healthcare Provider, that Healthcare Provider is subject to the same terms and conditions under this Plan as the Covered Individual.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time,

amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

An amendment to the Plan may be retroactively effective but shall not adversely affect the rights of a Covered Individual under this Plan for covered medical expenses provided after the effective date of the amendment but before the amendment is adopted.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the Plan is terminated, the rights of the Covered Individuals are limited to expenses Incurred before termination. Benefits will be paid only for Covered Services Incurred prior to the termination date. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Section XVIII:

ERISA Statement of Rights

A Covered Individual under this Plan is entitled to certain rights and protections under ERISA. ERISA provides that all Covered Individuals shall be entitled to:

1. Receive information about this Plan and benefits.

2. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing this Plan, including insurance contracts and collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 Series) if required to be filed by this Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

3. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of this Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

4. Receive a summary of this Plan's annual financial report, if an annual financial report is required. The Plan Administrator is required by law to furnish each Covered Employee with a copy of this summary annual report.

Continue Group Health Plan Coverage

1. Continue health care coverage for the Employee, Spouse or Dependents if there is a loss of coverage under this Plan as a result of a qualifying event. Covered Individuals may have to pay for such coverage. Review the COBRA Notice of Rights in this document and the Plan rules governing COBRA continuation coverage rights.

2. Covered Individuals should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when they lose coverage under this Plan, when they become entitled to elect COBRA continuation coverage, when their COBRA continuation coverage ceases, if they request it before losing coverage, or if they request it up to twenty-four (24) months after losing coverage. This provision may no longer apply after December 31, 2014.

Prudent Actions by Plan Fiduciaries

1. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Covered Individuals.

2. No one, including the Employer, a union, or any other person, may fire an employee or otherwise discriminate against an employee in any way to prevent him/her from obtaining a welfare benefit or exercising rights under ERISA.

Enforce Rights

1. If a Claim for a welfare benefit is denied or ignored, in whole or in part, a Covered Individual has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see*: Claim Filing and Claim Appeals* appearing in this document).

2. Under ERISA, there are steps Covered Individuals can take to enforce the above rights. For instance, if a Covered Individual requests a copy of Plan Documents or the latest annual report from this Plan and does not receive them within thirty (30) days, the Covered Individual may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Individual up to $110 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Covered Individual has a Claim for benefits which is denied or ignored, in whole or in part, the Covered Individual may file suit in a state or federal court after exhausting the appeal procedures provided in this Plan (see *Claim Filing and Claim Appeals* appearing in this document). In addition, if a Covered Individual disagrees with this Plan's decision or lack thereof concerning the qualified status of a medical child support order, the Covered Individual may file suit in federal court. If it should happen that Plan fiduciaries misuse this Plan's money, or if a Covered Individual is discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Individual is successful the court may order the person he has sued to pay these costs and fees. If the Covered Individual loses, the court may order the Covered Individual to pay these costs and fees, for example, if it finds the Claim is frivolous.

3. Exhaustion of Administrative Procedures Required. To the fullest extent permitted under applicable law, the right to maintain a court action is subject to the Plan's requirements that administrative procedures be completed first. This is called exhaustion of administrative remedies. Failure to exhaust administrative procedures may preclude a Covered Individual from bringing an action in court.

Assistance with Questions

1. For questions about this Plan, contact the Plan Administrator.

2. For questions about this statement or about a Covered Individual's rights under ERISA, or if a Covered Individual needs assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

3. A Covered Individual may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section XIX:

General Provisions

Applicable Law: This is a self-funded benefit plan coming within the purview of ERISA. As such, when applicable, federal law and jurisdiction preempt state law and jurisdiction.

Conformity with Governing Law: If any provision of this Plan is contrary to any law to which it is subject, such provisions is hereby amended to conform thereto.

Type of Administration: The Plan is a self-funded group health plan and the administration is provided through a Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by Covered Individuals. The Plan is not insured.

Funding: For each Plan Year, the Employer will determine the amount of Covered Individual contributions, if any, that Covered Individuals or any subgroup of Covered Individuals will be required to pay for coverage under this Plan. The portion of the cost of coverage for which the Covered Individual is responsible may be paid by the Covered Employee on a pre-tax basis through a cafeteria plan of the Employer if such a plan is made available by the Employer and the Covered Employee meets the eligibility requirements of the cafeteria plan.

- **Operating Expenses for this Plan**. Operating expenses may be paid either (1) out of Plan assets, if any, or (2) by the Employer.
- **Plan Assets**. To the extent this Plan has assets, such assets shall be used for the sole and exclusive purpose of providing benefits under this Plan and defraying reasonable administrative costs of this Plan (including disposition of Plan assets upon termination of this Plan).
- **No Trust**. There is no trust. Benefits under this Plan are paid from the general assets of the Employer.

Not a Contract: This and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Employer and any Covered Employee or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this Plan Document shall be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee at any time.

No Rights to Assets of Employer or Plan Assets: No Covered Individual shall have any right to, or interest in, any assets of the Employer, or if applicable, any assets of the Plan upon termination of his employment or otherwise. All payments of benefits as provided for in the Plan shall be made solely out of the assets of the Plan and none of the fiduciaries shall be liable therefore, in any manner.

Amendments: The Employer, by action of its Board of Directors at a meeting duly called and held, or by written agreement, reserves the right at any time to make any amendment or amendments, to the Plan at its sole discretion by a signed written document. The Employer will inform all Covered Individuals of any amendment modifying the substantive terms of the Plan not later than two hundred ten (210) days after the close of the Plan Year in which the amendment was adopted; provided however, that if the amendment is a material reduction in services or benefits, the Covered Individual will be notified not later than sixty (60) days after the date of adoption of the amendment.

Non-Alienation of Benefits: Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder shall be void except for the payment of medical services provided under the Plan. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

Legal Entity: This Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Non Discrimination Policy: This Plan will not discriminate against any Covered Individual based on race, color, religion, national origin, disability, gender, sexual preference, or age. This Plan will not establish rules for eligibility based on health status, medical condition, Claims experience, receipt of healthcare, medical history, evidence of insurability, Genetic Information, or disability.

This Plan is intended to be nondiscriminatory and to meet the requirements under applicable sections of the Internal Revenue Code of 1986. If the Plan Administrator determines before or during any Plan Year, that this Plan may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code of 1986 or any limitation on benefits provided to highly compensated individuals, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Covered Employees, to assure compliance with such requirements or limitation.

Effect of Prior Coverage: Coverage for any Covered Individual under this Plan Document replaces any prior coverage in effect for that Covered Individual provided by the Employer under any immediately prior Plan or policy.

Severability: In the event that any provision of this Plan shall be held to be illegal or invalid for any reason by a court of competent jurisdiction, such illegality or invalidity shall not affect the remaining provisions of the Plan and the Plan shall be construed and enforced as if such illegal or invalid provision had never been contained in the Plan.

Headings: Headings are for reference and not for interpretation or construction.

Word Usage: Whenever words are used in this document in the singular or masculine form, they shall where appropriate be construed so as to include the plural, feminine, or neuter form.

Titles for Reference: The titles used within this document are for reference purposes only. In the event of a discrepancy between a title and the content of a section, the content of a section shall control.

Clerical Error: No clerical errors made by the Employer, Plan Administrator, or the Claims Administrator in keeping records pertaining to this coverage or delays in making entries in such records will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any benefits paid will be made.

Misstatements: If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan and its amount.

Refund of Overpayments: If the Plan pays benefits for expenses incurred on account of a Covered Individual, that Covered Individual, or any other person or organization that was paid, must provide a refund to the Plan if either of the following apply:

- All or some of the expenses were not paid by the Covered Individual or did not legally have to be paid by the Covered Individual.
- All or some of the payment the Plan made exceeded the benefits under the Plan.

The refund shall equal the amount the Plan made in excess of the amount it should have paid under the terms of the Plan. If the refund is due from another person or organization, the Covered Individual agrees to help the Plan obtain the refund when requested.

If the Covered Individual, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Mental Health Parity: Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Newborns' and Mothers' Health Protection Act (NMHPA): Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with NMHPA. Federal law requires the following statement be included in the Plan Document, verbatim:

> Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the treating Physician (e.g., the Physician, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour (or ninety-six (96) hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other Healthcare Provider obtain authorization for prescribing a length of stay of up forty-eight (48) hours (or ninety-six (96) hours). However, to use certain providers or facilities, or to reduce the out-of-pocket costs, a Covered Individual may be required to obtain Precertification. For information on Precertification, contact the Plan Administrator.

Women's Health and Cancer Rights Act of 1998 (WHCRA): Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with the WHCRA.

Genetic Information Nondiscrimination Act of 2008 (GINA): Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with the GINA.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA): Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with USERRA. The Plan Administrator shall, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by USERRA.

Section XX:

Definitions

This section defines the terms used in this Plan. These terms appear in initial capital letters throughout this Plan when referred to in the context defined.

Note: There may be other terms defined in specific sections of this Plan that appear just in those sections. Those terms may not be defined in this section.

Accident/Accidental: an unforeseen or unexplained sudden occurrence by chance, without intent or volition.

Admission: the period from entry (admission) into a Hospital or other covered facility until discharge or release. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

Adverse Benefit Determination: a denial, reduction or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit.

Ambulance: a specially designed or equipped vehicle used only for transporting the critically ill or injured to a healthcare facility. The Ambulance service must meet state and local requirements for providing transportation of the sick or injured and must be operated by qualified personnel who are trained in the application of basic life support.

Ambulatory Surgical Center: a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Approved Clinical Trial: a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

1. Federally-funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    a) The Nation Institutes of Health.
    b) The Centers for Disease Control and Prevention.
    c) The Agency for Health Care Research and Quality.
    d) The Centers for Medicare and Medicaid Services.
    e) Cooperative group or center of any of the entities described in subsections (a) through (d) above, or the Department of Defense or the Department of Veterans Affairs.
    f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

g) The Department of Veterans Affairs. The Department of Defense, or the Department of Energy, provided that the study or investigation has been reviewed and approved through a system of peer review that the U.S. government determines –

i. To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and
ii. Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Authorized Representative: a person designated by the Claimant or this Plan to act on behalf of the Claimant.

Benefit Committee: The committee consisting of at least three persons; including a representative from the Executive Branch of the Employer, a representative from the Finance Department, and a representative from the Human Resources Department, to oversee administration of the Plan in accordance with the Plan design, and in accordance with the applicable laws and governmental regulations. If a member of either the Executive Branch or the Finance Department are not available, then a second member of the Human Resources Department will assist in the administration of the Plan.

Birthing Center: any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.
The Birthing Center must provide facilities for obstetrical delivery and short term recovery after delivery; provide care under the full time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name/Brand Name Drug: a trade name medication.

Calendar Year: a twelve month period beginning on the first day of January and ending on the last day of the following December.

Case Manager: the person, who develops, coordinates and implements a plan of care unique to the needs of the Covered Individual. The Case Manager may be (1) made available through the Claims Administrator, or (2) a separate entity with a direct contractual relationship with the Plan.

Child: To be considered an Eligible Dependent, a Covered Employee's Child must be one of the following: natural Child; step Child; legally adopted Child; a Child placed in the Covered

Employee's physical custody whom the Covered Employee intends to adopt; Foster Child; a Child for whom the Covered Employee and/or Spouse has been named Legal Guardian; an Eligible Employee's Child or Children for whom the Eligible Employee has a Qualified Medical Child Support Order (QMCSO).

Furthermore, each Child must be considered a Dependent who is participating under this Plan in accordance with the Eligibility, Enrollment and Effective Dates section and whose coverage has not terminated.

CHIP/CHIPRA: the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time, including the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Claim: a submission to the Plan for payment made under the Plan in accordance with the Plan requirements.

Claimant: a Covered Individual (or the Authorized Representative of the Covered Individual) who is entitled to and makes a Claim for benefits under the Plan.

Claims Administrator: a third party retained by the Plan Administrator and the Plan Sponsor. The Claims Administrator's responsibilities typically consist of initially determining the validity of the Claims and administering benefit payments under this Plan. The actual responsibilities of the Claims Administrator are described in the contract between the Plan Administrator, Plan Sponsor, and Claims Administrator. The Claims Administrator is HealthSmart Benefit Solutions, Inc.

COBRA: the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

Concurrent Care Claim: a Claim that requires Precertification under this Plan that is reconsidered after a course of treatment has been initially approved. There are two types of Concurrent Care Claims: (1) where reconsideration by this Plan results in a reduction or termination of coverage for a previously approved benefit, and (2) where an extension is requested by the Claimant for coverage beyond the initially approved benefit.

Cosmetic Surgery: any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by Illness or Injury.

Cost Sharing Amounts: the dollar amount a Covered Individual is responsible for paying when Covered Services are received from a Healthcare Provider. Cost Sharing Amounts include Coinsurance, Copayment, and Deductible amounts. Cost Sharing Amounts are identified in the applicable Benefit Schedule(s). Healthcare Providers may bill a Covered Individual directly or

request payment of Cost Sharing Amounts at the time Covered Services are provided.

1. **Coinsurance** - the charge a Covered Individual must pay for certain Covered Services after any applicable Deductibles and Copayments have been paid. Covered Services subject to Coinsurance and the amounts are listed in the applicable Benefit Schedule(s). Coinsurance is a percentage of the Covered Services.

2. **Copayment** - the amount a Covered Individual must pay for certain Covered Services. Covered Services subject to a Copayment and the amounts are listed in the applicable Benefits Schedule(s). A Copayment is a flat dollar amount. In some instances, the Covered Individual will be responsible at the time and place of service to pay any Copayment directly to the Healthcare Provider. In other instances, the Covered Individual will be billed by the Healthcare Provider. These arrangements are between the Covered Individual and the Healthcare Provider. Copayments do not count toward the Deductible.

3. **Deductible** - the aggregate amount for certain Covered Services that is a Covered Individual's responsibility each Calendar Year before this Plan will begin to pay for most Covered Services. Copayments do not count toward the Deductible.

4. **Out-of-Pocket Maximum** – the total Copayment amounts for certain Covered Services that are a Covered Individual's responsibility during a Calendar Year. The Out-of-Pocket Maximums are listed in the applicable Benefits Schedule(s). When the Out-of-Pocket Maximum for Medical Benefits is met, this Plan will pay one hundred (100%) percent of the Covered Charges for certain Covered Services Incurred during the remainder of the Calendar Year.

   The Out-of-Pocket Maximum renews on January 1st of each consecutive Calendar Year. The following amounts are not considered or taken into account with respect to the Out-of-Pocket Maximum for Medical Benefits: Charges that are not Covered Services under this Plan (e.g., charges which exceed Reasonable and Customary Charge, and costs paid by the Covered Individual as a result of the Covered Individual's failure to comply with Precertification requirements), and charges in excess of applicable Plan maximums.

Covered Charges: any expense that is eligible for benefits and not otherwise excluded under this Plan.

Covered Dependent: a Dependent who is participating under this Plan in accordance with the Eligibility, Enrollment and Effective Dates section and whose coverage has not terminated.

Covered Employee: an employee who is participating under this Plan in accordance with the Eligibility, Enrollment and Effective Dates section and whose coverage has not terminated.

Covered Individual: a Covered Employee or Covered Dependent who is participating under this Plan in accordance with the Eligibility, Enrollment and Effective Dates section and whose coverage has not terminated. Covered Individual also includes former Covered Employees and former Covered Dependents who are otherwise entitled to coverage and properly enrolled under this Plan.

Covered Services: the reasonable Healthcare Services described in this Plan for which Plan benefits are payable, to the extent described in the Plan and unless otherwise limited or excluded by the Plan.

Creditable Coverage: is coverage required by law to be counted for purposes of offsetting a pre-existing condition period, including most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans. Creditable Coverage does not include liability, dental, vision, specified diseases and/or other supplemental type plans which are defined as excepted benefits by HIPAA.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of sixty-three (63) days or more.

This provision may no longer apply after December 31, 2014.

Custodial Care: is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist: a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent: an individual who meets the requirements for such status as stated in the Eligibility, Enrollment and Effective Dates section of this document.

Durable Medical Equipment: is equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Educational: the primary purpose of a service or supply is to provide the Covered Individual with any of the following: training in the activities of daily living, instructions in scholastic skills such as reading and writing, preparation for an occupation or treatment for learning disabilities.

Elective Surgical Procedure: a surgical procedure that can be scheduled in advance; that is, it is not an Emergency or of a life threatening nature.

Eligible Employee: an employee or former employee who meets the eligibility criteria for this Plan as described in the Eligibility, Enrollment and Effective Dates section and who has not ceased to meet the eligibility criteria.

Employee Contribution. The amount, if any, specified from time to time by the Employer that a participating employee is required to contribute to this Plan in order for such employee and, if applicable, his Dependent(s) to participate in the Plan.

Employer: Roberts Oxygen Company, Inc. and any subsidiary or affiliated entities recognized by Roberts Oxygen Company, Inc. as eligible to participate and that agree to participate in this Plan.

Enrollment Date: the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

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

Experimental or Investigative: for the purposes of determining eligible expenses under the Plan, a treatment (other than off label drug use) will be considered to be Experimental or Investigational if:

- The treatment is governed by the US Food and Drug Administration (FDA) and the FDA has not approved the treatment for the particular condition at the time the treatment is provided; or
- The treatment is subject to ongoing phase I, II, or III clinical trials as defined by the National Institute of Health, National Cancer Institute, or FDA; or
- There is documentation in published US peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine safety, toxicity or efficacy of the treatment.

Any expenses for experimental or investigational treatment, or any Hospital confinement or treatment that results from the experimental or investigational treatment will be excluded from coverage by the Plan.

External Review: Health Care Reform requires External Review be made available in certain circumstances under applicable state or federal procedures. The specifics of External Review are being determined through regulatory guidance. External Review decisions are binding on the Plan and Claimant except to the extent other remedies are available under applicable state and/or federal law.

Family Deductible: the Deductible amount that if incurred by the family members, in aggregate, in a Calendar Year will cause each family member to be treated as having met the Deductible for the remainder of that Calendar Year. For purposes of this calculation, no more than the Individual Deductible will be counted for any family member.

FMLA: the Family and Medical Leave Act of 1993, as amended.

Formulary: a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child: a Child who is placed with the Covered Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. (Proof may be required.)

A Foster Child is not a Child temporarily living in the Covered Employee's home; one placed in the Covered Employee's home by a social service agency which retains control of the Child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic Drug: a prescription drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information: information about the genetic tests of an individual or his family Covered Individuals, and information about the manifestations of disease or disorder in family Covered Individuals of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

GINA: the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information.

Health Care Reform: the provisions of the Patient Protection and Affordable Health Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act (Reconciliation Act), applicable to major medical coverage to the fullest extent allowed by law.

Healthcare Provider: institutional Healthcare Providers or professional Healthcare Providers providing Healthcare Services to Covered Individuals.

Healthcare Services: the provision by Healthcare Providers of all medical treatment, disposable supplies, Durable Medical Equipment, Orthotics, or Prosthetics as defined in this Plan.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency: an organization that meets all of these tests:

1. Its main function is to provide Home Health Care Services and Supplies;
2. It is federally certified as a Home Health Care Agency; and
3. It is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan: must meet these tests: it must be a formal written plan made by the patient's treating Physician; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital Confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies: include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency: an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan: a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies: are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit: a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six (6) months.

Hospital: an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises twenty-four (24) hour a day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

1. A facility operating legally as a Rehabilitation Facility for rehabilitative care.
2. A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
3. A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full time facilities for bed care and full time confinement of at least fifteen (15) resident patients; has a Physician in regular attendance; continuously provides twenty-four (24) hour a day nursing service by a registered nurse (R.N.); has a full time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Hospital Confinement: any confinement in a Hospital for which a charge is made for room and board.

Illness: is a person’s sickness, disease or Pregnancy (including complications).

Including: Including, but not limited to.

Incurred: a Covered Charge is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Charges are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Charges for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Individual Deductible: the Deductible amount that if Incurred by a Covered Individual in a Calendar Year will cause Covered Individual to be treated as having met the Deductible for the remainder of that Calendar Year.

Individual Out-of-Pocket Maximum: the Out-of-Pocket Maximum amount that if satisfied by the Covered Individual in a Calendar Year will cause the Covered Individual to be treated as having met the Out-of-Pocket Maximum for the remainder of that Calendar Year.

Injury: an Accidental physical Injury to the body caused by unexpected external means.

In-Network: the Hospitals, Physicians and other health care providers who are members of or affiliated with the applicable provider Network selected by the Employer. Refer to the Membership ID Card for specific Network provider information.

Intensive Care Unit: a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Late Enrollee: a Covered Individual who enrolls under the Plan other than during the first thirty (30) day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian: a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor Child.

Licensed Practical Nurse or Licensed Vocational Nurse: an individual who is licensed to perform nursing service by the state in which the person performs such service and who is performing within the scope of that license.

Life-threatening Condition: any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Medical Emergency: a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary/Medical Necessity: care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Healthcare Provider of medical or dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare: the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Membership ID Card: an identification card issued in the Covered Employee's name identifying the membership number of the Covered Employee.

Mental Disorder: any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Morbid Obesity: a diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Individual.

Named Fiduciary: Roberts Oxygen Company, Inc.

NMHPA: the Newborns' and Mothers' Health Protection Act.

No-fault Auto Insurance: the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Orthotic: a custom made brace or external device made for a weak, diseased or injured body part. An Orthotic can increase, decrease or eliminate motion or support the weak, diseased or injured body part.

Other Plan: shall include, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Covered Individual;
4. Any first party insurance through medical payment coverage, personal Injury protection, No-fault Auto Insurance coverage, uninsured or underinsured motorist coverage;

5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Workers' compensation or other liability insurance company; or
8. Any other source including, but not limited to, crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Out-of-Network: Healthcare Providers that are not In-Network.

Outpatient Care and/or Services: the treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Physician: a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Medical Dentistry (D.M.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Registered Nurse Anesthetist, Certified Nurse Midwife (C.N.M.), Licensed Clinical Professional Counselor (L.C.P.C.), Licensed Professional Clinical Counselor (L.P.C.C.), Licensed Professional Counselor (L.P.C.), Midwife, Nurse Practitioner (N.P.), Occupational Therapist, Optometrist (O.D.), Physician Assistant (P.A.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Registered Physical Therapist, Registered Respiratory Therapist, Social Workers (S.W., M.S.W., L.C.S.W., A.C.S.W.), Speech Language Pathologist. In addition, the above providers must be licensed and regulated by a state or federal agency and must be acting within the scope of his or her license.

Plan: the Roberts Oxygen Company, Inc. Health Care Plan for the provision of healthcare benefits to Covered Individuals, which is one part of the Roberts Oxygen Company, Inc. Health Care Plan, as amended from time to time.

Plan Administrator: Roberts Oxygen Company, Inc. The Plan Administrator retains ultimate authority for this Plan including final appeal determinations. The Plan Administrator is also the Named Fiduciary for purposes of ERISA.

Plan Sponsor: Roberts Oxygen Company, Inc.

Plan Year: The plan's fiscal year, the twelve (12) month period beginning on April 1 and ending on March 31.

Post-Service Claim: any Claim for a benefit under this Plan that is submitted for payment or reimbursement after the services have been rendered.

Precertification: authorization from this Plan for specific Covered Services before they are rendered, in accordance with the Care Management Programs Section. Requesting Precertification is a Pre-Service Claim as described in the Claim Appeals Procedures Section.

Pregnancy: childbirth and conditions associated with Pregnancy, Including complications.

Pre-Service Claim: any Claim for a benefit under this Plan where receipt of the benefit is specifically conditioned, in whole or part, on receiving approval in advance of obtaining the medical care. Benefits under this Plan that are Pre-service Claims (i.e., require approval in advance) are described in the Care Management Programs Section of this Plan Document.

Preventive Care: Healthcare Services rendered solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.*

(See pages 23-24.)

Prosthetic: a fixed or removable device that replaces all or part of an extremity or body part, Including such devices as an artificial limb, intraocular lens or breast prosthesis.

QMCSO: Qualified Medical Child Support Order as determined by the Plan Administrator under procedures established by the Plan Administrator.

Qualified Individual: a Covered Individual who meets the following conditions:

1. The Covered Individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-threatening Condition; and
2. Either –
   a. The referring Healthcare Provider is participating in the Approved Clinical Trial and has concluded that the Covered Individual's participation in the Approved Clinical Trial would be appropriate based upon the individual meeting the conditions in paragraph 1, above; or
   b. The Covered Individual provides medical and scientific information establishing that the Covered Individual's participation in the Approved Clinical Trial would be appropriate based upon the Covered Individual meeting the conditions described in paragraph 1, above.

Reasonable and Customary Charge: the amount the Plan determines to be the usual charge for comparable services, treatment, or materials in a geographical area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. Geographical area means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

The Plan will base Plan benefits on the actual charge billed if it is less than the Reasonable and Customary Charge.

Reasonable and Customary limitations will not apply to In-Network repriced claims, or Synagis injections.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Registered Nurse: a professional person who is licensed to perform nursing service by the state in which the person performs such service and who is performing within the scope of that license.

Rehabilitation Facility: an inpatient medical facility that is licensed as a Hospital or freestanding Rehabilitation Facility, where licensure is required, or it may be CARF accredited. Physicians and Registered Nurses are on staff and available. This type of facility provides physical, occupational and speech therapy by licensed therapists and also have available a program of structured cognitive therapy. Social work and discharge planning are provided, to include planning for care and equipment needs after discharge.

Rescind or Rescission: to retroactively terminate coverage under the Plan.

Routine Patient Costs: all items and services consistent with the coverage provided by this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include:
- The investigational item, device, or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Covered Individual; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular condition.

Skilled Care: nursing or rehabilitative services requiring the skills of technical or professional medical personnel to develop, provide and evaluate the care and assess the Covered Individual's changing condition.

Skilled Nursing Facility: a facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Illness or Injury. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full time supervision of a Physician.
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or Educational care or care of Mental Disorders.
7. It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Special Enrollee: a Covered Individual who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan and during a Special Enrollment Period. A Late Enrollee is not a Special Enrollee.

Special Enrollment Period: the period of time during which a person may become a Covered Individual due to the occurrence of an event recognized by the Plan as triggering a Special Enrollment Period.

Spinal Manipulation/Chiropractic Care: skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse: the lawful husband or wife of a participating Employee who is not legally separated from such Employee. This does not include a common-law spouse.

Substance Abuse: any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidence by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The current version of the Diagnostic and Statistical Manual of Mental Disorders' definition is maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
4. Continued substance use despite having persistent and recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments within spouse about consequences of intoxication, physical fights).

Temporomandibular Joint (TMJ) Syndrome: Abnormal functioning of the temporomandibular joint which is the connecting hinge mechanism between the base of the skull (temporal bone) and the lower jaw (mandible).

Urgent Pre-Service Claim: a type of Pre-Service Claim. An Urgent Pre-Service Claim is any Claim for medical care or treatment with respect to which the application of timeframes for making non-urgent determinations could seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or- in the opinion of a Physician with knowledge of the Claimant's medical condition – would subject the Claimant to severe pain that cannot be adequately managed without care or treatment that is the subject of the Claim.

USERRA: the Uniformed Services Employment and Reemployment Rights Act of 1994.

Waiting Period: the period of time that must pass before an Eligible Employee and/or Dependent becomes covered under this Plan.

Well Care: see Preventive Care.

WHCRA: the Women's Health and Cancer Rights Act of 1998.

Section XXI

General Plan Information

The following information about this Plan is important for Covered Individuals to know, and much of it is required to be provided.

Plan Name:
Roberts Oxygen Company, Inc. Health Care Plan

Plan Sponsor:
Roberts Oxygen Company, Inc.
P.O. Box 5507
Rockville, Maryland 20855
1 (301) 315-9090

Agent for Service of Legal Process:
Roberts Oxygen Company, Inc.
P.O. Box 5507
Rockville, Maryland 20855
1 (301) 315-9090

Employer Identification Number:
52-0822869

Plan Number:
503

Type of Plan:
Medical Plan

Plan Year Ends:
March 31

Funding:
Health benefits are self-funded by the Employer. The Employer estimates the projected costs of health benefits and determines the amount of these costs to be contributed by the Employees. The Employer deposits Employee contributions and additional Employer contributions from its general assets to a separate trust. The separate trust, known as a voluntary employees beneficiary association ("VEBA"), is tax-exempt under Section 501(c)(9) of the Internal Revenue Code. The Claims Administrator (see below), uses funds from the VEBA to pay medical submitted by Covered Individuals.

Trustee of the VEBA Trust:
William P. Roberts, III c/o Roberts Oxygen Company, Inc. P.O. Box 5507
Rockville, Maryland 20855, telephone 1 (301) 315-9090

Plan Administrator:
Roberts Oxygen Company, Inc.
P.O. Box 5507
Rockville, Maryland 20855
1 (301) 315-9090

Claims Administered By:
HealthSmart Benefit Solutions, Inc.
PO Box 3262
Charleston, West Virginia 25332
1 (800) 624-8605

Type of Plan Administration:
Self-Administered

Source of Plan Contributions:
Contributions for the Plan expenses are obtained from the Employer and from the Employee, and, if applicable, his Dependent(s). The Employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the Employer and the amount to be contributed by the Employees.

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Roberts Oxygen Company, Inc. as of April 1, 2016, hereby amends and restates the Roberts Oxygen Company, Inc. Health Care Plan, which was originally adopted by the Employer.

Effective Date. The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the "Effective Date").

Adoption of the Plan document. The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. (ERISA). This Plan document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan document to be executed.

Roberts Oxygen Company, Inc.

BY:

NAME: William P. Roberts, III

TITLE: President

Addendum

Roberts Oxygen Company, Inc.
Medical Wellness Plan

The Roberts Wellness Plan is a comprehensive health management program that rewards employees, based on their health status and follows the Federal guidelines on “Wellness,” set forth by the DOL, Treasury Department, the Health and Human Services Department and the Affordable Health Care Act. The program was established April 1, 2014.

Eligibility:

Employees and Spouses enrolled in the Roberts Oxygen Company, Inc. plan are eligible to participate in the Wellness Plan.

Purpose:

The Wellness Plan has not only been designed to positively affect the ever-increasing trends in the company’s health care costs, but has also been designed to improve productivity and create an overall improved sense of well-being for our Employees and their Spouses.

The basic goals of the Wellness Plan are:

- Support employees’ and Spouses’ efforts to improve their personal health through educational materials and individual coaching
- Create an attitude of accountability and responsibility for personal health habits
- Coach the participants in healthy lifestyles and the better use of the health care system

Employee Incentive:

The Wellness Program uses an employer insurance premium discount incentive structure to reward employees and spouses who meet a health standard established by Roberts Oxygen, and encourage participation in healthy lifestyles by setting an alternative health standard for those employees and Spouses who don’t meet the Roberts Oxygen health standard. Those people who meet the health standard and those who don’t meet the standard but choose to participate in the Wellness Program by meeting an individually-tailored alternative health standard will enjoy a reduction in their contribution to their health insurance premium. If at any time those participating in the program elect not to participate, they will lose their incentive for the remainder of the plan year, however, they will be allowed to re-enroll at the beginning of the following plan year.