ECM ENERGY SERVICES, INC.
EMPLOYEE HEALTH BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

EFFECTIVE MARCH 1, 2016

THIS DOCUMENT CONTAINS ALL PROVISIONS OF THE PLAN. ANY CONFLICT OR AMBIGUITY ARISING BETWEEN THIS DOCUMENT AND ANY OTHER DOCUMENT OR COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, ANY SUMMARY PLAN DESCRIPTION, BROCHURE, OR ORAL OR VIDEO PRESENTATION, DESCRIBING THE RIGHTS, BENEFITS, OR OBLIGATIONS OF THE COMPANY AND PARTICIPANTS UNDER THE PLAN SHALL BE RESOLVED IN FAVOR OF THIS PLAN DOCUMENT.

MEDICAL BENEFITS ADMINISTRATORS, INC.

Established in 1989, Medical Benefits Administrators, Inc. (MBA) is a subsidiary of Medical Benefits Mutual Life Insurance Co., one of the oldest health insurance firms in the United States. In 1938, the Company entered the insurance business operating under the name Hospital Services Association. Later, it became known as HSA of Ohio.

The name, Medical Benefits Mutual, was adopted in 1987, signaling the Company's establishment as a full-fledged mutual life insurance company. Medical Benefits Administrators, Inc. builds on this great service tradition and commitment to the future by delivering the services the marketplace demands.

MBA is pleased to have been chosen as your Benefit Manager. MBA is committed to the fundamental criteria that distinguish us from the crowd. The first is a commitment to excellent claims administration. The second is a commitment to long term relationships with the people we serve.

We will appreciate your comments and strive to make any dealings with us as simple as possible. If you have any questions about a claim, we invite you to call us at (800) 423-3151, e-mail us at medben@medben.com or to drop in at our offices at 1975 Tamarack Road, Newark, Ohio 43055.

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ARTICLE I

PLAN INFORMATION

NAME OF PLAN
The name of the Plan is the ECM Energy Services, Inc. Employee Health Benefit Plan.

PURPOSE OF THE PLAN
ECM Energy Services, Inc. executes this document, including any amendments, to establish a health benefit plan for the exclusive benefit of its participating employees and their eligible Dependents and to grant them legally enforceable rights under this Plan. While ECM Energy Services, Inc. has every intention of continuing this Plan indefinitely, it reserves the right to amend or terminate the Plan, and the benefits provided hereunder, at any time.

The Plan Administrator has issued a Summary Plan Description to each Participant that summarizes the benefits to which that person is entitled, to whom benefits are payable, and the provisions of this Plan principally affecting the Participant and his or her covered Dependents.

PLAN EFFECTIVE DATE
The Plan Effective Date is March 1, 2016.

AMENDMENT OR TERMINATION
ECM Energy Services, Inc. may amend or terminate the Plan at any time by means of a writing signed by a person authorized by ECM Energy Services, Inc. to do so. Any such amendment or termination shall become effective upon its execution or on such date as may be specified in that writing. Such amendment, modification or termination may result in the termination of Participant and Dependent coverage under the Plan. Expenses incurred prior to any Plan termination will be paid as provided under the terms of the Plan prior to such termination. Any termination of the Plan will be communicated by ECM Energy Services, Inc. to the Participants.

Upon Plan termination, any Plan assets remaining in the Plan's account(s) will be distributed by the Plan Administrator to the Plan Sponsor and/or Participants, in accordance with method(s) set forth in ERISA, or any other applicable law or regulation. The Plan Administrator shall pay all eligible Plan benefits and expenses before any distribution is made.

The terms of the Plan cannot be amended or modified by oral statement(s). Only the Plan Administrator can interpret the terms of the Plan.

ECM Energy Services, Inc. reserves the right, at any time and from time to time, to modify or amend, in whole or in part, any or all of the provisions of the Plan.

PLAN ADMINISTRATOR TAX ID NUMBER (EIN)
46-3275821

PLAN ADMINISTRATOR
ECM Energy Services, Inc.
130 Court Street, Suite #203
Williamsport, Pennsylvania 17701
(888) 523-9095

PLAN NUMBER
501

GROUP NUMBER
10469

PLAN YEAR
The Plan Year is a time period defined for fiscal purposes and used for certain Plan reporting and disclosure requirements. The Plan Year will begin on March 1st and end on the last day of February of the following year.

CALENDAR YEAR
The Calendar Year is the period beginning January 1st and ending December 31st that is used in the application of Deductible, Coinsurance and benefit maximum amounts.

TYPE OF ADMINISTRATION
Contract Administration.

DESCRIPTION OF PLAN
The Plan is an employee health and welfare benefit plan providing medical benefits utilizing a Preferred Provider network, and prescription drug benefits. A copy of the Plan documents and insurance contracts, if any, are on file at the Plan Administrator's office and may be read by any Covered Person at any reasonable time. In the event of any discrepancy between any summary of this Plan and the actual provisions of the Plan document, the Plan document shall govern.

This Plan is self-funded by the Company or Employers, and administered in accordance with the provisions of ERISA. As such, the provisions of ERISA preempt the application of state insurance law to this Plan.

The Plan shall not be deemed to constitute a contract between the Company and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any employee at any time.

NAMED FIDUCIARY
ECM Energy Services, Inc.
130 Court Street, Suite #203
Williamsport, Pennsylvania 17701
(888) 523-9095

AGENT FOR SERVICE OF LEGAL PROCESS
ECM Energy Services, Inc.
130 Court Street, Suite #203
Williamsport, Pennsylvania 17701
(888) 523-9095

In addition, service of legal process may be made upon the Plan Administrator or a Plan Trustee, if a Trustee has been appointed.

FUNDING
The Plan is funded by the Employer. Funds for payment of claims considered under the Plan are forwarded to account(s) from which claims are to be paid.

ASSIGNMENT
A Covered Person’s benefits may not be assigned, except by consent of the Company, other than to Providers of Plan benefits.

SOURCE OF CONTRIBUTIONS

The Plan is funded by contributions made by the Employer and employees who are participating under the Plan. Participant Contributions are currently required for both Participant and Dependent Coverage.

The Company shall, from time to time, evaluate the funding method of the Plan benefits and determine the amount to be contributed by the Employer and the amount to be contributed, if any, by the Participants for each type of coverage.

BENEFIT MANAGER

Medical Benefits Administrators, Inc.
1975 Tamarack Road
P. O. Box 1099
Newark, Ohio 43058-1099
(740) 522-8425
(800) 423-3151
www.medben.com

UTILIZATION REVIEW SERVICE

Quality Care Partners
(888) 258-7621

GRANDFATHERED STATUS UNDER PPACA

This Plan is currently considered to be non-grandfathered for the purposes of the Patient Protection and Affordable Care Act.

ARTICLE II

SCHEDULE OF BENEFITS

2.1 OPTIONS AVAILABLE UNDER THIS PLAN

This Plan offers Plan Participants and their eligible Dependents two (2) different Deductible and Out-of-Pocket maximum options (Base Option or Buy-Up Option, as described in this Article). Both options also include a prescription drug benefit (as listed in Section 2.8 and Section 2.9) with different Copayment structures depending on the option selected. At the time of initial enrollment, and during any subsequent special enrollment or open enrollment period (as described in Article V), the Participant can elect which of these options such Participants and his or her Dependents will be enrolled. All eligible Family members must be enrolled in the same option. Subsequent to his or her initial enrollment, a Participant can only change Plan options during the annual open enrollment period.

2.2 SCHEDULE OF MEDICAL BENEFITS

This Plan provides a higher level of benefits when a Covered Person uses a Preferred Provider for covered services described under this Schedule of Benefits and the Plan. Covered Expenses for services obtained from Preferred Providers are paid at the In-Network (Preferred Provider) level of benefits shown in this Article. Services provided by non-Preferred Providers are considered at the Out-of-Network (non-Preferred Provider) level of benefits, unless one (1) or more of the following conditions are met:

A. the Covered Person requires treatment in an Emergency, and cannot reasonably obtain such treatment from a Preferred Provider or cannot express a Provider preference due to his or her medical condition. The In-Network level of benefits will apply until the Covered Person's condition has sufficiently stabilized so that transfer to a Preferred Provider for any required continued treatment is reasonably possible;

B. the Covered Person requires Medically Necessary services or supplies, and there is no Preferred Provider reasonably available in the Preferred Provider network who is qualified to provide such services, as determined by the Plan Administrator;

C. diagnostic services are collected on a Covered Person in a Preferred Provider's office, that are then sent to an outside Facility for processing and/or interpretation; or

D. the Covered Person receives professional services for pathology, radiology or anesthesiology, or the services of an emergency room Physician, Hospitalist or assistant surgeon at a Preferred Provider Hospital or other Preferred Provider Facility.

In any of the above described situations, such charges will be considered at the In-Network level of benefits described in this Article.

The Preferred Providers have agreed to provide services and supplies to Covered Persons under this Plan in accordance with a previously determined discounted fee schedule. The provisions of the agreements with the Preferred Providers allow Covered Persons to benefit from these discounted fees. After the Plan has paid the appropriate benefits to a Preferred Provider based on such fees, these Providers have agreed not to bill a Covered Person under this Plan for the amount above the discounted fee. Of course, the Covered Person's Deductible, Copayments and Coinsurance will still be applied as described in this Plan.

The Plan will determine Covered Expenses for non-Preferred Providers based upon the Reasonable and Customary fee for the services. In many cases, the amount that would be considered as Reasonable and Customary will be in excess of the fee that a Preferred Provider would charge for the same service under the Plan. This means that the Covered Person may be responsible for an increased dollar amount if an Out-of-Network Provider is utilized. In addition, the payment of any amount in excess of the Reasonable and Customary fee shall be the

responsibility of the Covered Person, in addition to the Deductibles and Coinsurance otherwise applicable under this Plan.

The Plan Administrator will provide, at no cost, a directory of the Preferred Providers.

This Schedule of Medical Benefits is intended to provide only a general description of a Covered Person's medical benefits. This Plan contains limitations and restrictions that are described later in this booklet and could affect any benefits that may be payable.

2.3 MEDICAL DEDUCTIBLE

	In-Network	Out-of-Network
Individual Calendar Year Deductible		
Base Option	$3,000.00	$6,000.00
Buy-Up Option	$750.00	$1,500.00
Family Calendar Year Deductible Limit		
Base Option	$6,000.00	$12,000.00
Buy-Up Option	$1,500.00	$3,000.00

The In-Network Deductible shall not apply to the Out-of-Network Deductible, and vice versa.

2.4 COPAYMENTS

A Copayment of twenty dollars ($20.00) shall apply to charges made by a Preferred Provider Physician for an office visit, not including office visits for wellness services, including Recommended Wellness Services, for second surgical opinions or related to the treatment of Mental/Nervous Disorders, Alcoholism or Substance Abuse. The Copayment will be forty dollars ($40.00), per visit, if the Physician is a Specialist. The Deductible listed in Section 2.3 shall not apply to the office visit charges. The balance of the charges for the office visit will be paid at one hundred percent (100%.) The balance of the Covered Expenses for services performed during the visit will be paid as described in Section 2.6.

Copayments may apply to other visits under this Plan on a per visit or per date of service basis, as described in Section 2.6. If more than one (1) Copayment would apply during the same visit to the same Provider, total Copayments will be limited to the highest Copayment that would otherwise apply.

2.5 MEDICAL COINSURANCE AND OUT-OF-POCKET LIMITS

In-Network (Preferred Provider) Coinsurance	100%
Out-of-Network (non-Preferred Provider) Coinsurance	80%

See Section 2.6, Medical Copayment and Coinsurance Amounts, for Coinsurance amounts that vary from this standard.

Calendar Year Out-of-Pocket Limits

	In-Network *(Applies to In-Network Deductible, any Coinsurance paid at the In-Network level (except as noted below), and any Copayments paid under either the In-Network medical or pharmacy coverage)*	Out-of-Network *(Applies to Out-of-Network Deductible and any Coinsurance paid at the Out-of-Network level (except as noted below)*
Per Individual		
Base Option	$6,850.00	$14,000.00
Buy-Up Option	$6,850.00	$3,000.00

	In-Network *(Applies to In-Network Deductible, any Coinsurance paid at the In-Network level (except as noted below), and any Copayments paid under either the In-Network medical or pharmacy coverage)*	Out-of-Network *(Applies to Out-of-Network Deductible and any Coinsurance paid at the Out-of-Network level (except as noted below)*
Per Family		
Base Option	$13,700.00	$28,000.00
Buy-Up Option	$13,700.00	$6,000.00

Charges that are related to the removal of impacted teeth (and related charges), Out-of-Network Copayments for non-Emergency use of an emergency room, specifically not covered under this Plan, in excess of the Reasonable and Customary limits, attributable to any penalty imposed under this Plan, or in excess of any stated Plan maximum will not apply to the Out-of-Pocket limits listed above. Amounts applied to the In-Network limits shall not apply to the Out-of-Network limits, and vice versa.

2.6 MEDICAL COPAYMENT AND COINSURANCE AMOUNTS

Deductibles are applied on a Calendar Year basis, while Copayments will be applied on a per visit or per service basis, and both reflect amounts to be paid by the Covered Person. Coinsurance reflects the percentage amount of Covered Expenses to be paid by the Plan after any applicable Deductible or Copayment.

	In-Network/ Preferred Provider			**Out-of-Network/ Non-Preferred Provider**	
	Copayment	Deductible	Coinsurance	Deductible	Coinsurance
Routine Pediatric Eye and Vision Examinations included in the Recommended Wellness Services	None	None	100%	*Not Covered*	
Breast Pumps, including Related Supplies/Counseling①	None	None	100%	*Not Covered*	
FDA Approved Female Injectable & Implantable Contraceptives and Contraceptive Devices & Contraception Related Medical Services for Females	None	None	100%	*Not Covered*	
Elective Sterilizations					
All Covered Females	None	None	100%	Applies	80%
Male Participants/Spouses Only	None	None	100%	Applies	80%
Mammograms					
Routine	None	None	100%	None	80%
Diagnostic/Medically Necessary	None	None	100%	Applies	80%
Office-Based Immunizations	None	None	100%	None	80%

	In-Network/ Preferred Provider			Out-of-Network/ Non-Preferred Provider	
	Copayment	Deductible	Coinsurance	Deductible	Coinsurance
Nutritional Counseling Services (including Weight Loss Counseling), Age 2 and Older①	None	None	100%	Applies	80%
Routine Colonoscopy, Sigmoidoscopy, Other Colorectal Screenings, Pap Smears and Prostate Testing①	None	None	100%	None	80%
Other Recommended Wellness Services	None	None	100%	Applies	80%
Second Surgical Opinions	None	Applies	100%	Applies	80%
Chiropractic Services, including Visits, Manipulations and Diagnostics (*per date of service*) ①	$40.00	None	100%	Applies	80%
Occupational Therapy (*per date of service*)①	$40.00	None	100%	Applies	80%
Physical Therapy (*per date of service*)①	$40.00	None	100%	Applies	80%
Speech Therapy (*per date of service*)①	$40.00	None	100%	Applies	80%
Cardiac or Pulmonary Rehabilitation *(per date of service)*①	None	Applies	100%	Applies	80%
Treatment of Autism *(up to age 21)* ①	None	Applies	100%	Applies	80%
Physician's Office Visits not Listed Elsewhere *(per visit)*					
Primary Care Physician/Retail Care Clinic	$20.00	None	100%	Applies	80%
Specialist	$40.00	None	100%	Applies	80%
Other Office-Based Services/Supplies	None	Applies	100%	Applies	80%
Other Physician's Charges	None	Applies	100%	Applies	80%
Post-Partum Home Health Care	None	None	100%	None	100%
Removal of Impacted Teeth, including any Related Medically Necessary Facility/Anesthesia Charges	None	None	50%	None	50%
Other Medically Necessary Facility/ Anesthesia in Connection with Dental Procedures	None	Applies	100%	Applies	80%
Ambulance Services					
Emergency	None	None	100%	None	80%
Non-Emergency	None	Applies	100%	Applies	80%
Urgent Care Facility *(Facility only – per date of service*)	$40.00	None	100%	Applies	80%
Emergency Room Treatment					
Emergency					
Facility	$100.00	None	100%	*Paid at In-Network level*	
Physician	None	Applies	100%		

	In-Network/ Preferred Provider			Out-of-Network/ Non-Preferred Provider	
	Copayment	Deductible	Coinsurance	Deductible	Coinsurance
Non-Emergency					
Facility	$100.00	None	100%	③	100%
Physician	None	Applies	100%	Applies	80%
Dialysis Treatment④	None	Applies	100%	*Paid at In-Network level*	
Hospital Room & Board, Intensive Care Units②	None	Applies	100%	Applies	80%
Other Hospital Expenses	None	Applies	100%	Applies	80%
Ostomy Supplies①	None	None	50%	Applies	80%
Metabolic Formulas	None	None	100%	Applies	80%
Human Organ/Tissue Transplants					
Special Transplant Network	None	Applies	100%	*Not Applicable*	
All Other Providers	*Paid same as other conditions*				
Inpatient and Outpatient Treatment of Mental/Nervous Disorders, Alcoholism & Substance Abuse	None	Applies	100%	Applies	80%
Other Covered Services & Supplies①	None	Applies	100%	Applies	80%

EXPLANATION

① Please see additional limitations in Section 2.7, Medical Plan Benefit Maximums.

② Covered Expenses for Hospital Room & Board will be determined based on the Hospital's daily Semi-Private room rate, unless the Hospital primarily has only private rooms. Charges for Intensive Care Units or other Special Care Units will be considered at the Reasonable and Customary charge for such a unit.

③ In lieu of Deductible, a one hundred dollar ($100.00) Copayment will apply to the Facility charges, per visit. This Copayment will not apply to any Out-of-Pocket limits.

④ No network applies to these services. The Reasonable and Customary amount which, at the Plan Administrator's sole discretion and if applicable, will not exceed the maximum payable amount applicable to the treatment, supplies, and/or services, which typically is one hundred twenty five percent (125%) of the current Medicare allowable fee for the appropriate area. Dialysis Treatment includes kidney dialysis and dialysis related claims.

2.7 MEDICAL PLAN BENEFIT MAXIMUMS

The medical plan maximum benefits and limitations are shown below. All limits listed below are per Covered Person. A daily, per visit or per accident maximum indicates the total Covered Expenses that will be payable at the appropriate Coinsurance percentages shown in the "Medical Copayment and Coinsurance Amount" section above. Both Calendar Year and Lifetime maximums indicate the actual benefits payable under the Plan. Amounts applied to any Calendar Year or Lifetime maximums under any Plan option offered by the Company will also apply to similar limits any other Plan option offered by the Company.

Skilled Nursing Facilities	Sixty (60) days per Calendar Year
Hospice Care, not including Bereavement Counseling	One hundred eighty (180) days per Lifetime
Inpatient Rehabilitation	Forty-five (45) days per Calendar Year
Treatment of Autism Spectrum Disorders, including Related Therapy Services	Limited to Covered Persons up to age twenty-one (21) Forty thousand dollars ($40,000.00) per Calendar Year
Chiropractic Manipulative Therapy	Limited to Covered Persons age eighteen (18) and older Twelve (12) visits per Calendar Year
Other Therapy Services	
Occupational Therapy	Twelve (12) visits per Calendar Year
Physical Therapy	Twenty (20) visits per Calendar Year
Cardiac Rehabilitation	Thirty-six (36) visits per Calendar Year
Pulmonary Rehabilitation/Respiratory Therapy	Eighteen (18) visits per Calendar Year
Speech Therapy	Twelve (12) visits per Calendar Year
Dental Services Related to Early Childhood Caries	Limited to Covered Persons up to age four (4) One (1) treatment per Lifetime
Breast Pumps	Limited to Preferred Providers only One (1) per Pregnancy maximum
Prosthetic Bras following a Mastectomy	Two (2) per Calendar Year
Post-Cataract Prescription Glasses or Contact Lenses	Three hundred fifty dollars ($350.00), per Lifetime for both eyes
Ostomy Supplies *(not including supplies to a Homebound Covered Person through Hospice Care or home health care)*	One thousand dollars ($1,000.00) per Calendar Year
Nutritional Therapy, including Weight Loss Counseling *(not including nutritional counseling provided through home health care)*	Limited to Covered Persons age two (2) and older Six (6) visits per Calendar Year
Routine Prostate Testing	One (1) per Calendar Year

2.8 SCHEDULE OF PRESCRIPTION DRUG CARD PROGRAM

The Plan has a prescription drug card program that covers prescriptions dispensed through a participating pharmacy. The Plan Administrator will provide a listing of the pharmacies that are participating in this program and the drugs that are considered formulary/preferred or high or low cost generic drugs. The Covered Person can elect a thirty (30), sixty (60) or ninety (90) day supply through this program at one (1) time at the applicable Copayment listed below. Certain

exclusions and limitations apply to the prescription drug card program. These are described in Section 10.3 of the Plan.

COPAYMENTS – BASE OPTION

	Thirty (30) Day Supply	Sixty (60) Day Supply	Ninety (90) Day Supply
Certain Over-the-Counter Products (see Section 10.3 for a complete listing)	None	None	None
FDA Approved Contraceptive Products for Females and Tobacco Cessation Products	None	None	None
Tamoxifen and Raloxifene	None	None	None
Other Products included in the Recommended Wellness Services	None	None	None
Other Generic Equivalent Prescription Drugs			
Low Cost	$3.00	$6.00	$9.00
High Cost	$15.00	$30.00	$45.00
Other Brand Name Prescription Drugs			
On Formulary/Preferred Listing	$40.00	$80.00	$120.00
Not on Formulary/Preferred Listing	$65.00	$130.00	$195.00

COPAYMENTS – BUY-UP OPTION

	Thirty (30) Day Supply	Sixty (60) Day Supply	Ninety (90) Day Supply
Certain Over-the-Counter Products (see Section 10.3 for a complete listing)	None	None	None
FDA Approved Contraceptive Products for Females and Tobacco Cessation Products	None	None	None
Tamoxifen and Raloxifene	None	None	None
Other Products included in the Recommended Wellness Services	None	None	None
Other Generic Equivalent Prescription Drugs			
Low Cost	$3.00	$6.00	$9.00
High Cost	$10.00	$20.00	$30.00
Other Brand Name Prescription Drugs			
On Formulary/Preferred Listing	$30.00	$60.00	$90.00
Not on Formulary/Preferred Listing	$55.00	$110.00	$165.00

2.9 SCHEDULE OF MAIL ORDER PRESCRIPTION PROGRAM

The Plan has a mail order prescription drug service. The Covered Person will be able to receive up to a ninety (90) day supply of the medication at one (1) time with a single Copayment. Certain exclusions and limitations apply to the mail order prescription drug program. These are described in Section 10.4 of the Plan.

The Plan Administrator can provide a copy of the drugs that are considered formulary/preferred and the low or high cost generics under this Plan.

COPAYMENTS – BASE OPTION

FDA Approved Contraceptive Products for Females and Tobacco Cessation Products	None
Tamoxifen and Raloxifene	None
Other Products included in the Recommended Wellness Services	None
Other Generic Equivalent Prescription Drugs	
Low Cost	$6.00
High Cost	$30.00
Other Brand Name Prescription Drugs	
On Formulary/Preferred Listing	$80.00
Not on Formulary/Preferred Listing	$130.00

COPAYMENTS – BUY-UP OPTION

FDA Approved Contraceptive Products for Females and Tobacco Cessation Products	None
Tamoxifen and Raloxifene	None
Other Products included in the Recommended Wellness Services	None
Other Generic Equivalent Prescription Drugs	
Low Cost	$6.00
High Cost	$20.00
Other Brand Name Prescription Drugs	
On Formulary/Preferred Listing	$60.00
Not on Formulary/Preferred Listing	$110.00

ARTICLE III

DEFINITIONS

All terms that are defined in this Article III are capitalized wherever they appear in this Plan.

3.1 GENERAL AND MEDICAL PLAN DEFINITIONS

ACTIVELY AT WORK or ACTIVE WORK

The terms "Actively at Work" or "Active Work" mean the active expenditure of time and energy in the service of the Company. A Participant shall be deemed Actively at Work while working the full number of hours shown in Section 5.2 and while in a relationship with the Employer within the meaning of "employee" for federal tax withholding purposes. In addition, individuals acting as independent contractors; leased employees; consultants; a member of the Board of Directors; temporary, free lance, incidental, seasonal or occasional employees; individuals on retainers; or retirees are not considered Actively at Work unless each meets the requirements specified in Section 5.2. This term shall not apply to any provision of this Plan to the extent that such application would be deemed to violate the requirements of HIPAA.

ADJUNCTIVE PROCEDURE

The term "Adjunctive Procedure" means physical measures, such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage and mobilization performed by an individual holding the appropriate licensure and certification.

ADVERSE BENEFIT DETERMINATION

The term "Adverse Benefit Determination" means any of the following:

A. a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's eligibility to participate in the Plan;

B. a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigative or not Medically Necessary or appropriate;

C. a reduction or termination by the Plan Administrator of a previously approved course of treatment, other than by Plan termination or amendment; or

D. any retroactive rescission of coverage (other than due to the failure to make Participant Contributions, fraud or intentional misrepresentation of a material fact), whether or not there is an adverse effect on any particular benefit at that time.

ALCOHOLISM

The term "Alcoholism" means any use of alcohol that produces a pattern of pathological use causing impairment in social or occupational functioning or that produces physiological dependency evidenced by physical tolerance or withdrawal.

In making the determination as to whether the Covered Person's condition meets the definition of Alcoholism under this Plan, the Plan Administrator shall use recognized authorities, including designations contained in the most current editions of the *International Classification of Diseases* (ICD) of the World Health Organization and the *Diagnostic and Statistical Manual of Mental Diseases* (DSM) published by the American Psychiatric Association.

AMBULATORY SURGICAL FACILITY

The term "Ambulatory Surgical Facility" means a Facility Provider with an organized staff of Physicians that has been approved by the Joint Commission, the Accreditation Association for Ambulatory Health Care, Inc., or a similar accrediting agency acceptable to the Plan Administrator that:

A. has permanent facilities and equipment for the purpose of performing surgical procedures on an Outpatient basis;
B. provides nursing services and treatment by or under the supervision of Physicians whenever the patient is in the Facility;
C. does not provide Inpatient accommodations; and
D. is not, other than incidentally, a Facility used as an office or clinic for the private practice of a Physician or Dentist.

APPLIED BEHAVIORAL ANALYSIS
The term "Applied Behavioral Analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

APPROVED CLINICAL TRIAL
The term "Approved Clinical Trial" means 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 Condition and is one of the following:

A. a federally funded trial that is approved or funded, including in-kind contributions, by one (1) or more of the following entities:
    1. the Centers for Disease Control and Prevention;
    2. the Agency for Health Care Research and Quality;
    3. the Centers for Medicare & Medicaid Services;
    4. the National Institutes of Health;
    5. the United States Department of Defense;
    6. the United States Department of Veterans' Affairs;
    7. cooperative group or center of any of the above entities;
    8. the United States Department of Energy; and
    9. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
B. a clinical trial conducted under an FDA investigational new drug application; or
C. a drug trial that is exempt from the requirement of an FDA investigation new drug application.

AUTISM or AUTISM SPECTRUM DISRODER
The terms "Autism" or "Autism Spectrum Disorder" mean any of the Autism Spectrum Disorders defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), or its successor.

AUTISM SERVICE PROVIDER
The term "Autism Service Provider" means a person, entity or group providing treatment of Autism Spectrum Disorders pursuant to a Treatment Plan for Autism Spectrum Disorders that is licensed to perform such treatment in the jurisdiction in which the treatment is rendered or that is enrolled in the state's Medicaid program to provide such services.

BEHAVIOR SPECIALIST
The term "Behavior Specialist" means an individual who designs, implements or evaluates a behavior modification intervention component of a Treatment Plan for Autism Spectrum Disorders, including those based on Applied Behavioral Analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function, through skill acquisition and the reduction or problematic behavior.

BENEFIT MANAGER
The term "Benefit Manager" means the individual or business entity, if any, appointed and retained by the Plan Administrator to supervise the management, consideration, investigation and settlement of claims, maintain records, submit reports and other such duties as may be set forth in a written agreement. If no Benefit Manager is appointed or retained (as a result of the termination or expiration of such agreement or other reason) or if the term is used in connection with a duty not expressly assigned to and assumed by the Benefit Manager in writing, the term will mean the Plan Administrator.

As of the Plan Effective Date, the Benefit Manager of the Plan is Medical Benefits Administrators, Inc.

CALENDAR YEAR
The term "Calendar Year" means the period of time from January 1st, at 12:00 A.M. midnight, through the next December 31st.

CARDIAC REHABILITATION
The term “Cardiac Rehabilitation” means an exercise program that is effective in the physiological and psychological rehabilitation of patients with cardiac conditions.

CHEMOTHERAPY
The term “Chemotherapy” means the treatment of disease by chemical or biological therapeutic agents.

CHIROPRACTIC MANIPULATIVE TREATMENT or SPINAL MANIPULATION
The terms “Chiropractic Manipulative Treatment” or “Spinal Manipulation” mean a form of manual treatment to influence joint and neurophysiological function or the use of Adjunctive Procedures in treating misalignment and displaced vertebrae or articulation and related conditions of the nervous system provided by an individual holding the appropriate licensure and/or certification.

CLEAN CLAIM
The term “Clean Claim” means a billing for a service and/or supply that is submitted to the Plan by a Covered Person or Provider that has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment. It must clearly identify the Covered Person receiving the services or supplies and the Plan to which it is being submitted, and be submitted on an appropriate form that has been properly and entirely completed, as described in Section 4.1 and Section 4.2, including all data elements required by the applicable form. If a claim that has been submitted to this Plan is determined by the Plan Administrator to not constitute a Clean Claim within this definition, the Covered Person and/or the Provider will be notified of the defects, and it will not be considered to have been received by the Plan until all required information is received.

CLOSE RELATIVE
The term "Close Relative" means the Covered Person’s spouse or the child, parent, brother or sister of the Covered Person, whether by blood or by law.

COBRA
The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COGNITIVE REHABILITATION THERAPY
The term “Cognitive Rehabilitation Therapy” means a structured set of therapeutic activities that are designed to retain an individual’s ability to think, use judgment and make decisions. The focus is on improving deficits in memory, attention, perception, learning, planning and judgment. This term is applied to a variety of intervention strategies or techniques that attempt to help patients reduce, manage or cope with cognitive deficits caused by a brain injury.

COINSURANCE
The term “Coinsurance” means the specific percentage of the Covered Expenses that the Plan will pay, after any applicable Deductible or Copayments are taken. The Covered Person must pay the balance of the Covered Expenses after the Coinsurance has been applied, until the applicable Out-of-Pocket maximum is satisfied.

COMPANY
The term "Company" means ECM Energy Services, Inc., the Plan sponsor.

COMPLICATIONS OF PREGNANCY
The term “Complications of Pregnancy” mean physical effects directly caused by Pregnancy, but that were not considered from a medical viewpoint to be the effect of a normal Pregnancy, including conditions related to ectopic Pregnancy or those that require cesarean section. Complications of Pregnancy do not ordinarily include conditions usually associated with the management of a difficult Pregnancy.

COPAYMENT
The term “Copayment” means a specific dollar amount of the Covered Expenses that the Covered Person must pay before the Plan pays benefits for a particular service or supply. The Copayment does not apply to any Deductible.

COSMETIC PROCEDURE
The term “Cosmetic Procedure” means a medical or surgical procedure that is primarily performed to improve the appearance of any portion of the body.

COVERED EXPENSES
The term "Covered Expenses" means expenses incurred by a Covered Person for any Medically Necessary treatments, services or supplies that are not specifically excluded from coverage elsewhere in this Plan, or other charges that are specifically listed as covered under this Plan.

COVERED PERSON
The term "Covered Person" means any person meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan.

CUSTODIAL CARE
The term “Custodial Care” means services to assist an individual in the activities of daily living, such as:

A. assistance in walking, getting in and out of bed, bathing, dressing, feeding and using the toilet;
B. preparation of special diets; and
C. supervision of medication that usually can be self-administered.

Custodial Care essentially is personal care that does not required the continuing attention of skilled, trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, the factors considered by the Plan Administrator are the level of care and medical supervision that are required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation, rehabilitation potential or place of service.

CUSTOMARY
The term "Customary" refers to the designation of a charge as being the usual charge made by a Physician or other Provider of services and supplies, medication or equipment that does not exceed the general level of charges made by other Providers rendering or furnishing such care or treatment within the same general geographic area, taking into consideration differences in demographics of specific locations and using generally accepted standards of medical practice. The term "area" in this definition means a county or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances

that require additional time, skill or expertise. In regards to services or supplies provided by Preferred Providers, this term refers to the contracted rate for the service or supply in question, as determined by the agreement between the Plan and the network to which the Provider belongs.

DEDUCTIBLE

The term "Deductible" means the amount of Covered Expenses incurred by a Covered Person in a Calendar Year before any other Covered Expenses can be considered for payment at the percentages stated in the Schedule of Benefits and this Plan.

An Individual Deductible is the amount that each individual Covered Person must pay during a Calendar Year before the Plan begins paying benefits for that person.

A Family Deductible limit is the maximum amount that all Family members who are covered under the same Participant must pay in Deductible expense in a Calendar Year. Once this cumulative Family Deductible is reached, the Deductible will be considered satisfied for all Family members covered under the Plan during the remainder of the Calendar Year.

DEPENDENT

The term "Dependent" means:

A. the Participant's legal spouse. Such spouse must have met all requirements of a valid marriage contract in the state in which such parties were married; or

B. the Participant's child who meets all of the following conditions:

   1. is the Participant’s or the Participant’s spouse’s natural child, adopted child, a child Placed for Adoption with the Participant or the Participant’s spouse, or is a child that the Participant or the Participant’s spouse is required to provide coverage pursuant to a valid court order; and

   2. is less than twenty-six (26) years of age. The age requirement above is waived for any mentally, developmentally or physically handicapped child who is incapable of self-sustaining employment, provided the child suffered such incapacity prior to attaining twenty-six (26) years of age and was covered under this Plan as a Dependent of the Participant on that date. Proof of incapacity must be furnished to the Plan Administrator, or its designee, within thirty-one (31) days of the date the child’s coverage would have ended due to age.

The Plan Administrator has the right to obtain sufficient proof of Dependent status from any Participant under the Plan who is requesting coverage of his or her Dependents.

This definition and all provisions of this Plan are intended to comply with state and federal law as both regard "Qualified Medical Child Support Orders" and "Medical Child Support Orders," as those terms are defined in the law. The Plan Administrator has established procedures governing “Qualified Medical Child Support Orders”. Covered Persons under this Plan can receive upon request, free of charge, a copy of such procedures from the Plan Administrator.

The term "Dependent" excludes these situations:

A. a spouse who is legally separated or divorced from the Participant. Such separation/ divorce must have met all the requirements of a valid legal separation or divorce in the state granting it; or

B. any person who is covered under this Plan as an individual Participant, or as the Dependent of another Participant.

DEPENDENT COVERAGE

The term "Dependent Coverage" means coverage under the Plan for benefits payable as a consequence of an illness or injury of a Dependent.

DETOXIFICATION

The term “Detoxification” means the process whereby an alcohol intoxicated, drug-intoxicated or alcohol or drug dependent person is assisted, in a Facility licensed by the appropriate Department or Health or similar agency in the state in which the Facility is located, through the period of

time necessary to eliminate, by metabolic or other means, the intoxication alcohol or other drugs, alcohol , drug or other drug dependency factors or alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

DIAGNOSTIC ASSESSMENT OF AUTISM SPECTRUM DISORDERS
The term “Diagnostic Assessment of Autism Spectrum Disorders” means Medically Necessary assessments, evaluations or tests performed by a licensed Physician, licensed physician assistant, likened Psychologist or certified Registered Nurse practitioner to diagnose whether an individual has an Autism Spectrum Disorder.

DIAGNOSTIC SERVICES
The term “Diagnostic Services” means any of the following procedures that have been ordered by a Physician because of specific symptoms and signs to determine a defined condition or disease, including, but not limited to:

A. diagnostic imaging, including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computed tomography (CT) scan, positron emission tomography (PET) scans, and nuclear cardiology studies;
B. diagnostic pathology, including laboratory and pathology tests;
C. diagnostic medical procedures, such as electrocardiogram (ECG), electroencephalogram (EEG) and other diagnostic medical procedures that have been approved by the Plan Administrator;
D. diagnostic radiology, including x-ray, mammograms, ultrasound and nuclear medicine; and
E. allergy testing, including percutaneous, intracutaneous and patch tests.

DIALYSIS TREATMENT
The term “Dialysis Treatment” means the treatment of acute renal failure or chronic irreversible renal insufficiency or the removal of waste materials from the body, to include hemodialysis or peritoneal dialysis.

DURABLE MEDICAL EQUIPMENT
The term “Durable Medical Equipment” means equipment that:

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.

EMERGENCY
The term "Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

A. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
B. serious impairment to bodily functions; or
C. serious dysfunction of any bodily organ or part.

EMPLOYER
The term "Employer" means the Company and any entity that is affiliated with the Company within the meaning of Section 414(b), (c) or (m) of the Internal Revenue Code of 1986, as amended, that adopts this Plan for the benefit of its employees, whose participation in the Plan is approved by the President (or any duly authorized officer) of the Company. An employer may

withdraw from the Plan by delivering to the Plan Administrator written notice of its withdrawal no later than thirty (30) days prior to the date withdrawal is to be effective.

ERISA
The term "ERISA" refers to the Employee Retirement Income Security Act of 1974, as amended.

EXPERIMENTAL or INVESTIGATIVE
The terms “Experimental” or “Investigative” mean the use of any treatment, procedure, Facility, equipment, drug, device or supply that is determined by the Plan Administrator, in its discretion, to be not supported by evidence-based medicine, and therefore:

A. not accepted by the general medical community as standard medical treatment of the condition being treated, or does not have definitive outcome studies in peer-reviewed medical literature demonstrating safety and efficacy for treating or diagnosing the condition or illness for which its use is proposed and/or lacks studies comparing outcomes to existing approved modalities of therapy or diagnosis;
B. not approved by the FDA to be lawfully marketed for the proposed use or not identified in the *American Hospital Formulary Service Drug Information* or the *United States Pharmacopeia Drug Information for the Health Care Professional* as appropriate for the proposed use at the time the services were rendered; or
C. subject to review and approval by any institution review board for the proposed use.

This does not exclude coverage for Routine Patient Costs provided as part of an Approved Clinical Trial for the treatment of cancer or another Life Threatening Condition or disease for a Qualified Individual.

The Plan Administrator, in its sole discretion, shall determine whether or not a treatment, procedure, drug, device, equipment and/or supply is Experimental or Investigative under the Plan.

FACILITY
The term “Facility” means a Hospital or other institution or entity that is licensed, were required, to provide services that are Covered Expenses under this Plan.

FAMILY
The term "Family" means a covered Participant and his or her covered Dependents.

FDA
The term “FDA” means the United States Food and Drug Administration, an agency of the United States Department of Health and Human Services that is charged with the responsibility for regulation and supervision of food safety, tobacco products, dietary supplements, prescription and over-the-counter pharmaceutical drugs (medications), vaccines, biopharmaceuticals, blood transfusions, medical devices, electromagnetic radiation emitting devices (ERED), cosmetics, animal foods & feed and veterinary products within the United States.

FREESTANDING DIALYSIS FACILITY
The term “Freestanding Dialysis Facility” means a Facility that is primarily engaged in providing Dialysis Treatment, maintenance or training to patients on an Outpatient or home-care basis.

FREESTANDING OUTPATIENT FACILITY
The term “Freestanding Outpatient Facility” means a Facility that is primarily engaged in providing Outpatient Diagnostic Services and or therapeutic services by or under the direction of Physicians.

HEALTH CARE REFORM, PPACA, AFFORDABLE CARE ACT or ACA
The terms “Health Care Reform,” “PPACA,” “Affordable Care Act” or “ACA” mean the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and as otherwise amended, including all current final regulations that are issued regarding such acts.

HEALTH INFORMATION
The term "Health Information" means any information, whether oral or recorded in any form or medium that:

A. is created or received by this Plan, or a Plan designee; and
B. relates to any of the following:
    1. the past, present or future physical or mental health or condition of an individual;
    2. the provision of health care to an individual; or
    3. the past, present or future payment for the provision of health care to an individual.

HIPAA
The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

HOMEBOUND
The term "Homebound" means an individual who has a condition due to an illness or injury that restricts his or her ability to leave such individual's place of residence, except with the aid of a supportive device, such as crutches, canes, wheelchairs and walkers, the use of special transportation or the assistance of another person, or if the individual has a condition that is such that leaving his or her home is medically contraindicated. The condition of the individual is such that there exists a normal inability to leave home, and consequently, leaving the home, would require a considerable and taxing effort.

HOME HEALTH CARE AGENCY
The term "Home Health Care Agency" means a Facility that has been approved by the Joint Commission or a similar accrediting agency that is acceptable to the Plan Administrator and is recognized and licensed by the appropriate regulatory agency in the jurisdiction in which it is located to provide services within the scope of such license. Such entity must:

A. provide skilled Outpatient services on a visiting basis in the patient's home; and
B. be responsible for supervising the delivery of such services under a plan authorized by a Physician.

HOME INFUSION THERAPY
The term "Home Infusion Therapy" means the preparation and administration of parenteral and enteral nutrition and/or intravenous solutions and drugs that are provided in a home or infusion center setting.

HOME INFUSION THERAPY AGENCY
The term "Home Infusion Therapy Agency" a Facility that has been approved by the Joint Commission or a similar accrediting agency that is acceptable to the Plan Administrator, is recognized and licensed by the appropriate regulatory agency in the jurisdiction in which it is located to provide services within the scope of its license, provides Home Infusion Therapy services in the patient's home or an infusion center and is responsible for supervising the delivery of such services under a plan authored by a Physician.

HOSPICE
The term "Hospice" means a Facility Provider that is primarily engaged in providing supportive care to terminally ill individuals.

HOSPICE CARE
The term "Hospice Care" means a health care program that provides an integrated set of services, primarily in the patient's home, designed to provide supportive care intended to promote comfort to and relieve suffering of terminally ill patients and their families. Services are coordinated through a Hospice interdisciplinary team and the patient's Physician.

HOSPITAL
The term "Hospital" means a Provider that is a short-term, acute care or Rehabilitation Hospital that has been approved by the Joint Commission, the American Osteopathic Hospital Association, the Department of Health or similar agency in the jurisdiction in which it is located, or a similar accrediting agency that has been approved by the Plan Administrator and that:

A. is a duly licensed institution;
B. is primarily engaged in providing Inpatient Diagnostic Services and therapeutic services for the diagnosis, treatment and care of injured and sick persons by or under the supervision of Physicians;
C. has organized departments of medicine and/or major Surgery;
D. provides twenty-four (24) hour nursing service by or under the supervision of Registered Nurses; and
E. is not, other than incidentally, one (1) of the following:
    1. a Skilled Nursing Facility;
    2. a nursing home;
    3. a Custodial Care home;
    4. a health resort;
    5. a spa or sanitarium;
    6. a place of rest;
    7. a place for the aged;
    8. a place for the provision of Hospice Care; or
    9. a personal care home.

For the purposes of this Plan, Hospital includes a state-owned Psychiatric Hospital.

HOSPITALIST
The term “Hospitalist” means a Physician whose primary focus is the Medical Care of hospitalized patients. A Hospitalist’s area of practice is based on the site of care (the Hospital) rather than by organ or body system, such as a cardiologist, or age, such as a pediatrician. Hospitalist activities may include patient care, teaching, research, and leadership related to Hospital care.

IN-NETWORK
The term “In-Network” means Providers who are part of the Plan’s Preferred Provider network at the time such Providers render services to Covered Persons that are Covered Expenses under this Plan. The Plan Administrator can provide a listing of Providers who are considered to be In-Network for the purposes of this Plan.

INPATIENT
The term "Inpatient" refers to the classification of a Covered Person when that person is admitted to a Hospital, Hospice, Skilled Nursing Facility or other covered Facility for treatment and charges are made for Room and Board to the Covered Person as a result of such admission.

INTENSIVE CARE UNIT or SPECIAL CARE UNIT
The term “Intensive Care Unit” or “Special Care Unit” means a designated unit within a Hospital with concentrated facilities, equipment and supportive services that are required to provide an intensive level of care for a critically ill patient.

JOINT COMMISSION
The term “Joint Commission” means an independent commission that accredits and certifies health care organizations and programs in the United States, including Hospitals, Skilled Nursing Facilities, ambulatory Facilities, behavioral health Facilities, laboratories, Home Health Care Agencies and pharmacies. To receive and maintain accreditation from the Joint Commission, an

organization must undergo an on-site survey by a Joint Commission survey team at least every three (3) years. (Laboratories must be surveyed every two (2) years.) Information about the accreditation status of an organization can be found on the Joint Commission website (www.qualitycheck.org/consumer/searchQCR.aspx).

The Joint Commission was formerly known as the Joint Commission on Accreditation of Healthcare Organizations.

LICENSED PRACTICAL NURSE or LPN
The terms "Licensed Practical Nurse" or "LPN" mean a nurse who has graduated from a formal practical nursing education program, and who is licensed by the appropriate authority in the jurisdiction in which services are rendered.

LIFE THREATENING CONDITION
The term "Life Threatening Condition" means any disease or condition from which the likelihood of death is probable, unless the course of the disease or condition is interrupted.

LIFETIME
The term "Lifetime" is a word used in the Plan in reference to benefit maximums and limitations. The term "Lifetime" means the total time period of a Covered Person's coverage under this Plan, regardless of the number of breaks in that coverage. Under no circumstances does the term "Lifetime" mean the duration of a Covered Person's life.

LONG TERM RESIDENTIAL CARE
The term "Long Term Residential Care" means the provision of long-term diagnostic or therapeutic services (i.e., assistance or supervision in managing basic day to day activities and responsibilities) to patients suffering from Alcoholism and/or Substance Abuse or dependency. This care is provided in a long-term residential environment know as a transitional living Facility, on an individual, group and/or family basis, with a program duration greater than sixty (60) days. Long-Term Residential Care is not the same as Inpatient treatment in a Residential Treatment Facility.

MASTECTOMY
The term "Mastectomy" means removal of all or part of the breast for Medically Necessary reasons, as determined by a licensed Physician.

MEDICAL CARE
The term "Medical Care" means professional services given by a Physician or other Provider to treat an injury, ailment, condition, disease, disorder or illness, including medical advice, treatment, medical diagnosis and the taking of prescription drugs.

MEDICALLY NECESSARY or MEDICAL NECESSITY
The terms "Medically Necessary" or "Medical Necessity" mean services or supplies provided by a Provider that the Plan Administrator, in its discretion, determines are:

A. appropriate for the symptoms and diagnosis or treatment of the Covered Person's condition, illness, disease or injury;
B. provided for the diagnosis, or the direct care and treatment of, the Covered Person's condition, illness, disease or injury;
C. provided in accordance with current standards of medical practice;
D. not provided primarily for the convenience of the Covered Person or the Provider; and
E. the most appropriate source or level of service that can safely be provided to the Covered Person. When applied to hospitalization, this further means that the Covered Person requires acute care as an Inpatient due to the nature of the services rendered or his or her condition, and the Covered Person cannot receive safe or adequate care as an Outpatient.

The fact that a Physician has prescribed, ordered, recommended or approved a service, treatment, hospitalization or supply does not, of itself, make such service, treatment, hospitalization or

supply Medically Necessary under the Plan, nor does it make the charge a Covered Expense. The Plan reserves the right to make the final determination of Medical Necessity on the basis of final diagnosis and supporting medical data. This determination will be based on, and consistent with, standards approved by the Plan's medical review consultants.

MEDICARE
The term "Medicare" means the programs established by Title I of Public Law 89-98, as amended, entitled "Health Insurance for the Aged Act," and that includes parts A, B, C and D of Subchapter XVIII of the Social Security Act, as amended from time to time.

MENTAL HEALTH HOSPITAL
The term "Mental Health Hospital" means a short-term acute care Hospital that has been approved by the Joint Commission, or the American Osteopathic Hospital Association, or a similar accrediting agency that has been approved by the Plan Administrator that provides services that are necessary for short-term evaluation, diagnosis and treatment (or crisis intervention) of serious Mental/Nervous Disorders.

MENTAL/NERVOUS DISORDER
The term "Mental/Nervous Disorder" means any disease or condition that is classified as a mental disorder in the current edition of the *International Classification of Diseases*, published by the World Health Organization, or is listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association, with the exception of disorders related to Alcoholism or Substance Abuse. Mental/Nervous Disorders include, but are not limited to:

A. neurosis;
B. psychoneurosis;
C. psychopathy; or
D. psychosis.

METABOLIC FORMULA
The term "Metabolic Formula" means special nutritional formulas administered under the direction of a Physician that are necessary to sustain life for an individual suffering from a genetic metabolic disorder.

MULTIPLE SURGICAL PROCEDURES
The term "Multiple Surgical Procedures" means separate surgical procedures performed by a Physician on the same patient during the same operative session or during the same day. This term does not include procedures that are components of, or incidental to, a primary procedure, an intraoperative service or an incidental Surgery.

For the purposes of determining Covered Expenses under this Plan, Multiple Surgical Procedures will be considered, as follows:

A. the Plan will consider as Covered Expenses up to one hundred percent (100%) of the Reasonable and Customary charge for the primary or highest valued procedure;
B. the Plan will consider as Covered Expenses up to fifty percent (50%) of the Reasonable and Customary charge for each additional procedure, for the second procedure through the fifth procedure; and
C. if more than five (5) procedures are performed in the same operative session/day, coverage of any additional procedures will be subject to the review and approval of the Plan Administrator, in its discretion. In order for any additional payment to be considered by the Plan under the provision, the operating Physician must submit the applicable operative notes.

Other restrictions and limitations may be applied to the payment of Multiple Surgical Procedures. Such restrictions and limitations will be consistent with the rules applied under the Medicare program, as listed in the most recent Medicare payment manuals.

NAMED FIDUCIARY
The term "Named Fiduciary" means the individual or entity that has the ultimate authority to control and manage the overall operation of the Plan.

NEVER EVENTS
The term "Never Events" means errors or omissions in Medical Care that are clearly identifiable, preventable, and serious in their consequences for patients. Examples of Never Events include, but are not limited to:

A. Surgery on the wrong body part;
B. a foreign body left in a patient after Surgery;
C. a mismatched blood transfusion;
D. a major medication error;
E. a severe “pressure ulcer” acquired in the Hospital;
F. falls or traumas experienced by a patient while confined in a healthcare Facility; and
G. preventable post-operative deaths.

NEWBORN
The term "Newborn" means an infant from the date of birth until the earlier of the initial Hospital discharge or the last day of the mother’s covered admission for a vaginal or cesarean delivery.

NUTRITIONAL THERAPY
The term “Nutritional Therapy” means nutritional diagnostic, therapy and counseling services for the purpose of disease management that are furnished by a licensed health care professional to help a person make and maintain health dietary changes.

OCCUPATIONAL THERAPY
The term “Occupational Therapy” means the treatment of a physically disabled person by means of constructive activities that are designed and adapted to promote the restoration of the person’s ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person’s particular occupational role.

ORTHOSIS or ORTHOTIC DEVICE
The terms “Orthosis” or “Orthotic Device” mean a rigid or semi-rigid appliance used for the purpose of supporting a weak or deformed body part, or for restricting or eliminating motion in a diseased or injured part of the body.

OSTOMY
The term “Ostomy” means an artificial stoma or opening into the urinary tract, gastrointestinal canal or the trachea.

OSTOMY SUPPLIES
The term “Ostomy Supplies” means generally non-reusable items or appliances, such as pouches, irrigation equipment and skin barriers, specifically used in the maintenance of hygiene and skin protection in Ostomy patients, ordered by or used on the advice of a healthcare Provider.

OUT-OF-NETWORK
The term “Out-of-Network” means Providers who are not part of the Plan’s Preferred Provider network at the time such Providers render services to Covered Persons that are Covered Expenses under this Plan.

OUT-OF-POCKET
The term “Out-of-Pocket” means the amount of Covered Expenses that are the responsibility of the Covered Person and that accumulate towards the Plan’s Out-of-Pocket maximum, not including amounts:

A. related to the removal of impacted teeth;
B. for the Out-of-Network Copayment for non-Emergency use of an emergency room;
C. for expenses that are not covered under this Plan;
D. in excess of the Reasonable and Customary charge for a service or supply;
E. in excess of any maximum benefit listed in the Plan; or
F. attributable to any penalty.

OUTPATIENT
The term "Outpatient" refers to the classification of a Covered Person when that Covered Person receives Medical Care, treatment, services or supplies at a clinic, a Physician's office, or at a Hospital, if not a registered bed patient at that Hospital or other covered Facility.

PARTIAL HOSPITALIZATION FOR PSYCHIATRIC CARE
The term “Partial Hospitalization for Psychiatric Care” means the provision of diagnostic and therapeutic services for the treatment of Mental/Nervous Disorders on an Outpatient basis only during the day or night through a Hospital or Psychiatric Hospital-based program that is approved by the Joint Commission.

PARTIAL HOSPITALIZATION FOR ALCOHOLISM AND SUBSTANCE ABUSE CARE
The term “Partial Hospitalization for Alcoholism and Substance Abuse Care” means the provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a Hospital or other Facility that is licensed by the appropriate Department of Health or similar agency in the jurisdiction in which the Facility is located to provide an alcohol or drug addiction treatment program designed for a patient or client who would benefit from more intensive services than are offered in Outpatient treatment, but who does not require Inpatient care.

PARTICIPANT
The term "Participant" means a person who meets the eligibility requirements listed in Section 5.2 and who is properly enrolled in the Plan.

PARTICIPANT CONTRIBUTION
The term "Participant Contribution" means that amount that is due from an eligible employee in order for that employee to obtain Participant and/or Dependent coverage(s) under the Plan. The Company shall determine the amount of the Participant Contribution that may vary depending upon the type of coverage an eligible employee desires to obtain. Eligible Participants will be advised of any required Participant Contributions at the time each applies for Participant and/or Dependent coverage. Participants in the Plan will be notified by the Plan Administrator prior to an increase in the required Participant Contribution amount. Participants in the Plan that are not required to make Participant Contributions at the time of enrollment will be notified by the Plan Administrator prior to the date a Participant Contribution requirement is made effective.

PHYSICAL THERAPY
The term “Physical Therapy” means the treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical and neuro-psychological principles, and devices to relive pain, restore maximum function and prevent disability following disease, injury or loss of a body part. Such therapy is performed by a licensed physical therapist.

PHYSICIAN
The term "Physician" means a person who is a doctor of medicine (MD) or a doctor of osteopathy (DO) and who is licensed and legally entitled to practice medicine in any or all of its branches, perform Surgery and prescribe and administer drugs.

PLACED FOR ADOPTION or PLACEMENT FOR ADOPTION
The terms "Placed For Adoption" or "Placement For Adoption" mean the assumption and retention by such Participant hereunder of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such Participant terminates upon the termination of such legal obligation.

PLAN
The term "Plan" means the sickness and accident plan, as described in and administered by the ECM Energy Services, Inc. Employee Health Benefit Plan.

PLAN ADMINISTRATOR
The entity responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan related services. ECM Energy Services, Inc. is the Plan Administrator as of the Plan Effective Date.

PLAN YEAR
The term "Plan Year" means a period of time used for certain reporting and disclosure requirements of the Plan. The Plan Year will begin on March 1st and end on the last day of February of the following year.

PLAN EFFECTIVE DATE
The Plan Effective Date of this Plan is March 1, 2016.

PRIMARY CARE PHYSICIAN or PCP
The terms “Primary Care Physician” or “PCP” mean a Physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis. Primary Care Physicians include those trained and actively practicing in family practice, general practice, pediatrics, geriatrics, internal medicine or gynecology.

PREFERRED PROVIDER
The term “Preferred Provider” means a health care professional, group of professionals or medical Facilities, that have agreed to provide medical services to a group of individuals for an agreed upon fee. The Plan will specify which professionals and/or Facilities have Preferred Provider status. A list of Preferred Providers for this Plan will be provided by the Plan Administrator.

For the purposes of the organ and tissue transplant benefits, Preferred Provider includes Providers that are in this Plan’s special transplant network. The specific amount of the benefits provided, and any limitations applied, will be determined based on the terms of the specific contract with this network.

PREGNANCY
The term "Pregnancy" means that physical state that results in childbirth, abortion or miscarriage, and any medical complications arising out of, or resulting from, such state.

PRIVATE DUTY NURSING
The term “Private Duty Nursing” means total patient care provided by a Registered Nurse or Licensed Practical Nurse on an individual basis.

PROFESSIONAL PROVIDER
The term “Professional Provider” means an individual or practitioner who is licensed or certified, as required, to render services that are Covered Expenses under this Plan. Professional Providers include:

A. certified additions counselors;
B. chiropractors;
C. clinical Psychologists;
D. clinical nurse specialists;
E. licensed dietitians;
F. Licensed Practical Nurses;
G. nurse midwives;
H. nurse practitioners;
I. optometrists;
J. physical therapists;
K. Physicians;
L. physician assistants;
M. podiatrists;
N. Registered Nurses;
O. clinical social workers;
P. Speech Therapists;
Q. Occupational Therapists; and
R. other licensed or certified health care Providers who are approved by the Plan Administrator for coverage under this Plan.

PROSTHESIS or PROSTHETIC APPLIANCE
The term "Prosthesis" or "Prosthetic Appliance" means an artificial body part that replaces all or part of a body organ or that replaces all or part of the function of a permanently inoperative or malfunctioning body part.

PROTECTED HEALTH INFORMATION
The term "Protected Health Information" means Health Information that either identifies an individual, or for which there is a reasonable basis to believe can be used to identify an individual and that is one (1) of the following:

A. transmitted by electronic media, including:
    1. the internet;
    2. an extranet;
    3. leased lines;
    4. dial-up lines;
    5. private networks; and
    6. those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media;
B. maintained in any electronic media; or
C. transmitted or maintained in any other form or medium.

PROVIDER
The term "Provider" means a Hospital or other Facility, a Professional Provider or other medical Supplier who is licensed, if required, to perform services or provide supplies that are Covered Expenses under this Plan.

PSYCHIATRIC HOSPITAL
The term "Psychiatric Hospital" means a Facility that has been approved by the Joint Commission or a similar accrediting agency that is acceptable to the Plan Administrator that is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of

Mental/Nervous Disorders. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided by or under the supervision of a Registered Nurse.

PSYCHOLOGIST
The term “Psychologist” means a licensed clinical Psychologist.

PULMONARY REHABILITATION
The term “Pulmonary Rehabilitation” means a program of exercise training, psychological support and pulmonary physiotherapy education that is intended to improve the patient’s functioning and quality of life by controlling and alleviating symptoms, including complications of pulmonary disorders.

QUALIFIED INDIVIDUAL
The term “Qualified Individual” means an individual who is properly enrolled in the Plan and who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or another Life Threatening Condition or disease. To be a Qualified Individual, there is an additional requirement that a determination be made that the individual’s participation in the Approved Clinical Trial is appropriate to treat the disease or condition. That determination can be made based on the referring health care professional’s conclusion or based on the provision of medical and scientific information by the individual.

RADIATION THERAPY
The term “Radiation Therapy” means the treatment of disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

REASONABLE
The term "Reasonable" refers to the designation of a charge as being appropriate based on the services or supplies actually supplied by a Provider to a Covered Person. While the charge made for such service may be considered to be Customary within the general context of billing practices for similar services, the true circumstances of the case may warrant a lesser or higher charge than the Customary charge for the services and/or supplies that were, in fact, provided to the Covered Person. The Plan Administrator shall have the right to review Provider’s records relative to the service or supply, and shall determine, in its absolute discretion, whether or not the charge made by the Provider for the service or supply is Reasonable. In making this determination, the Plan Administrator will take into consideration additional charges that were attributable to the errors, negligence or inefficiency of the Provider, and may consult with medical experts in the related fields to determine whether such charges would be considered Reasonable within the context in which they were provided.

RECOMMENDED WELLNESS SERVICE
The term “Recommended Wellness Service” means a service or supply that is not intended to treat an existing medical condition, but rather is intended to detect or prevent potential future problems or assist the Covered Person in maintaining his or her health. They are recommended by recognized medical bodies, and are required to be covered without cost sharing by non-grandfathered health plans under the Affordable Care Act if received through a Preferred Provider. These recommendations include the following:

A. evidence-based preventive services with an A or B recommendation from the U.S. Preventive Services Task Force (www.uspreventiveservicestaskforce.org);
B. immunizations recommended by the Advisory Committee on Immunization Practices, as updated annually (www.cdc.gov/vaccines); and
C. guidelines supported by the Health Resources and Services Administration that are applicable to children and women, including:
    1. services provided to children under the Bright Futures recommendations of the American Academy of Pediatrics (brightfutures.aap.org) and the Secretary’s

Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC) national recommendations on Newborn screening - See (www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/index.html); and

2. women's health services recommendations developed by the Institute of Medicine (www.hrsa.gov/womensguidelines).

Any changes to the above recommendations will take effect for this Plan at the beginning of the first Plan Year beginning one (1) year after the issuance of such new recommendation or a change in the existing recommendations by the above entities, unless the change was prompted by safety or other concerns that make it inadvisable to continue to cover the service or supply.

RECONSTRUCTIVE PROCEDURE OR SURGERY
The term "Reconstructive Procedure or Surgery" means procedures, including surgical procedures, performed on a structure of the body to restore or establish satisfactory bodily function or correct a functionally significant deformity resulting from disease, accidental injury, or a previous therapeutic process.

REGISTERED NURSE or RN
The terms "Registered Nurse" or "RN" mean a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program), and who is licensed as a Registered Nurse by the appropriate state authority in the jurisdiction in which covered services were rendered.

RESIDENTIAL TREATMENT FACIILTY
The term "Residential Treatment Facility" means a Facility that is licensed by the appropriate authorityin the state in which it is located to render an Alcoholism or Substance Abuse treatment program that is designed to provide medical, nursing, counseling or therapeutic services to patients suffering from Alcoholism or Substance Abuse or dependency in a residential environment, according to individualized treatment plans. It does not include a half-way house or group home.

RESPIRATORY THERAPY
The term "Respiratory Therapy" means the introduction of dry or moist gases into the lungs for treatment purposes.

RESPITE CARE
The term "Respite Care" means residential Medical Care given in a setting outside of the patient's home, such as in a Skilled Nursing Facility or Hospice, in order to provide a brief interval of relief for the patient's primary caregiver, which is usually a family member.

RETAIL CARE CLINIC
The term "Retail Care Clinic" means a health care Facility located in a convenient setting, such as a retail store, grocery store or pharmacy, that treats common minor ailments, such as sore throats, coughs or pink eye, on an unscheduled, walk-in basis.

ROOM AND BOARD
The term "Room and Board" refers to all charges, by whatever name called, that are made by a Hospital, Hospice or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

ROUTINE PATIENT COSTS
The term "Routine Patient Costs" means all items and services consistent with the coverage provided under the Plan that is typically covered for a Qualified Individual for treatment of cancer or another Life Threatening Condition or disease who is not enrolled in a clinical trial. However, costs associated with the following are excluded from that definition, and the Plan is not required under federal law to pay for the following:

A. the cost of the investigational item, device or service;

B. the cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; and

C. the cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SEMI-PRIVATE
The term "Semi-Private" refers to a class of accommodations in a Hospital or other covered Facility in which at least two (2) patient beds are available per room.

SERVICE IN THE UNIFORMED SERVICES
The term "Service in the Uniformed Services" means performance of duty in the Armed Forces or Uniformed Services for a period of five (5) years or less, on a voluntary or involuntary basis, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty in the Armed Forces, the Army National Guard, Air National Guard, the commissioned corps of the Public Health Service, or any other category of persons designated by the President of the United States in time of war or emergency. Service in the Uniformed Services also includes a period for which an individual is absent from a position of employment for the purpose of an examination to determine the fitness of the person for duty in the Armed Forces or the commissioned corps of the Public Health Service.

SKILLED NURSING FACILITY
The term "Skilled Nursing Facility" means a Facility Provider that is an institution or a distinct part of an institution, other than one (1) that is primarily for the care and treatment of Mental/Nervous Disorders, Alcoholism or Substance Abuse, that is certified for reimbursement as a Skilled Nursing Faculty under Medicare, or that is qualified to receive such certification, if requested.

SOUND NATURAL TOOTH
The term "Sound Natural Tooth" means a tooth that has not been weakened by significant decay, or that does not have a previous restoration, such as a filling or crown.

SPECIALIST
The term "Specialist" means a Physician who primarily practices in any medical specialty, such as neurology, cardiology, or pulmonology, and who is not a Primary Care Physician.

SPEECH THERAPY
The term "Speech Therapy" means treatment for the correction of a speech impairment resulting from disease, Surgery, injury, anomalies or previous therapeutic processes.

SUBSTANCE ABUSE
The term "Substance Abuse" means any use of drugs that produces a pattern of pathological use causing impairment in social or occupational functioning or that produces physiological dependency evidenced by physical tolerance or withdrawal. For the purposes of this definition, "drugs" shall include any addictive drugs or drugs of abuse listed as scheduled drugs in the Pennsylvania Controlled Substance, Drug, Device and Cosmetic Act (35 P.S. § 780-110 through § 780-113).

In making the determination as to whether the Covered Person's condition meets the definition of Substance Abuse under this Plan, the Plan Administrator shall use recognized authorities, including designations contained in the most current editions of the *International Classification of Diseases* (ICD) of the World Health Organization and the *Diagnostic and Statistical Manual of Mental Diseases* (DSM) published by the American Psychiatric Association.

SUMMARY HEALTH INFORMATION
The term "Summary Health Information" means information that may be individually identifiable Health Information that:

A. summarizes the claims history, claims expenses or type of claims experienced by Covered Persons under this Plan; and

B. from which the following information has been removed:

1. names;
2. geographic subdivisions smaller than the level of a five (5) digit zip code, including, but not limited to, street addresses;
3. all elements of dates (except year) for dates directly related to an individual, including, but not limited to, birth dates and dates of admission and discharge;
4. telephone numbers;
5. fax numbers;
6. electronic mail addresses;
7. social security numbers;
8. medical record numbers;
9. Plan identification numbers; or
10. Other identifiers as listed in 45 C.F.R. § 164.514(b)(2)(i).

SUPPLIER
The term "Supplier" means an individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies, Prostheses and Orthoses.

SURGERY
The term "Surgery" means any of the following:

A. the performance of generally accepted operative and cutting procedures, including specialized instrumentations, endoscopic examinations and other procedures;
B. the correction of fractures and dislocations; and
C. usual and related pre-operative and post-operative care.

THERAPY SERVICE
The term "Therapy Service" means services or supplies used for the treatment of an illness or injury to promote the recovery of the patient. Such services include:

A. Cardiac Rehabilitation;
B. Cognitive Rehabilitation Therapy;
C. Dialysis Treatment;
D. Occupational Therapy;
E. Physical Therapy;
F. Pulmonary Rehabilitation;
G. Radiation Therapy;
H. Respiratory Therapy; and
I. Speech Therapy.

TREATMENT PLAN FOR AUTISM SPECTRUM DISORDERS
The term "Treatment Plan for Autism Spectrum Disorders" means a plan for the treatment of Autism Spectrum Disorders that is developed by a licensed Physician or licensed Psychologist pursuant to a comprehensive evaluation or re-evaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

TRANSPLANT PROCEDURES
The term "Transplant Procedures" means the pre-testing and/or initial evaluations and/or consultation processes occurring before, as well as leading up to, and including Surgery, for the non-Experimental transplant of human tissue and/or organs.

UNATTENDED SERVICES
The term "Unattended Services" means services that are not preformed by a Provider or monitored by a Provider.

USERRA

The term "USERRA" means the Uniformed Services Employment and Re-employment Rights Act of 1994, as amended.

ARTICLE IV

CLAIM AND APPEAL PROCEDURES

4.1 INITIAL FILING OF CLAIMS

A Clean Claim for benefits should be filed within ninety (90) days after the occurrence or commencement of any loss covered by this Plan. Failure to give such notice and proof within the time required will neither invalidate nor reduce any claim if it is shown that written notice and proof are given no later than one (1) year after the claim is incurred, unless the Covered Person is legally incapacitated.

Upon termination of the Plan, final claims must be received within ninety (90) days of termination. In any of the events described above, notice and proof of claim will be determined at the discretion of the Plan Administrator, subject to the requirements listed below.

Claims should be submitted to the appropriate address listed on the Covered Person's identification card, and can be submitted either by the Provider or the Covered Person. Such claim should be on any of the following appropriate forms (or their successor forms):

A. CMS 1500;

B. UB-04 or UB-92;

C. HCFA-1450 or CMS 1450;

D. NCPDP Form 1983; or

E. J512 claim forms.

A Clean Claim can be submitted by the Provider in electronic format if the Provider submits it in accordance with the electronic transaction requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent laws.

In order to be considered a Clean Claim, such claim must use the most current CPT code in effect as published by the American Medical Association, the *International Statistical Classification of Diseases and Related Health Problems* ("ICD") codes, including ICD-9 and ICD-10, published by the World Health Organization, the most current dental code in effect as published by the American Dental Association in the *Code for Dental Procedures or Nomenclature* or the most current HCPCS code in effect, as published by U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

If the Plan is not the primary carrier for a Covered Person who has, or had at the time the claim was incurred, more than one health plan that would provide benefits for the services or supplies for which the claim is being made, including, but not limited to Medicare, copies of the explanations of benefit payment from all carriers who would pay benefits before the Plan should be submitted with the claim. For more information regarding which plan pays first, see Section 12.1, or contact the Benefit Manager.

4.2 REQUESTS FOR ADDITIONAL INFORMATION

If the claim is not submitted in accordance with the procedures listed in Section 4.1, the claim will not be considered to be a Clean Claim, and the Participant or Covered Person will be notified of the claim deficiencies, and requested to refile it in the proper format.

If the Plan Administrator or the Benefit Manager needs more information to process the claim, a letter will be sent to the Participant, the Covered Person, the Provider or other parties requesting additional information. In some situations, information is needed on a periodic basis, including:

A. information regarding other coverage. This may include providing copies of medical child support orders for children of divorced parents; and

B. verification of handicapped status for overage Dependent children.

Other information may be requested on a case-by-case basis, including information pertaining to accident details or potential third-party liability.

The requested information must be provided within forty-five (45) days of the date the Participant or Covered Person receives notice of the required additional information. If the information is not received within this time period, the claim will be denied for failure to provide the needed information.

4.3 APPEALS OF ADVERSE BENEFIT DETERMINATIONS

The Covered Person can appeal an Adverse Benefit Determination by the Plan, including that coverage for a service or supply is denied or reduced under the Plan, or any rescission of coverage for an individual or pre-service coverage denials, provided such appeal is made in writing within one hundred eighty (180) days of the Covered Person or Participant's receipt of the explanation of benefit payment or the precertification letter reflecting the denial or reduction or any other notification made by the Plan of an adverse decision involving the individual. Any individual other than the Covered Person who wishes to submit an appeal on the Covered Person's behalf (other than a parent or Legal Guardian filing an appeal for a minor child) must be designated by the Covered Person, in a writing signed by the Covered Person, as his or her authorized representative specifically for the purpose of the appeal. An assignment of benefits is not sufficient to designate another person as an "authorized representative" for the purpose of an appeal. These appeal procedures shall not apply to any contractual dispute between a Provider and the Plan as to amounts due the Provider, rather than the Covered Person, under the terms of any agreement between the Provider and the Plan that does not affect the amount payable by the Covered Person (i.e. balance billing issues in a Preferred Provider contract).

A request for review in which the Covered Person is requesting an expedited appeal of a pre-service claim as an "urgent care" case, as described in Section 6.1, can be submitted either orally or in writing and can be submitted by a Provider with knowledge of the Covered Person's condition without prior designation by the Covered Person. If a course of treatment has been previously approved by the Plan to be provided over a period of time or for a number of treatments, no reduction or termination of coverage for such treatment (other than termination of the individual's coverage under this Plan) will be made without allowing the Covered Person sufficient advance notification and the opportunity to appeal this termination or reduction.

The appeal request should be addressed as follows (unless the Adverse Benefit Determination notification indicates otherwise):

Plan Administrator
ECM Energy Services, Inc. Employee Health Benefit Plan
c/o Benefit Manager
Medical Benefits Administrators, Inc.
P.O. Box 1099
Newark, Ohio 43058-1099

The writing should clearly be identified as an appeal, and include the name of the Plan, the Covered Person whose claims are the subject of the appeal, the Participant's identification number, and the identity of the specific treatment, service or supply for which coverage was denied or limited under the Plan.

The Covered Person should submit with the appeal written comments, documents, records and other information relating to the claim for benefits, even if such information was not submitted as part of the initial claim or request for preauthorization or precertification. The Covered Person will also have the right to present testimony as part of the appeal.

The Covered Person has the right to request information from the Plan Administrator as part of the appeals process, as described in Section 4.4.

Appeals submitted under this Plan will be adjudicated in a manner designed to ensure the independence and impartiality of the person making the decision. The Plan Administrator has the sole authority for the final decision on all Plan matters, including appeals.

4.4 ACCESS TO DOCUMENTS, RECORDS OR OTHER INFORMATION

A Covered Person is entitled to examine the claim file, and present testimony as part of the internal claims and review process. He or she will also receive, free of charge, copies of documents, records and other information generated by the Plan Administrator that is relevant to his or her claim for benefits, including any new or additional information received during the appeals process, and the rationale behind the Plan's adverse decision. Such information will be provided within sufficient time to respond prior to the final decision of the appeal by the Plan Administrator. Such information is considered to be relevant if it:

A. was relied upon by the Plan Administrator in making the benefit determination;
B. was submitted, considered or generated in the course of making the benefit determination;
C. demonstrates compliance with the administrative processes required by ERISA;
D. constitutes a statement of policy or guidance with respect to the Plan concerning the denial of a treatment option or benefit; or
E. involves the identity of medical or vocational experts whose advice was obtained in connection with the claim.

In addition, if an Adverse Benefit Determination is based upon the Medical Necessity or Experimental nature of the service or supply, the Covered Person can request an explanation of the scientific or clinical judgment of the determination, free of charge.

4.5 EXTERNAL REVIEW RIGHTS AND PROCEDURES

If the Covered Person is not satisfied with the Plan Administrator's decision on his or her appeal of a medical issue, including issues involving Medical Necessity or the Experimental status of a medical procedure, or any coverage rescission, he or she may file a request for an external review with the Plan Administrator at the address listed above for submitting an appeal. The request must be filed within four (4) months after the date of receipt of the Plan Administrator's determination on his or her appeal. If there is no corresponding date four (4) months after the date of receipt of notice, then the request must be filed by the first (1st) day of the fifth (5th) month following the receipt of the Plan's determination on his or her appeal. The Covered Person can make a request for an expedited review of a precertification denial if the timeframe for completion of a standard review would seriously jeopardize the life or health of the Covered Person or would jeopardize his or her ability to regain maximum function, or if the determination concerns an admission, availability of care, continued stay or health care item or service for which the Covered Person received Emergency services, but has not been discharged from a Facility. A standard external review would generally be completed within fifty (50) days of the Plan's receipt of the request, while an expedited review must be completed by the independent review organization (IRO) within seventy-two (72) hours of the IRO's receipt of such request. The Plan Administrator will review the request and determine whether or not the request meets the criteria for external review or an expedited review, including whether or not the person was a Covered Person under the Plan at the time the claim arose, whether the person has exhausted the Plan's appeal process, and whether the sufficient information has been submitted to process the external review. A notification will be issued by the Plan Administrator regarding the Covered Person's incomplete request for an external review. If the request is incomplete, the Covered Person will be given additional time to complete the external review request. Once a determination has been made by the Plan Administrator that the request qualifies for external review, it will be forwarded by the Plan Administrator to a qualified IRO. The IRO will notify the Covered Person if the request is accepted for review, and, if a standard review, that he or she can submit additional information that is relevant to the request within ten (10) days of the notification. The IRO may also request additional information from the Covered Person and/or the Plan. Additional information provided by the Covered Person will be provided to the Plan Administrator. If, based on this additional information, the Plan Administrator determines that the initial determination should be reversed, and that coverage should be provided under the Plan, all parties will be notified, and the external

review will be closed. Otherwise, after the IRO has completed the review, the Covered Person and the Plan Administrator will be notified of the IRO's determination. If the IRO determines that coverage under the Plan should have been provided, the Plan will promptly pay any additional benefits deemed due on the Covered Person's behalf. However, either the Plan or the Covered Person has the right to appeal the decision, or utilize any other remedy available under any applicable state or federal law, if either disagrees with the decision of the IRO.

4.6 ADDITIONAL APPEAL RIGHTS

If, after the Covered Person has exhausted all appeal and review rights listed above, he or she is still not satisfied with the disposition of the claim, such Covered Person has the right to bring an action under section 502(a) of the Employee Retirement Income Security Act (ERISA).

No action at law or in equity shall be brought to recover benefits under the Plan prior to the exhaustion of all claims and appeals procedures described in this Article, nor shall such action be brought at all unless brought within three (3) years from the expiration of the time within which proof is required by the Plan.

4.7 EXAMINATION

The Plan Administrator shall have the right and opportunity to have the Covered Person examined whose injury or illness is the basis of a claim hereunder when and as often as it may reasonably require during the pending claim. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in case of death, where it is not forbidden by law.

4.8 PLAN ADMINISTRATOR DISCRETION

Nothing in this Plan precludes the Plan Administrator from exercising full discretionary authority and responsibility with respect to all aspects of Plan administration and interpretation. The Plan Administrator shall have all powers necessary to carry out the purposes of the Plan, including supplying any omissions in accordance with the intent of the Plan and deciding all questions concerning eligibility for participation in the Plan and concerning the amount of benefits payable to a Covered Person.

ARTICLE V

COVERAGE AND ELIGIBILITY

5.1 COVERAGE UNDER THIS PLAN

Coverage provided under the Plan for a Participant shall be in accordance with the Participant Eligibility, Participant Effective Date and Participant Termination provisions included herein.

5.2 PARTICIPANT ELIGIBILITY

Only employees of the Employer who meet all of the conditions listed below shall be deemed eligible for coverage as a Participant under the Plan:

A. the employee is employed on a full-time basis for at least thirty (30) hours per week, or one hundred thirty (130) hours per month; and

B. he or she has satisfied a ninety (90) waiting period, commencing with his or her date of hire at the level listed above. This ninety (90) day waiting period may be waived, in whole or in part, under either of the following circumstances:

   1. if an employee loses coverage under this Plan due to his or her failure to be employed for the number of hours listed in A, above, but is once again employed at such level, he or she will be reinstated with no additional waiting period on the first of any month in which the employee is again employed for at least one hundred thirty (130) hours. This provision will not apply if a period of thirteen (13) weeks or more have expired during which the employee is not credited with any hours of employment with the Employer; or

   2. if an employee is employed by the Employer for any or all of this ninety (90) waiting period prior to his or her entry into Service in the Uniformed Services, this period of previous employment shall be credited towards the partial or full satisfaction of any waiting period imposed under this Plan if the employee is re-employed by the Employer at the expiration of the term of Service in the Uniformed Services, provided such employee applies for reemployment within the applicable time frame listed in the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as described in Section 5.13.

Participants must agree to any applicable Participant Contribution for such coverage.

5.3 DEPENDENT COVERAGES

A Participant eligible to elect Dependent Coverage shall be any Participant whose Dependents meet the definition of a Dependent, set forth in Article III of the Plan. A Participant must make written request for Dependent Coverage and agree to any applicable Participant Contribution for such coverage. Each Participant will become eligible to elect Dependent Coverage on the latest of the following:

A. the date he or she becomes eligible for Participant coverage; or

B. the date on which he or she first acquires a Dependent.

If two (2) spouses are employed by the Company, and both are eligible to elect Dependent coverage, one (1) spouse or the other, but not both, may elect Dependent Coverage for the eligible Dependents. In addition, no person can be covered under this Plan as both a Participant and a Dependent, or the Dependent of more than one (1) Participant.

5.4 PARTICIPANT EFFECTIVE DATE

Each eligible employee who makes written request for Participant coverage hereunder, on a form approved by the Plan Administrator, subject to the provisions of this section and who agrees to the applicable Participant Contribution for such coverage, shall become effective on the date he or she becomes eligible, provided the written application for such coverage is made within sixty (60) days of the date he or she becomes eligible for Participant Coverage.

Any eligible person who wishes to make an application for Participant coverage other than as described above, or as described Section 5.7, shall be required to wait until the next Plan open enrollment period, as described in Section 5.8, before such application can be submitted.

5.5 DEPENDENT EFFECTIVE DATE

Each Participant who makes written request for Dependent Coverage hereunder within the applicable period described in Section 5.4 or Section 5.7, on a form approved by the Plan Administrator, subject to the provisions of this section and who agrees to the applicable Participant Contribution for such coverage, shall become eligible for Dependent Coverage on the later of the date specified in the special enrollment period or the date the Participant becomes covered, as applicable.

Any Participant who wishes to make an application for Dependent Coverage other than as described above, or as described in Section 5.7, shall be required to wait until the next Plan open enrollment period, as described in Section 5.8, before such application can be submitted.

5.6 NEWBORN CHILDREN

If the Participant already has Family Dependent Coverage in effect as of the date of birth, the Participant's Newborn will be automatically covered. If the Participant does not have Family Dependent Coverage in effect as of the date of birth, application must be made for the Newborn within thirty (30) days after the birth. In either case, coverage will be effective on the date of birth. Any Participant who wishes to make an application for Dependent Coverage other than as described above, or as described in Section 5.7, shall be required to wait until the next Plan open enrollment period, as described in Section 5.8, before such application can be submitted.

5.7 SPECIAL ENROLLMENT PERIODS

An eligible person for whom written application for coverage is submitted under any of the circumstances listed below will be eligible for coverage on the date specified below:

A. within thirty (30) days of the date of a Dependent child's birth. The eligible employee, the Newborn and the Dependent spouse are eligible to enroll during this special enrollment period. Coverage shall become effective on the date of the Dependent child's birth;

B. within thirty (30) days after the adoption of a Dependent child, or the Placement for Adoption with the employee of such a child. The eligible employee, the newly acquired Dependent child and the Dependent spouse are eligible to enroll during this special enrollment period. Coverage shall become effective on the date of the adoption or Placement for Adoption;

C. within thirty (30) days of the date of the eligible employee's marriage. The eligible employee, the new Dependent spouse, and any other eligible Dependent children who are eligible as a result of the marriage are eligible to enroll during this special enrollment period. Coverage shall become effective on the date of the marriage;

D. within thirty (30) days of the entry of an order requiring the employee to provide medical coverage for a Dependent child. The eligible employee and the Dependent child or children who are the subject of the court order are eligible to enroll during this special enrollment period. Coverage shall become effective on the date of the court order;

E. within thirty (30) days of the date the date a Dependent otherwise first becomes eligible, or re-eligible for coverage after a period of ineligibility. The employee must already be enrolled as a Participant, and only the newly eligible/re-eligible Dependent is eligible to enroll during this special enrollment period. Coverage shall become effective the date the Dependent becomes eligible/re-eligible for coverage;

F. within sixty (60) days of the date an eligible employee and/or his or her Dependent(s) first become eligible for coverage under a state Medicaid or Children's Health Insurance Program (CHIP), or, if covered, becomes ineligible for coverage through such programs. The eligible employee and any eligible Family member who becomes eligible or loses

eligibility through such programs are eligible to enroll during this special enrollment period. Coverage shall become effective the date of eligibility/ineligibility for Medicaid/CHIP; or

G. within thirty (30) days of the date coverage under another group health plan or health insurance coverage was lost, if:
   1. the reason the eligible employee and/or Dependent did not enroll for coverage under this Plan when initially eligible was the existence of the other coverage; and
   2. the person lost coverage under the other plan due to one (1) of the following:
      a. if covered under a COBRA continuation provision, the exhaustion of COBRA continuation coverage under the other plan;
      b. the loss of eligibility for coverage due to legal separation, divorce, death, termination of employment, reduction in hours of employment or other involuntary loss of eligibility (with the exception of terminations due to fraud or failure to pay premiums);
      c. the overall lifetime maximum benefit under the other coverage has been exhausted so that no further expenses will be payable under such coverage; or
      d. the termination of employer contributions towards such other coverage.

      The employee must already be enrolled as a Participant, or be among those losing coverage under the other plan. Only the Family members losing coverage under the other plan are eligible for this special enrollment. Coverage for which a person is eligible under this provision shall become effective on the day following the last day of coverage under the other plan.

Any otherwise eligible Dependent not listed above as eligible for a special enrollment can only be enrolled in this coverage during an annual open enrollment period, as described in Section 5.8. In no event shall any person become covered under this Plan prior to the date the Participant becomes a Covered Person, or prior to the end of the waiting period listed in Section 5.2.

5.8 OPEN ENROLLMENT

The Plan will have an annual open enrollment period during which otherwise eligible persons who were not enrolled when initially eligible (or who previously terminated coverage) and do not qualify for one of the special enrollment periods described in Section 5.7 can be enrolled in the Plan. Changes in Plan options can also be made during this period. Applications submitted pursuant to this open enrollment provision must be submitted b during the month of March, each year. Coverage or any changes for any person for whom application for coverage under this Plan was submitted pursuant to this provision shall be effective March 1st of the same Calendar Year.

5.9 PARTICIPANT TERMINATION

Participant coverage terminates immediately upon the earliest of the following dates:

A. the date in which the Participant is no longer paid for working the number of hours listed in Section 5.2A, or otherwise fails to meet the eligibility requirements listed in such Section;

B. the date specified in the notification from the Plan Administrator that coverage is terminated due to fraud or a material fraudulent act committed or contributed to by the Participant, including, but not limited to, intentionally submitting false claims to the Plan, or knowingly allowing the use of a Plan identification card to obtain Plan benefits by a person who is not authorized to do so;

C. the last day of the period for which a Participant Contribution was made following the date the Participant fails to make any required Participant Contribution for coverage; or

D. the date the Plan is terminated or, with respect to any benefit of the Plan, the date of termination of any such benefit.

In addition, coverage may continue under the Plan, under certain circumstances and in accordance with applicable federal laws. Such continuation may be at the Participant's or Dependent's own expense. For further clarification, refer to the Family and Medical Leave provisions as described in Section 5.12, and COBRA continuation coverage as described in Article VII. This Plan will also comply with the continuation provisions contained in the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) as they apply to Participants entering Service in the Uniformed Services, as described in Section 5.13.

5.10 DEPENDENT TERMINATION

Dependent Coverage terminates immediately upon the earliest of the following dates:

A. the date the Participant's coverage ceases under this Plan;

B. if a Dependent child who reaches the limiting age, the last day of the month in which the Dependent turns age twenty-six (26);

C. otherwise, the date such Dependent ceases to be a Dependent, as defined on page 20;

D. the date specified in the notification from the Plan Administrator that coverage is terminated due to fraud or a material fraudulent act committed or contributed to by the Dependent, including, but not limited to, intentionally submitting false claims to the Plan, or knowingly allowing the use of a Plan identification card to obtain Plan benefits by a person who is not authorized to do so;

E. the last day of the period for which a Participant Contribution for Dependent Coverage was made following the date the Participant fails to make any required Participant Contribution for Dependent Coverage; or

F. the date of cancellation of Dependent benefits under this Plan.

In addition, coverage may continue under the Plan, under certain circumstances and in accordance with applicable federal laws. Such continuation may be at the Participant's or Dependent's own expense. For further clarification, refer to the COBRA continuation coverage as described in Article VII.

5.11 CONTINUATION OF COVERAGE

Coverage for a Participant and his or her eligible Dependents under this Plan may be continued if the Participant is no longer eligible for coverage because he or she is on an Employer approved leave of absence until the earliest of the following dates:

A. the date the Participant is required to return to Active Work by the Employer, and he or she fails to do so;

B. the date the Participant fails to make any required Participant Contribution for this coverage;

C. the date the Participant elects to drop this coverage, or, in regards to any Dependent, the date such Dependent becomes ineligible or coverage is voluntarily terminated for such Dependent (once such coverage is terminated, it cannot be reinstated);

D. the date that is six (6) months from the date the Participant was no longer Actively at Work including any period covered under the Family and Medical Leave Act of 1993 (FMLA);

E. the date the Participant becomes eligible for coverage as an employee under any other similar health plan sponsored by another employer; or

F. the date that this Plan is terminated.

Continuation as described above is limited to the Participant and any covered Family members who were covered as of the date the Participant became eligible for continuation. Any continuation rights that the Participant may be entitled to under the provisions of COBRA, as described in Article VII, shall begin after the period of continuation described above.

5.12 FAMILY AND MEDICAL LEAVE PROVISIONS

This Plan intends to comply with the Family and Medical Leave Act of 1993 (FMLA) regarding the maintenance of health benefits during any period that an eligible employee takes a leave of absence in accordance with the Employer's FMLA policy, if the Employer is subject to such law. In applicable situations, FMLA allows an eligible employee to maintain group health plan coverage at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of such leave. Employee eligibility requirements, the obligations of the Employer and employees concerning conditions of leave, and notification and reporting requirements are specified in the Employer's FMLA policy. If the Employer is subject to FMLA, any Plan provision that conflicts with FMLA is superseded by FMLA to the extent such provision conflicts with FMLA. Questions regarding rights and/or obligations under FMLA should be directed to an Employer representative or the Plan Administrator.

5.13 USERRA RIGHTS

A Participant under this Plan who is no longer Actively at Work due to his or her Service in the Uniformed Services can elect, under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) to continue Participant and Dependent Coverage under this Plan for up to twenty-four (24) months after such coverage would otherwise have terminated. This period of continued coverage shall run concurrently with any continuation for which any Covered Person would have been entitled to under the provisions of COBRA due to the Participant’s termination or reduction in hours of employment. If the Service in the Uniformed Services is for thirty-one (31) days or more, the Participant Contribution for such coverage will be one hundred two percent (102%) of the full cost of the coverage, without any Employer contribution. If the Service in the Uniformed Services is less than thirty-one (31) days, the Participant Contribution shall be the same as would have applied if the Participant were still an active employee.

If coverage is not continued as described above, or the Service in the Uniformed Services exceeds the time limit listed above, upon release from his or her Service in the Uniformed Services, coverage will be reinstated in the Plan effective the date the employee is reemployed by the Employer, provided the employees reapplies for employment or reports back to work within the following applicable time:

A. if the period of service was less than thirty-one (31) days, the beginning of the next regularly scheduled work period on the first full day after release from Service in the Uniformed Services, taking into account safe travel home plus an eight (8) hour rest period;

B. if the period of service was more than thirty (30) days, but less than one hundred eighty-one (181) days, within fourteen (14) days of release from Service in the Uniformed Services; and

C. if the period of service was more than one hundred eighty (180) days, but less than five (5) years, within ninety (90) days of the release from Service in the Uniformed Services.

This period may be extended for up to two (2) years from the date the Service in the Uniformed Services ended, under the provisions of USERRA, if the person is unable to return to active employment due to a disability incurred while performing Service in the Uniformed Services.

The Plan Administrator reserves the right to request verification of any Service in the Uniformed Services, including copies of military orders or the applicable Form DD 214.

ARTICLE VI

COST MANAGEMENT SERVICES

6.1 UTILIZATION REVIEW

The Plan has a utilization pre-certification provision. Pre-admission certification must be obtained for every Inpatient admission to a covered Facility, including, but not limited to Hospitals, Skilled Nursing Facilities, Hospices, psychiatric treatment Facilities and Alcoholism and Substance Abuse treatment Facilities, except Emergency admissions, Urgent Care admissions, and minimum stays following childbirth. ("Emergency" and "Urgent Care" admissions are defined below). A "minimum stay following childbirth" is either:

A. a stay following a normal vaginal delivery that is forty-eight (48) hours or less; or

B. a stay following a cesarean section that is ninety-six (96) hours or less.

If a Hospital stay following childbirth will exceed the limitations listed above, the Pre-Certification Center must be notified as soon as the Covered Person and/or her Provider have determined that the hospitalization will exceed such limitations, but not later than the end of the applicable period listed above.

Pre-admission certification may be made through the Utilization Review Service. The telephone number for the Utilization Review Service is listed in Article I, Plan Information, and on the medical identification card. A Covered Person may inform his or her health care Provider that he or she participates in a program that has pre-admission certification provisions. In order to obtain pre-admission certification:

A. contact the Utilization Review Service and report the upcoming Hospital or other Facility stay no later than forty-eight (48) hours prior to the admission;

B. notice can be given by:

   1. the Hospital or other covered Facility;
   2. the Covered Person's admitting Physician;
   3. the Covered Person;
   4. a family member of the Covered Person; or
   5. a representative of the Employer; and

C. the Utilization Review Service must be provided with information necessary to make a decision as to the Medical Necessity of the admission.

The Utilization Review Service may request additional information that is necessary to make the determination from the Covered Person or a Provider. In the case of an urgent care request, such information must be provided within forty-eight (48) hours of the request. A decision will be made as soon as reasonably possible, but not later than seventy-two (72) hours of the Plan's receipt of all information necessary to make the determination. If the request does not involve urgent care, the information must be provided within forty-five (45) days of such request. An "urgent care" request is one that, if a determination is not made on an expedited basis, the life or health of the Covered Person, or the ability of the Covered Person to regain maximum function, could be seriously jeopardized, or, in the opinion of the attending Physician, the Covered Person would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

When pre-admission certification is provided to the Covered Person, a certain number of Inpatient days for the stay will be assigned. If the Utilization Review Service is not informed of the Covered Person's admission within the required timeframe, there will be a penalty. Covered Expenses for Hospital or other Facility services the Utilization Review Service, as the entity designated by the Plan Administrator to handle Utilization Review, would have approved for payment under the Pre-Admission Certification program will be reduced by five hundred dollars ($500.00). (This reduction is the penalty.) The penalty will be figured before the Deductible and Coinsurance are applied. The penalty is not considered an eligible expense. Charges for Inpatient

days that are determined by the Utilization Review Service to not be Medically Necessary are not covered under this Plan.

The Plan Administrator shall have full discretionary authority and responsibility with respect to all aspects of Plan administration, including utilization review. If a Utilization Review Service is designated by the Plan Administrator, the Utilization Review Service agrees to recognize the ultimate authority of the Plan Administrator.

6.2 CONTINUED STAY REVIEW

During a Covered Person's Inpatient stay, a Continued Stay Review will be conducted. This review applies to all Hospital or other Facility admissions. The purpose of Continued Stay Review is to:

A. provide the Utilization Review Service with an update as to the Covered Person's condition and/or progress; and

B. if necessary, enable the Utilization Review Service to re-evaluate the Medical Necessity of a continued Inpatient stay.

The Utilization Review Service has the right to initiate a Continued Stay Review for any Inpatient admission. The Utilization Review Service will always confirm the outcome of the Continued Stay Review by telephone or in writing. This notification will go to the Covered Person and/or the Covered Person's Physician. The notification always includes any newly authorized length of stay.

If a stay is longer than the specified number of Inpatient days that the Utilization Review Service considers to be Medically Necessary, Covered Expenses will be denied for any charges incurred for the days not Medically Necessary. This will occur if the Utilization Review Service is informed that the confinement is no longer Medically Necessary and the Covered Person knowingly chooses to remain in the Hospital or other Facility.

If the Covered Person's Physician and the Covered Person disagree with the findings of the Utilization Review Service, the Covered Person may file an appeal, in accordance with the procedures described in Article IV, with the Plan Administrator. The Plan Administrator has final authority over any such decisions.

6.3 WEEKEND ADMISSION REVIEW

All weekend (Friday, Saturday, and Sunday) Hospital admissions will be reviewed. Coverage is limited to Medically Necessary admissions.

6.4 EMERGENCY AND URGENT CARE REVIEW

If a Covered Person is admitted to a Hospital or other covered Facility for an Emergency or Urgent Care admission, notice of the admission may be provided to the Utilization Review Service no later than forty-eight (48) hours after the admission or as soon as reasonably possible. Notice may be given to the Utilization Review Service by:

A. the Hospital or other Facility;

B. the Covered Person's admitting Physician;

C. the Covered Person;

D. a family member of the Covered Person; or

E. a representative of the Employer.

The Utilization Review Service will review the case with the Covered Person's Physician to determine if a continued Inpatient stay is Medically Necessary. If the Utilization Review Service is not informed of the Covered Person’s admission, there will be a penalty. Covered Expenses for Hospital or other Facility services the Utilization Review Service, as the entity designated by the Plan Administrator to handle Utilization Review, would have approved for payment under the Pre-Admission Certification program will be reduced by five hundred dollars ($500.00) (This reduction is the penalty.) The penalty will be figured before the Deductible and Coinsurance are

applied. The penalty is not considered an eligible expense. Charges for Inpatient days that are determined by the Utilization Review Service to not be Medically Necessary are not covered under this Plan.

An Emergency admission is an admission to a Hospital through the emergency room of that Facility for treatment of a life threatening illness or injury. An Urgent Care admission is an unplanned admission or an admission scheduled less than forty-eight (48) hours prior, for a condition requiring prompt medical attention. An Urgent Care admission is not an admission through the emergency room.

6.5 DISCHARGE PLANNING

Review for Discharge Planning occurs during hospitalization review. The purpose is to:

A. identify patients requiring extended care following discharge; and

B. determine the most appropriate setting for continued care.

6.6 PRE-CERTIFICATION OF OUTPATIENT SURGERY

The Plan requires that all non-office based Outpatient Surgery be pre-approved by the Utilization Review Service prior to any Outpatient surgical procedure. As soon as possible after a Covered Person's Physician has determined that Surgery is necessary, but not later than forty-eight (48) hours prior to the Surgery, the Covered Person's Physician, the Covered Person or the Hospital or Facility where the procedure is to be performed must notify the Utilization Review Service and submit any documentation required by such service. The Covered Person is ultimately responsible for making sure this notification is made. The Utilization Review Service reserves the right to request additional records or information from the Covered Person, the Covered Person's Physician, Hospital or other Facility or Provider that is related to the surgical procedure.

If prior approval is not obtained for any of these services, charges for such Surgery will be subject to a penalty. Covered Expenses for surgical services or supplies that would have been approved for payment by the Utilization Review Service, as the entity designated by the Plan Administrator to handle utilization review, will be reduced by five hundred dollars ($500.00). The penalty will be figured before the Deductible and Coinsurance are applied. This penalty will not be considered as a Covered Expense under any other Plan provision, and shall not apply towards any Deductible, Out-of-Pocket limit, or maximum benefit limit. In addition to this penalty, any services and supplies that would not have been approved for payment will not be covered under this Plan.

6.7 INDIVIDUAL BENEFITS MANAGEMENT

Individual benefits management is designed to inform Covered Persons of more cost effective settings for treatment. On an exception basis and subject to approval, the Plan may provide benefits for settings not expressly provided for under the Plan, but which are not prohibited by law, rule or federal policy.

Services and supplies provided in connection with individual benefits management must be:

A. for an acute level of care;

B. Medically Necessary; and

C. provided in a more cost effective setting.

Under Individual Benefits Management, the Plan Administrator may waive the Deductible or Coinsurance amount for certain services.

The Plan Administrator has the right to deny an extension of benefits under Individual Benefits Management. The Plan Administrator also has the right to administer benefits pursuant to the terms of the Plan, exclusive of this provision. If benefits are provided to a Covered Person, under this provision for individual benefits management, that are outside of the conditions, limitations and/or exclusions of this Plan, the Covered Person has no right to expect that the same or similar benefits (provided outside of the conditions, limitations and/or exclusions of this Plan) will be provided to that Covered Person in the future.

The Plan Administrator shall have full discretionary authority and responsibility with respect to all aspects of Plan administration, including utilization review. If a Utilization Review Service is designated by the Plan Administrator, the Utilization Review Service agrees to recognize the ultimate authority of the Plan Administrator.

6.8 SECOND SURGICAL OPINION

The Plan will provide benefits for a second surgical opinion, including necessary testing, prior to any elective Surgery (not an Emergency or life-threatening).

The Physician providing the second surgical opinion must be qualified to render such an opinion, through experience or training, in the field related to the surgical procedure, and must not be financially associated with the Physician who recommended and/or will perform the Surgery.

The Plan Administrator and the Utilization Review Service reserve the right to direct the Covered Person to a Physician of their choosing for a second surgical opinion.

ARTICLE VII

CONTINUATION COVERAGE UNDER COBRA

7.1 RIGHT TO ELECT CONTINUATION COVERAGE

If a Qualified Beneficiary loses coverage under the Group Health Plan due to a Qualifying Event, he or she may elect to continue coverage under the Group Health Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the Company. A Qualified Beneficiary must elect the coverage within the sixty (60) day period beginning on the later of:

A. the date of the Qualifying Event; or

B. the date the Qualified Beneficiary was notified of his or her right to continue coverage.

If a Covered Employee has been determined to be an Eligible TAA Recipient or an Eligible Alternative TAA Recipient, as those terms are defined in the Trade Act of 2002, such Covered Employee and his or her Dependents who lost coverage under the Plan due to a job loss that qualified such employee for TAA assistance shall be entitled to a second sixty (60) day election period (if continuation coverage was not elected during the period described above) beginning on the first day of the month in which the Covered Employee is determined to be TAA eligible, provided such election is made within six (6) months of the original loss of coverage. If elected under this provision, coverage shall begin on the first day of the month in which the Covered Employee is determined to be TAA eligible.

7.2 NOTIFICATION OF QUALIFYING EVENT

If the Qualifying Event is divorce, legal separation or a Dependent child's ineligibility under a Group Health Plan, the Qualified Beneficiary must notify the Company, in writing addressed to the Plan Administrator, of the Qualifying Event within sixty (60) days of the event, or sixty (60) days of the date the Qualified Beneficiary would lose coverage because of the event, in order for coverage to continue. Appropriate documentation of the Qualifying Event must be submitted, including, as appropriate, final divorce and legal separation decrees issued and properly signed by the court. In addition, a Totally Disabled Qualified Beneficiary must notify the Company in accordance with the section below entitled "Total Disability" in order for coverage to continue.

7.3 LENGTH OF CONTINUATION COVERAGE

A Qualified Beneficiary who loses coverage may continue coverage under the Group Health Plan for:

A. a Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee:
   1. for up to eighteen (18) months from the date of the Qualifying Event; or
   2. if a Qualified Beneficiary is Totally Disabled at any time during the first sixty (60) days of Continuation Coverage, he or she may continue coverage for up to twenty-nine (29) months from the date of the Qualifying Event, provided the Qualified Beneficiary notifies the Company of the determination of his or her Total Disability under the Social Security Act:
      a. before the end of the original eighteen (18) month continuation period; and
      b. within sixty (60) days following the date of such determination; or

B. a Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce, or Medicare eligibility and Dependent children who have become ineligible for coverage may continue under the Group Health Plan for up to thirty-six (36) months from the date of the Qualifying Event.

7.4 TERMINATION OF CONTINUATION OF COVERAGE

Continuation Coverage will automatically end earlier than the applicable eighteen (18) or thirty-six (36)-month period for a Qualified Beneficiary if:

A. the required monthly contribution for coverage is not received by the Company within thirty (30) days following the date it is due;

B. the Qualified Beneficiary becomes covered under any other Group Health Plan containing an exclusion or limitation relating to a pre-existing condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for Continuation Coverage as long as the exclusion or limitation relating to the pre-existing condition applies to the Qualified Beneficiary;

C. for Totally Disabled Qualified Beneficiaries continuing coverage for up to twenty-nine (29) months, the last day of the month coincident with or following thirty (30) days from the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer Totally Disabled;

D. the Qualified Beneficiary becomes entitled to Medicare benefits; or

E. the Company ceases to offer any Group Health Plans.

7.5 MULTIPLE QUALIFYING EVENTS

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum Continuation Coverage is eighteen (18) months, and a second Qualifying Event occurs during the eighteen (18) month period, the Qualified Beneficiary may elect, in accordance with the section entitled "Right to Elect Continuation Coverage," to continue coverage under the Group Health Plan for up to thirty-six (36) months from the date of the first Qualifying Event.

7.6 TOTAL DISABILITY

In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the "Act") to have been Totally Disabled at the time of a Qualifying Event or at any time during the first sixty (60) days of the Qualified Beneficiary's Continuation Coverage (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for Dependents who were covered under the Continuation Coverage) for a total of twenty-nine (29) months as long as the Qualified Beneficiary notifies the Employer, in writing addressed to the Plan Administrator:

A. prior to the end of eighteen (18) months of Continuation Coverage that he or she was disabled as of the date of the Qualifying Event; and

B. within sixty (60) days of the determination of Total Disability under the Act.

A copy of the determination letter from Social Security must be submitted with the notification.

The Employer will charge the Qualified Beneficiary an increased contribution for Continuation Coverage extended beyond eighteen (18) months pursuant to this Section.

If during the period of extended coverage for Total Disability (Continuation Coverage months nineteen (19) through twenty-nine (29)) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:

A. the Qualified Beneficiary shall notify the Employer of this determination within thirty (30) days; and

B. Continuation Coverage shall terminate the last day of the month following thirty (30) days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.

7.7 CARRYOVER OF DEDUCTIBLES AND PLAN MAXIMUMS

If Continuation Coverage under the Group Health Plan is elected by a Qualified Beneficiary under COBRA, expenses already credited to the Plan's applicable Deductible and Copayment features for the year will be carried forward into the Continuation Coverage elected for that year.

Similarly, amounts applied toward any maximum payments under the Plan will also be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

7.8 PAYMENTS OF PREMIUM

The Group Health Plan will determine the amount of premium to be charged for Continuation Coverage for any period, that will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

The Group Health Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed one hundred two percent (102%) of the applicable premium for that period.

For Qualified Beneficiaries whose coverage is continued pursuant to the Section entitled "Total Disability" of this provision, the Group Health Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed one hundred fifty percent (150%) of the applicable premium for continuation coverage months nineteen (19) through twenty-nine (29).

Contributions for coverage may, at the election of the payer, be paid in monthly installments.

If Continuation Coverage is elected, the first monthly contribution for coverage must be made within forty-five (45) days of the date of election.

Without further notice from the Company, the Qualified Beneficiary must pay the monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Company within thirty (30) days of the payment's due date, Continuation Coverage will terminate in accordance with the section entitled "Termination of Continuation Coverage," Subsection A.

No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

7.9 DEFINITIONS

For purposes of this Article VII, unless specifically stated otherwise, the following definitions apply:

A. “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

C. "Company" means the Employer, as defined in Article III.

D. "Continuation Coverage" means the Group Health Plan coverage elected by a Qualified Beneficiary under COBRA.

E. "Covered Employee" has the same meaning as that term is defined in COBRA and the regulations thereunder.

F. "Group Health Plan" has the same meaning as that term is defined in COBRA and the regulations thereunder.

G. "Qualified Beneficiary" means:

   1. a Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering the Covered Employee ineligible for coverage under the Plan; and

   2. a covered spouse or Dependent who becomes eligible for coverage under the Plan due to a Qualifying Event, as defined below. Qualified Beneficiary also includes any child who is born to or Placed for Adoption with the Covered Employee during the period of Continuation Coverage.

H. "Qualifying Event" means the following events that, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:

   1. termination of a Covered Employee's employment (other than gross misconduct) or reduction in the Covered Employee's hours of employment;

   2. the death of the Covered Employee;

   3. the divorce or legal separation of the Covered Employee from his or her spouse;

4. the Covered Employee becoming entitled to Medicare coverage; or
5. a child ceasing to be eligible as a Dependent child under the terms of the Group Health Plan.

I. "Totally Disabled" or "Total Disability" means totally disabled as determined under Title II or Title XVI of the Social Security Act.

ARTICLE VIII

MAJOR MEDICAL EXPENSE BENEFITS

8.1 COINSURANCE PERCENTAGE AND DEDUCTIBLE

Each Covered Person must pay the Deductible amount stated in Section 2.3, or the Copayment amount stated in Section 2.4 and Section 2.6, as applicable, before the Plan begins paying benefits. The Plan will pay the Coinsurance percentage stated in Section 2.5 to the limits shown.

The Deductible applies to Covered Expenses for each Calendar Year. The Deductible will be applied as explained in the definition of Deductible set forth on page 20.

8.2 ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan Administrator may allocate the Deductible amounts to any eligible charges and apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

Many times claims for Covered Expenses are not submitted in the same order in which they were incurred. Regardless of the order in which the claims were incurred, the Copayments, Deductible and Coinsurance will be applied to Covered Expenses in the sequence that the claims were submitted and ready for payment.

ARTICLE IX

DESCRIPTION OF BENEFITS

9.1 MEDICAL BENEFITS – COVERED EXPENSES

In order to be eligible for benefits under this section of the Plan, charges actually incurred by a Covered Person must be for services or supplies administered or ordered by a Physician, be provided by a properly licensed or certified Facility or Professional Provider, and be Medically Necessary for the diagnosis and treatment of an illness or injury unless otherwise specifically covered or included in the Recommended Wellness Services. In addition, such charges will only be covered to the extent that they do not exceed the Reasonable and Customary charge for the service or supply in question.

Covered charges include the following:

A. Charges made by a Hospital for:
   1. Inpatient care, including:
      a. Room and Board, including confinement in an Intensive Care Unit or Special Care Unit, subject to the limitations listed in Section 2.6;
      b. meals, including special meals or dietary services as required by the Covered Person's condition; and
      c. other necessary ancillary services and supplies provided by the Hospital during the Inpatient stay (not including personal convenience items), including:
         i) use of operating, recovery or other specialty service rooms, and any equipment of supplies therein;
         ii) casts, surgical dressing and supplies;
         iii) devices or appliances surgically inserted within the body;
         iv) oxygen and oxygen therapy;
         v) administration of blood and blood plasma, including the processing of blood from donors;`
         vi) anesthesia and related supplies, and the use of anesthetic equipment;
         vii) Diagnostic Services;
         viii) Therapy Services;
         ix) Inpatient rehabilitation therapy, subject to the limitations listed in Section 2.7; and
         x) all FDA-approved drugs, including intravenous solutions, cancer Chemotherapy and cancer hormone therapy treatment provided for use while in the Hospital;
   2. services furnished on a Hospital's premises, including the use of a bed and periodic monitoring by the Hospital's nursing or other staff that are Reasonable and necessary to evaluate an Outpatient's condition or determine the need for a possible admission to the Hospital as an Inpatient; and
   3. Outpatient care, including:
      a. treatment in a Hospital emergency room, including follow-up care provided in the Outpatient department of a Hospital; and
      b. other ancillary services and supplies listed above as covered that are provided in the Outpatient department of a Hospital.

      All Inpatient confinements and Outpatient Surgery must be pre-certified, as described in Article VI.

B. Charges for pre-admission testing and studies required in connection with the Covered Person's admission to a Hospital or other Facility that are rendered or accepted by a Facility and performed on an Outpatient basis prior to a scheduled admission to such Provider. Pre-admission testing does not include tests or studies performed to establish a diagnosis. Such testing will still be covered if the Facility or Physician cancels or postpones the admission, but not if the admission is cancelled by the Covered Person.

C. Charges for treatment for an illness or injury that is provided in a Free-Standing Outpatient Facility, including, but not limited to, an Ambulatory Surgical Facility, a Retail Care Clinic or an urgent care Facility. Covered Expenses include Professional Provider services provided in such a Facility and Medically Necessary services and supplies related to such treatment. All Outpatient surgical procedures performed in such a Facility must be pre-certified, as described in Section 6.6.

D. Charges for care provided in a Skilled Nursing Facility when determined to be Medically Necessary by the Plan Administrator, subject to the limitations listed in Section 2.7. All Skilled Nursing Facility confinements must be pre-certified, as described in Article VI. The Covered Person must require treatment by skilled nursing personnel that can only be provided on an Inpatient basis in such a Facility.

E. Charges for Hospice Care provided when the Covered Person's Physician certifies that the Covered Person has a terminal illness with a life expectancy of six (6) months or less if the Covered Person elects to receive care primarily in his or her home to relieve pain and to enable the Covered Person to remain at home rather than to receive other types of care. Care provided through a Hospice is subject to the limitations listed in Section 2.7. If the Covered Person elects to institute curative treatment to sustain life, he or she will not be eligible for any further Hospice Care benefits until the cessation of such curative treatment. Covered Hospice Care services and supplies include:

   1. continuous nursing care for up to twenty-four (24) hours per day that is necessary to maintain the Covered Person at home, including the professional services of a Registered Nurse or Licensed Practical Nurse;
   2. acute Inpatient care for a period of crisis when Medically Necessary and not solely for comfort measures, or short-term Respite Care when the Hospice considers such care necessary to relieve primary caregivers in the patient's home. All Inpatient confinements must be pre-certified, as described in Article VI; and
   3. other supportive care proved by a Hospice to a Covered Person who is terminally ill in accordance with a treatment plan approved by the Covered Person's Physician, including:
      a. pain management;
      b. Chemotherapy and Radiation Therapy;
      c. parenteral or enteral nutrition therapy;
      d. prescription drugs provided through the Hospice;
      e. laboratory services;
      f. dietitian services;
      g. medical and surgical supplies, Ostomy Supplies and Durable Medical Equipment;
      h. oxygen and its administration;
      i. medical social services provided by a social worker;
      j. bereavement counseling provided through the Hospice for covered immediate Family members, including a spouse, child or parent;
      k. home health aide and homemaker services; and

l. any needed Therapy Services.

F. Charges made by a Home Health Care Agency for services or supplies that are prescribed by the Covered Person's attending Physician and furnished pursuant to a plan of treatment that has been approved by such Physician. Such plan of treatment must be reviewed by the Physician no less than every thirty (30) days. The Covered Person must be Homebound in order to receive home health care services and supplies. Covered Expenses include:

1. the professional services of a Registered Nurse or Licensed Practical Nurse;
2. home health aide services that are assigned and supervised by a Registered Nurse or Licensed Practical Nurse;
3. Physical Therapy treatment performed by a licensed physical therapist;
4. Speech Therapy services when provided by a licensed speech therapist;
5. Occupational Therapy treatments when provided by, or supervised by, a licensed occupational therapist;
6. medical social service consultations when provided by a qualified medical social service worker holding a masters degree in social work;
7. nutritional therapy provided by a licensed dietitian;
8. diagnostic and therapeutic radiology services;
9. laboratory services;
10. medical diagnostic tests and studies;
11. oxygen and Respiratory Therapy;
12. medical and surgical supplies, including bandages, Ostomy Supplies, dressings and casts; and
13. the rental of Durable Medical Equipment, but only on a short term basis, and if not owned by the Home Health Care Agency.

Charges related to any of the following are not covered under this provision:

1. food or home delivered meals;
2. professional medical services billed by a Physician;
3. Custodial Care;
4. services of a housekeeper;
5. ambulance service;
6. drugs, including prescription drugs; and
7. services provided by a Close Relative or members of the Covered Person's household.

G. Charges for Home Infusion Therapy provided through a Home Infusion Therapy Agency, including:

1. total parenteral nutrition, enteral nutrition, anti-infective therapy (Lyme Disease) and immune globulin therapy that is non-Experimental and has been FDA approved;
2. intravenous therapy;
3. cancer Chemotherapy and cancer hormone treatment;
4. continuous and epidural analgesic pain management treatment; and
5. supplies furnished by the Home Infusion Therapy Agency that are used directly with Home Infusion Therapy to achieve therapeutic benefits and assure proper functioning of the system, including, but not limited to:
   a. catheters;

b. concentrated nutrients;
c. dressings;
d. enteral nutrition preparation;
e. extension tubing;
f. filters;
g. heparin sodium (parenteral only);
h. infusion bottles;
i. IV pole;
j. liquid diet (for catheter administration);
k. needles;
l. pumps;
m. tape; and
n. volumetric monitors.

Benefits will not be provided under this provision for:

1. Covered Persons who are receiving benefits through Hospice Care, as described above;
2. blood and blood products therapy; and
3. any injectable drugs that are covered under any other provision of this Plan.

H. Charges for Medically Necessary ambulance service by land, air or water, including advanced life support or basic life support, for local transportation. The ambulance must be transporting the Covered Person:

1. from home or from the scene of an accident or medical Emergency to the nearest Hospital;
2. between Hospitals;
3. between a Hospital and a Skilled Nursing Facility;
4. from a Hospital or Skilled Nursing Facility to the Covered Person's home;
5. from the Covered Person's home, or from a Facility, to an Outpatient treatment site; or
6. from an Outpatient treatment site to the nearest Hospital.

If there is no Facility in the local area that can provide services that are Covered Expenses under this Plan for the Covered Person's condition, the Plan will provide benefits to the closest Facility outside the local area that can provide the necessary service. If the Covered Person chooses to go to another Facility that is farther away, Covered Expenses will be limited to the Reasonable and Customary charge for transportation to the nearest Facility that can provide the necessary services.

I. Charges for Diagnostic Services when ordered by a Professional Provider, and provided through a Professional Provider or Facility, including an independent clinical laboratory, for any of the following:

1. diagnostic radiology, including x-rays, ultrasound and nuclear medicine;
2. diagnostic laboratory and pathology tests;
3. diagnostic medical procedures, including electrocardiograms (ECGs), electroencephalograms and other necessary diagnostic medical procedures;
4. diagnostic imaging procedures, including MRIs, MRAs, CT scans, PET scans and nuclear cardiology studies; and
5. allergy testing, including percutaneous, intracutaneous and patch tests.

J. Charges made by a Physician for:
   1. Medical Care, visits and consultations provided in a Physician's office, not including take-home drugs provided during the visit;
   2. visits to an Inpatient in a Hospital, Rehabilitation Hospital, Skilled Nursing Facility or other Inpatient Facility;
   3. consultation services provided at the request of the attending Physician, limited to one (1) visit per consultant, per Inpatient confinement. This does not include staff consultations required by the Facility's rules and regulations;
   4. concurrent care provided on an Inpatient basis in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Physician who is not in charge of the Covered Person's case, but whose particular skills are required for the treatment of complication conditions. This does not include observation or reassurance of the Covered Person, standby services, routine pre-operative physical examinations or Medical Care routinely performed in the pre- or post-operative period, or Medical Care that is required by the Facility's rules and regulations; and
   5. Medical Care provided on an Outpatient basis in other covered medical Facilities.

K. Charges for Medically Necessary Surgery rendered by a Professional Provider and/or provided in a Facility or Physician's office, or in a short procedure unit, Hospital, Outpatient department or Freestanding Surgical Facility for the treatment of disease or injury. Charges for Inpatient pre-operative or post-operative care normally provided by the surgeon as part of the procedure will be included in the Reasonable and Customary charge for the procedure. Surgical procedures are subject to the following:
   1. all non-office based procedures must be pre-certified, as described in Article VI;
   2. Covered Expenses include the services of an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery, provided the condition of the Covered Person or the type of Surgery requires the active assistance of such an assistant. This provision does not include services performed by a Professional Provider who also performs and bills for another surgical procedure during the same operative session;
   3. Covered Expenses for Multiple Surgical Procedures that are performed during the same operative session will be determined in accordance with the definition listed on page 26;
   4. Covered Expenses, including both Physician and Facility expenses, for robotic surgical procedures and related expenses will be limited to the Reasonable and Customary charge for the same surgical procedure performed under standard methods;
   5. Covered Expenses also include the administration of general anesthesia in a Hospital or Ambulatory Surgical Facility in connection with a Surgery or other Covered Expense when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Physician. Charges for local anesthesia and conscious sedation are covered regardless of setting; and
   6. in addition to Medically Necessary Surgery, Covered Expenses also include the following:
      a. the elective sterilization of a Participant, a Participant's spouse or any female Covered Person. Elective sterilization of a male Dependent child, or reversals of sterilization procedures, are not covered under this Plan; and
      b. reconstructive Surgery:
         i) when required to restore function following accidental injury, infection or disease in order to achieve reasonable physical or bodily function;

ii) in connection with congenital disease or anomaly for Covered Persons up to age eighteen (18);

iii) in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or

iv) breast reconstruction in connection with a mastectomy, including:

(1) reconstruction of the breast on which the mastectomy was performed;

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

(3) prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Such reconstruction must be performed in a manner determined in consultation with the attending Physician and the Covered Person.

L. Charges related to the Pregnancy of a Participant or Participant's spouse, including services provided in a Hospital or licensed birthing center, services of a Physician or other Professional Provider for pre-natal care, delivery and post-natal care, necessary testing, treatment of a miscarriage, abortions (but only if the mother's life is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest), and treatment of any Complications of Pregnancy. Charges related to the Pregnancy of a Dependent child are only covered under this Plan if included in the Recommended Wellness Services. Medical complications arising from a Dependent child's Pregnancy will also not be covered under this Plan, unless the Participant certifies, by written affidavit, that there is no other coverage available to the Dependent child to cover such expenses.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or Newborn's attending Provider, after consulting with the mother, from discharging the mother or her Newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

When a discharge occurs prior to the time periods listed above, the Plan will provided benefits for one (1) home health care visit within forty-eight (48) hours of the Hospital discharge. At the discretion of the mother, the visit may occur at home or at the Provider's office or Facility. Such visit may include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments.

M. Charges for the treatment of a well Newborn in the Hospital or birthing center following birth, up to the mother's initial discharge, including nursery charges, a Physician's examination following birth, routine male circumcisions, and any required or necessary testing. The Newborn must be an eligible Dependent, as defined on page 20, and enrolled in the Plan in accordance with the provisions described in Article V.

N. Charges for the following routine services:

1. Recommended Wellness Services. Routine eye and hearing examinations are not covered if provided by a non-Preferred Provider, even if included in these recommendations. In addition to services and supplies otherwise listed as a Covered Expense under this Plan, such services and supplies include, but are not limited to, tobacco cessation counseling; and

2. routine prostate examinations and testing, subject to the limitations listed in Section 2.7.

O. Charges for Medically Necessary services provided by a licensed chiropractor to Covered Persons age thirteen (13) and older, including consultations, visits, Diagnostic Services and Chiropractive Manipulative Therapy, subject to the limitations listed in Section 2.7.

P. Charges for the following Outpatient Therapy Services that have been prescribed by a Physician, and that are provided by a Professional Provider and/or Facility that are used in the treatment of an illness or injury to promote the recovery of the Covered Person:

1. Cardiac Rehabilitation, subject to the limitations listed in Section 2.7;
2. Dialysis Treatment. Dialysis Services, diagnostic testing, lab expenses, equipment and supplies are those services and items used in the treatment of acute renal failure and/or chronic renal insufficiency (treatment of anemia and other diagnoses related to renal failure). This also includes injectable and intravenous medications, including but not limited to, Heparin, Epogen, Procrit and other medications administered directly before, during or after a dialysis procedure. Dialysis procedures are for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis regardless of whether they are provided on an Inpatient or Outpatient basis.

   As outlined within Footnote ④ of Section 2.6, the Plan provides an alternative basis for payment of claims associated with dialysis-related services and products. This alternative basis may be applied to claims by any healthcare Provider, regardless of the healthcare Provider's participation in the Preferred Provider organization (PPO).

   All eligible Participants and their Dependents requiring dialysis are subject to cost containment review, claim audit and/or review, negotiation and/or other related administrative services which the Plan Administrator may elect to apply in the exercise of the Plan Administrator's discretion.

   Covered Persons that are diagnosed with a condition requiring dialysis may be able to enroll in Medicare. The Plan will not enroll any Covered Person in Medicare; it is the Covered Person's decision and responsibility to enroll in Medicare, if applicable;
3. Pulmonary Rehabilitation, subject to the limitations listed in Section 2.7;
4. Radiation Therapy, including the cost of radioactive materials;
5. Respiratory Therapy, subject to the limitations listed in Section 2.7; and
6. short-term Occupational Therapy, Physical Therapy or Speech Therapy that:
   a. is prescribed by a Physician;
   b. is Medically Necessary to regain function lost after an accidental injury, Surgery or an acute illness; and
   c. will result in improvement in the Covered Person's condition within a period of three (3) months from the initiation of the therapy.

   Therapy or devices to correct stuttering or pre-speech deficiencies, or to improve speech skills that are not fully developed, are not covered under this Plan.

   All such therapy is subject to the limitations listed in Section 2.7.

Q. Charges related to Durable Medical Equipment that has been prescribed by a Professional Provider. Replacements of Durable Medical Equipment are not covered under this Plan unless Medically Necessary for children due to the normal growth process. Coverage of equipment with deluxe or non-standard features that are not Medically Necessary will be limited to the Reasonable and Customary charge for standard equipment serving the same purpose. Covered Expenses include, but are not limited to:

1. hospital-type beds and related equipment, such as bed rails and mattresses;

2. equipment to increase mobility, such as walkers or wheelchairs;
3. commodes, including elevated seats and portable bedside commodes;
4. breathing apparatus, such as positive and intermittent positive pressure breathing machines and suction machines;
5. therapeutic equipment;
6. apnea monitors;
7. Jobst pressure garments used in burn treatment;
8. Unna boots and air casts; and
9. the rental, or purchase, if less, of breast feeding equipment, including related counseling and supplies, but only if received through a Preferred Provider, subject to the limitations listed in Section 2.7.

R. Charges for Orthotic Devices and Prosthetic Appliances that have been prescribed by a Professional Provider. Repairs and replacements of such devices/appliances are not covered under this Plan unless Medically Necessary for children due to the normal growth process, or if prescribed in connection with the treatment of diabetes. Covered Expenses include, but are not limited to:

1. artificial limbs;
2. knee braces not made of elastic or fabric support;
3. splints (acrimo-clavicular or zimmer, carpal tunnel, clavicle or "figure-8" finger, Pavlik harness and wrist);
4. immobilizers;
5. supportive back braces with metal stays;
6. dynasplints;
7. Orthotic Devices used in the treatment of diabetes, including foot orthotics. No other routine foot orthotics are covered under this Plan, even if custom made;
8. prosthetic bras following a mastectomy, subject to the limitations listed in Section 2.7;
9. eyeglasses or contact lenses that perform the function of a human lens lost as a result of ocular or cataract Surgery, subject to the limitations listed in Section 2.7, or injury;
10. pinhole glasses prescribed for use after Surgery for a detached retina;
11. lenses prescribed in lieu of Surgery for any of the following conditions:
    a. contact leases used for the treatment of infantile glaucoma;
    b. corneal or sclera lenses prescribed in connection with the treatment of keratoconus;
    c. sclera lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; or
    d. corneal or sclera lenses to reduce a corneal irregularity other than astigmatism; and
12. cryocuffs.

S. Charges for Ostomy Supplies, subject to the limitations listed in Section 2.7. Covered Ostomy Supplies are limited to the following:

1. Ostomy appliances and supplies specifically relating to an Ostomy, including colostomy, ileostomy, urostomy or tracheostomy, are limited to:
    a. collection devices;

b. irrigation equipment and supplies;

c. skin barriers; and

d. skin protectors; and

2. urinary catheters, both reusable or disposable, whether or not used in conjunction with an Ostomy.

T. Charges for FDA approved therapeutic drugs, including cancer Chemotherapy and cancer hormone treatments, that are not self-administrable, and that are required in the treatment of an illness or injury in all medically appropriate treatment settings that are covered under this Plan.

U. Charges for Metabolic Formulas, but only if used in the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria. Normal food products used in the dietary management of disorders, including rare genetic metabolic disorders, is not covered under this Plan.

V. Charges for allergy extracts and antigen injections.

W. Charges for oxygen and related equipment and supplies for use in the Covered Person's home.

X. Charges for whole blood, blood plasma, the administration of blood and blood processing and blood derivatives.

Y. Charges for FDA approved contraceptive implants, injectables and devices that are prescribed for females, and contraception related medical services for such Covered Persons. Oral contraceptives and over-the-counter products are only covered through the pharmacy programs described in Article X.

Z. Charges for the following dental treatment (related to the mouth, teeth and gums):

1. oral Surgery performed by a Professional Provider for treatment of diseases and injuries to the jaw, head and neck, but not including diseases related to the teeth and gums;

2. treatment rendered by a Professional Provider that is required as a result of an accidental injury to the jaws, a Sound Natural Tooth, the mouth or the face, provided that such treatment is completed within one (1) year of the accident, unless any delay in treatment is Medically Necessary due to the Covered Person's age or medical condition;

3. dental services directly associated with early childhood caries that are rendered prior to age four (4), subject to the limitations listed in Section 2.7;

4. the surgical removal of full, partial or soft tissue impacted teeth;

5. the orthodontic treatment of congenital cleft palates involving the maxillary arch performed in conjunction with bone graft Surgery to correct the body deficits associated with extremely wide clefts affecting the alveolus;

6. surgical treatment for the total reconstruction or replacement of a completely degenerated jaw joint;

7. for dental treatment provided under any of the following conditions:

a. the dental treatment is required as part of a broader treatment plan requiring radiation of the head and/or neck;

b. there is a non-dental disease eroding or invading the maxilla and/or mandible, the treatment of which necessitates the removal of the Covered Person's teeth; or

c. there is an infection of the teeth and gums that places the Covered Person's health at risk if uncorrected prior to other Medically Necessary treatment, such as, but not limited to, Chemotherapy or a transplant; and

8. Hospital or Ambulatory Surgical Facility charges, including general anesthesia, in connection with dental procedures or dental Surgery, but only under the following circumstances:
   a. for children under the age of eighteen (18);
   b. for adults with significant cognitive impairment or developmental disabilities; or
   c. for Covered Persons with complex medical conditions that would make the performance of the Surgery/procedure in a non-Facility setting an unacceptable risk to the Covered Person's health.

   Charges for the dental Surgery/procedure itself will only be a Covered Expense if specifically listed above as covered.

AA. Charges for Nutritional Therapy to promote a healthy diet when provided through a licensed health care professional, including weight loss counseling, subject to the limitations listed in Section 2.7. Covered Persons age two (2) through age twelve (12) must be accompanied by a parent. Covered Persons from age thirteen (13) through age seventeen (17) can be provided such counseling with parental consent. No coverage is provided for children under age two (2).

AB. Charges for Outpatient diabetes self-management training and education that has been prescribed by a Physician, and provided or supervised by a licensed health care professional with expertise in diabetes. Such training will be covered if provided:
   1. if Medically Necessary upon the diagnosis of diabetes;
   2. under circumstances when a Physician identifies or diagnoses a significant change in the Covered Person's symptoms or condition that necessitates changes in his or her self-management; or
   3. where there is a new medication or therapeutic process relating to the Covered Person's treatment and/or management of diabetes that has been identified as Medically Necessary by a licensed Physician.

AC. Charges for genetic or genomic testing that is Medically Necessary in connection with the treatment of an existing health condition, such as cancer. No other genetic or genomic testing is covered under this Plan, unless included in the Recommended Wellness Services.

AD. Charges for Medically Necessary sleep studies, and other treatment of serious sleep disorders, such as obstructive sleep apnea.

AE. Charges related to the diagnosis, assessment and treatment of Autism Spectrum Disorders by a qualified Autism Service Provider or Behavioral Specialist pursuant to a Treatment Plan for Autism Spectrum Disorders for Covered Persons up to age twenty-one (21), subject to the limitations listed in Section 2.7.

AF. Charges for any Diagnostic Services that are necessary to determine infertility. Active infertility treatment of infertility, or correction of any defects causing infertility, is not covered under this Plan.

AG. Charges related to human organ and tissue Transplant Procedures that are not Experimental. In addition to services and supplies that are otherwise covered under this Plan in connection with the treatment of other conditions, the following will be covered if provided in connection with a covered transplant procedure:

1. reasonable medical expenses of a transplant donor that are directly related to the transplant, but only if the transplant recipient is a Covered Person, and the transplant is a Covered Expense under this Plan, to the extent that there is no other coverage reasonably available to the donor for such expenses. No benefits will be provided for the purchase price of any organ or tissue provided to the transplant recipient;
2. other reasonable costs related to the evaluation and acquisition of organ or tissue for transplant to a Covered Person, including costs related to receiving such items through a non-living human donor; and
3. reasonable costs related to the testing of potential donors for a covered Transplant Procedure.

The Plan Administrator has an agreement with a special transplant network that allows Covered Person's under this Plan to receive transplant related services and supplies for transplants that are performed at a Facility that is part of this network at a cost that is less, for the most part, than those charged other patients of the Facility. Covered Persons under this Plan can benefit from this agreement by incurring lower Out-of-Pocket costs related to the transplant. For more information about accessing this network, contact the Benefit Manager or the Utilization Review Service.

AH. Charges for the treatment of Mental/Nervous Disorders. Covered Expenses include:

1. Inpatient care in a Hospital, including an Inpatient Mental Health Hospital or Psychiatric Hospital. All Inpatient confinements must be pre-certified, as described in Article VI;
2. Outpatient care, including professional visits; and
3. Partial Hospitalization for Psychiatric Care,

AI. Charges for the treatment of Alcoholism and Substance Abuse or dependency. The Covered Person's need for such treatment must be certified by a licensed Physician or licensed Psychologist, who also determines the nature and duration of the Covered Person's treatment. The following are covered under this provision:

1. Inpatient Detoxification in either a Hospital or an Inpatient Residential Treatment Facility, including:
   a. lodging and dietary services;
   b. rehabilitation therapy and counseling;
   c. diagnostic x-rays;
   d. psychiatric, psychological and medical laboratory testing; and
   e. drugs, medicines, equipment use and supplies;
2. other Inpatient treatment in a Residential Treatment Facility, including:
   a. lodging and dietary services;
   b. Physician, Psychologist, nurse, certified addiction counselors and trained staff services;
   c. rehabilitation therapy and counseling;
   d. family counseling and intervention;
   e. psychiatric, psychological and medical laboratory testing; and
   f. drugs, medicines, equipment use and supplies;
3. Partial Hospitalization for Alcholism and substance Abuse Care;
4. Outpatient treatment provided in an Alcoholism or Substance Abuse treatment Facility, including the following service performed by an employee of the Facility:

a. Physician, Psychologist, nurse, certified addition counselors and trained staff services;
b. rehabilitation therapy and counseling;
c. family counseling and intervention;
d. psychiatric, psychological and medical laboratory testing; and
e. drugs, medicines, equipment use and supplies; and

5. other non-Facility based Outpatient care, including professional visits, counseling and testing.

ARTICLE X

OTHER BENEFITS

10.1 PRESCRIPTION DRUG CARD PROGRAM

The Plan has a prescription drug card program that covers prescriptions dispensed through a participating pharmacy. There is a Copayment for most prescriptions, as described in Section 2.8, depending on the Plan option elected, the Plan's classification of the drug and the days supply, that must be paid for each such prescription obtained until the Out-of-Pocket limit is satisfied. Any Copayment paid under the prescription drug card program shall not be a Covered Expense under any other provision of this Plan.

10.2 MAIL ORDER PRESCRIPTION PROGRAM

The Plan provides a mail order prescription drug program. The Plan covers both brand name and generic equivalents in accordance with the Copayment amounts shown in Section 2.9, of the Plan. The Plan covers up to a ninety (90) day supply of the medication with a single Copayment. Any Copayment paid under the mail order prescription program shall not be a Covered Expense under any other provision of this Plan.

10.3 COVERED EXPENSES AND LIMITATIONS UNDER THE PRESCRIPTION DRUG CARD AND MAIL ORDER PRESCRIPTION PROGRAMS

Prescriptions covered under the prescription drug card and the mail order prescription programs include the following:

A. federal legend drugs not specifically excluded below. A prescription legend drug is any medicinal substance that is required to bear the label, "Caution: Federal law prohibits dispensing without a prescription" or "Rx only";

B. DESI drugs;

C. the following over-the-counter drugs, including all generic and trade alternatives to such drugs, with a Physician's prescription:

   1. Allegra Allergy and Allegra D Allergy and Congestion;
   2. Claritin and Claritin-D;
   3. Zyrtec and Zyrtec-D;
   4. Nasacort Allergy 24;
   5. Flonase Allergy Relief;
   6. Nexium 24, Prilosec OTC, Prevacid-24 and Zegerid OTC;
   7. Zaditor;
   8. Slo-Niacin Oral Tablet Extended Release; and
   9. Abreva;

D. insulin, and needles and syringes for use with insulin. If purchased together, only one (1) Copayment will apply to the insulin and the syringe;

E. needles and syringes for use with other covered injectables;

F. other diabetic supplies, including blood/urine test strips, lancets, swabs, control solutions, lancet devices and blood glucose monitors (other than continuous blood glucose monitors/components. Over-the-counter products are covered with a Physician's prescription;

G. emergency injectables, including Epi-Pens and Glucagon. Other injectable drugs require prior authorization;

H. Praluent, with prior authorization;

I. growth hormones, with prior authorization;

J. immunosuppressants, including oral and injectables;

K. anti-influenza agents, such as Tamiflu and Relenza, limited to two (2) therapies per year;

L. drugs for Alzheimer's therapy;
M. FDA approved contraceptives prescribed for females, including oral, emergency, transdermal, intravaginal, injectable, devices, IUDs, implantable and over-the-counter with a Physician's prescription;
N. migraine agents;
O. FDA approved tobacco cessation products, including over-the-counter with a Physician's prescription, limited to two (2) ninety (90) day supplies, per year;
P. Chemotherapy drugs;
Q. drugs for treatment of acne and other topicals, with prior authorization;
R. COX-2 inhibitors;
S. drugs for treatment of irritable bowel syndrome;
T. drugs for treatment of impotence, limited to six (6) doses per thirty (30) days;
U. drugs for the treatment of Alcoholism or Substance Abuse;
V. legend pre-natal vitamins or pediatric fluoride vitamins;
W. HIV agents;
X. amphetamines/CNS stimulants. Prior authorization is required for Covered Persons age nineteen (19) and older;
Y. immunizations and vaccines; and
Z. other drugs that are part of the Recommended Wellness Services, including over-the-counter with a Physician's prescription:
    1. low dose aspirin products (up to 325 mg);
    2. sodium fluoride products, not including combinations;
    3. folic acid products, not including combinations;
    4. iron suspension, ferrous sulfate; and
    5. Vitamin D supplements.

The following items are excluded from the prescription drug card and mail order prescription programs:

A. compounded drugs, regardless of whether they contain any covered drug;
B. drugs dispensed in excess of any age or other limitation listed above;
C. drugs listed above as requiring prior authorization if such authorization is not obtained;
D. male contraceptives and contraceptives not approved by the FDA;
E. over-the-counter products not specifically listed as covered above;
F. devices not listed above as covered, including, but not limited to, inhaler spacers, Ostomy Supplies and peak flow meters;
G. fertility agents;
H. drugs prescribed for cosmetic uses, including, but not limited to, hair growth stimulants or hair removal products;
I. vitamins not specifically listed above as covered;
J. anti-obesity/appetite suppressant products;
K. shampoos and soaps, even if legend products;
L. progesterone;
M. dental fluoride products not specifically listed above as covered;
N. allergy sera and biologicals; and
O. blood and plasma products.

ARTICLE XI

EXCLUSIONS AND LIMITATIONS

11.1 GENERAL BENEFIT EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Persons and to all benefits provided by this Plan. Any exclusion listed below shall not apply to the extent that coverage for the service or supply is specifically provided under this Plan, or that the exclusion is prohibited under any applicable law. Additional exclusions that apply to the prescription programs are listed in Article X.

A. Charges for services or supplies that are determined by the Plan Administrator, in its discretion, to be not Medically Necessary, except as specifically listed as Covered Expenses under this Plan, or included in the Recommended Wellness Services.

B. Charges to the extent that they exceed the Reasonable and Customary charge for the service or supply in question.

C. Charges for any services or supplies that are determined by the Plan Administrator, in its discretion, to be Experimental or Investigative. This exclusion applies even if the service or supply is the only available treatment for a particular condition.

D. Charges for services or supplies that are not prescribed or performed by or under the direction of a Physician or qualified Professional Provider, or performed by a Provider who is licensed or certified to perform such services.

E. Charges to the extent payment has been made for the services or supplies under a state or federal workers' compensation, employer's liability or occupational disease law, or any similar local governmental program, or that payment for the injury or illness would have been made if the Covered Person had claimed compensation under such laws.

F. Charges related to any illness or injury that occurred while the individual was on active duty as the member of the armed forces of any nation (except as coverage in continued in accordance with USERRA, as described in Section 5.13), or that resulted from any act of war, whether declared or undeclared.

G. Charges for any injury or illness that was due to the Covered Person's voluntary participation in a riot or insurrection.

H. Charges for services or supplies for which benefits are provided under any governmental program, except as this exclusion is prohibited under any applicable law.

I. Charges to the extent they exceed any maximum listed in Section 2.7 or otherwise listed in this Plan.

J. Charges resulting from an injury or illness sustained during the Covered Person's commission of a felony, or any other criminal act, other than a minor traffic violation. Whether the Covered Person's actions constitute a felony or criminal act will be determined at the Plan Administrator's discretion, based on the law of the jurisdiction where the act occurred and on information that is reasonably available to such Plan Administrator at the time the claim is submitted for payment.

K. Charges for services or supplies that were received prior to the date the individual became a Covered Person under this Plan, or after such coverage is terminated.

L. Charges for services or supplies that the Covered Person or the Participant has no legal obligation to pay, or that would not have been made in the absence of this coverage.

M. Charges for services provided by a Close Relative of the Covered Person, or by a regular member of the Covered Person's household.

N. Charges for any Cosmetic Procedure or Reconstructive Procedure or Surgery performed to improve the appearance, or performed for psychological or psychosocial reasons, except as specifically listed as a Covered Expense. Excluded procedures include, but are not limited to:
   1. removal of skintags;
   2. treatment of alopecia;
   3. dermabrasion;
   4. diastasis recti repair;
   5. ear or body piercing;
   6. electrolysis for hirsutism;
   7. excision or treatment of decorative or self-induced tattoos;
   8. salabrasion;
   9. chemosurgery, and other such skin abrasion procedures associated with the removal of scars;
   10. hairplasty;
   11. lipectomy;
   12. otoplasty;
   13. rhytidectomy;
   14. blepharoplasty;
   15. chemical peels;
   16. surgical treatment of acne;
   17. removal of port wine lesions, except when involving the face;
   18. augmentation mammoplasty, except to establish symmetry following a Mastectomy;
   19. removal, repair or replacement of an implant, except when such reconstruction and implant are pursuant to a breast reconstruction following a Mastectomy;
   20. treatment of gynecomastia, except when mandated for breast disease;
   21. echosclerotherapy for treatment of varicose veins;
   22. non-invasive laser treatment of superficial small veins and treatment of spider veins; and
   23. superficial telangiectasias.

O. Charges for any service or treatment in connection with, or required by, a procedure or treatment that is not a Covered Expense under this Plan, including any medical complications (except as specifically listed as covered).

P. Charges for the treatment of temporomandibular joint disorders (TMJ), except as specifically listed as covered under this Plan.

Q. Charges for or related to dental procedures, except as specifically listed as a Covered Expense under this Plan. Excluded items or procedures include, but are not limited to:
   1. removal of natural teeth, except when in is a part of a broader treatment plan related to diseases and injuries of the jaw, head and neck, or fractures and dislocations;
   2. all diagnostic, preventive and primary dental care related to the care of filling of natural teeth, regardless of where or by whom performed, except as specifically listed as covered;
   3. dental appliances, including, but not limited to, dentures and bridges, except for the primary restoration following facial or dental trauma, or when an integral part of a cleft palate repair;

4. dental implants;
5. treatment of diseases of the teeth or gums, including, but not limited to, treatment of dental cavities, except as covered in relation to early childhood caries;
6. periodontics, endodontics and Orthognathic Surgery;
7. orthodontics, except as relates to cleft palate repair;
8. repair, restoration or extraction of non-impacted erupted teeth, except as specifically listed as a Covered Expense; and
9. surgical removal of teeth and procedures performed for the preparation of the mouth for dentures, unless such procedures were for the treatment of an accidental bodily injury.

R. Charges for any of the following treatment of an Autism Spectrum Disorder:
1. diagnostic assessment and treatment of Autism Spectrum Disorders in excess of the limitation listed in Section 2.7, or for a Covered Person age twenty-one (21) and older;
2. treatment of mental retardation, defects, deficiencies and specific delays in development, learning and speech;
3. chelation therapy;
4. therapeutic day treatment and/or summer camp; and
5. any services listed in an individual education plan (IEP).

S. Charges for services or supplies for the treatment of anti-social personality or conduct disorders, or parphilias.

T. Charges for biofeedback or neurofeedback therapy, or for acupuncture.

U. Charges for the procurement of blood or for blood storage (except as specifically listed as covered), or the cost of securing the services of professional blood donors or cord blood collection, preparation or storage.

V. Charges for routine and cosmetic foot care, except as is Medically Necessary in connection with the treatment of diabetics.

W. Charges for sport medicine treatment plans, corrective appliances or artificial aids primarily intended to enhance athletic functions, or for work hardening programs.

X. Charges for Custodial Care, domiciliary care, convalescent care or rest cures, Private Duty Nursing or specialized nursing care, except as specifically listed as a Covered Expense.

Y. Charges for physical psychiatric or psychological examinations, testing, reports or treatments when such services are provided for:
1. the purpose of obtaining, maintaining or otherwise related to career, education, sports or camp, travel, employment, insurance, marriage or adoption;
2. relating to judicial or administrative proceedings or orders;
3. conducted for the purposes of medical research; or
4. to obtain or maintain a license of any type.

This exclusion will not apply to the extent that the service is included in, or related to, the Recommended Wellness Services or is otherwise specifically listed as a Covered Expense under this Plan.

Z. Charges for the purchase of organs or tissue that are sold, rather than donated, to a transplant recipient.

AA. Charges for Long Term Residential Care for Alcoholism or Substance Abuse.

AB. Charges for Outpatient Cognitive Rehabilitation Therapy that has been determined by the Plan Administrator, in its discretion, to not be Medically Necessary and appropriate for the treatment of a brain injury.

AC. Charges for Pulmonary Rehabilitation services performed on an Inpatient basis.

AD. Charges for the reversal of a voluntary sterilization, or the sterilization of a male Dependent child.

AE. Charges for transsexual Surgery and treatment and services in support of transsexual Surgery.

AF. Charges for or related to penile implants.

AG. Charges for elective abortions not specifically listed as a Covered Expense.

AH. Separate charges made by interns, residents and other health care professionals who are directly or indirectly employed by a Hospital or other Facility that makes their services available.

AI. Charges for any of the following vision related services or supplies:

1. corneal Surgery to change the shape of the cornea to correct vision problems not related to an accidental injury, or to correct refractive errors of the eye;
2. routine eye examinations not included in the Recommended Wellness Services or performed by an Out-of-Network Provider;
3. refractions for prescribing eyeglasses and contact lenses; and
4. all services associated with eyeglasses or contact lenses (except as specifically listed as a Covered Expense), including:
    a. visual fields testing;
    b. orthoptics;
    c. syntonics;
    d. optometric therapy;
    e. vision augmentation devices; and
    f. vision enhancement systems.

AJ. Charges that the Plan Administrator, in its discretion, determines are personal hygiene, physical fitness or convenience items, whether or not they are prescribed by a Physician or other Professional Provider, including, but not limited to:

1. bedboards and over-bed tables;
2. exercise equipment;
3. self-help devices, including, but not limited to, lift chairs:
4. allergen filtration systems , air conditioners, saunas, humidifiers and air purifiers; and
5. motor vehicles or any modification to any vehicle for the use of a disabled person.

AK. Charges for telephone calls or telephone consultations, for failure to keep a scheduled appointment, for completion of forms, for the transfer or copying or records or for the generation of correspondence.

AL. Charges related to infertility beyond the initial diagnosis, including, but not limited to:

1. visits;
2. drugs;
3. diagnostic monitoring, such as ultrasound;
4. oral or injectable prescription medication treatment;
5. embryo acquisition, storage and transport;

6. human chorionotropin;
7. urofollitropin, menatropins or derivatives;
8. artificial insemination, including donor ovum and semen and related costs, collection, preparation, preservation or storage;
9. for or in connection with surrogate parenting;
10. the surgical correction of physical defects preventing Pregnancy; and
11. in vitro fertilization or similar procedures, including, but not limited to, gamete Intrafallopian tube transfer (GIFT) or zygote Intrafallopian transfer (ZIFT) procedures.

AM. Charges for any of the following, including replacement of such items:

1. disposable supplies not specifically listed as covered, including, but not limited to, elastic bandages, support stockings or prosthetic socks, except when provided through a Home Health Care Agency as part of a covered home health care plan;
2. the repair or replacement of Durable Medical Equipment, Prosthetic Appliances or Orthotic Devices, except as specifically listed as a Covered Expense;
3. any device or equipment that is no longer Medically Necessary;
4. intra-oral Prostheses;
5. hearing aids and cochlear implants, including related Surgery, prescription, fitting or adjustment;
6. corsets;
7. supportive back braces without metal stays;
8. knee braces made of elastic fabric support or sports braces;
9. comfort, non-therapeutic casts/braces;
10. nose braces;
11. tongue retainers (equalizer, positioned);
12. slings and other non-sterile or over-the-counter supplies;
13. other special appliances, supplies or equipment, including bio-mechanical devices; and
14. modification or customization of any Durable Medical Equipment.

AN. Charges for travel or transportation expenses, even if prescribed by a Physician, except as related to covered ambulance charges.

AO. Charges related to an adult circumcision in the absence of disease.

AP. Charges for educational classes, disease management programs or support groups that are not specifically listed as a Covered Expense under this Plan.

AQ. Charges for Unattended Services, except as related to at-home sleep studies.

AR. Charges for any Pharmacy-based drugs not obtained through the pharmacy program listed in Article X, or for Outpatient prescription or over-the-counter products not specifically listed as a Covered Expense, including, but not limited to, take-home drugs provided in a Physician’s office.

AS. Charges for screening examinations, except as included in the Recommended Wellness Services.

AT. Charges for marital counseling.

AU. Charges for genetic or genomic testing that is not specifically listed as a Covered Expense in connection with an existing illness, or included in the Recommended Wellness Services.

AV. Additional charges that are the result of a Never Event.

AW. Charges related to the Pregnancy of a Dependent child. Complications of a Pregnancy of a Dependent child will only be covered under this Plan if no other coverage is available for such services.

AX. Charges for breast feeding equipment, supplies or counseling received from the non-Preferred Provider, or any Out-of-Network contraceptive services or supplies.

AY. Charges related to weight control or the medical or surgical treatment of obesity, including morbid obesity, except as specifically listed as covered or as included in the Recommended Wellness Services.

AZ. Charges related to any injury or illness that was incurred due to the Covered Person's participation in any activity that has been determined by the Plan Administrator, in its discretion, to be hazardous or to provide an unusual possibility of harm, including:

1. bungee jumping;
2. mountaineering;
3. mountain or rock climbing;
4. hang gliding;
5. yacht racing;
6. motor or motorcycle racing;
7. competing in rodeos;
8. horse racing;
9. other racing of any kind, other than foot;
10. all professional and semi-professional sports;
11. cage fighting;
12. boxing; and
13. other similar voluntary activities that are determined, by the Plan Administrator, in its discretion, to have a high risk of harm.

BA. Charges for any treatment, services or supplies that are not specifically set forth as covered under this Plan.

ARTICLE XII

GENERAL INFORMATION

12.1 COORDINATION OF BENEFITS

Coordination of benefits (COB) is a feature that prevents duplicate payment under this Plan and other health insurance or prepayment plans, including Medicare Part A or Part B or other types of insurance. A Covered Person may have coverage under this Plan, some other health plan of coverage or other kind of insurance policy at the same time. Other health plans of coverage include a group sickness and accident insurance policy or program, a group contract of a health maintenance organization, an individual sickness and accident insurance policy and an individual contract of a health maintenance organization. Other kinds of insurance policies include your automobile insurance policy's medical payments and uninsured motorist's coverage. For example, a person may be covered by an employer's group insurance program and also by the group program provided by a spouse's employer. Or a person may be covered by an employer's group insurance and also have coverage under a parent's group plan.

If a Covered Person files a claim under this Plan for services or supplies that are also covered under another plan or insurance policy, for instance, one of the plans or policies listed in the first paragraph, payments will be "coordinated." This means that this Plan will adjust its benefit payments so that combined payments under this and any other health plan(s) or insurance policy will be no more than the usual, Customary, and Reasonable fee payments.

Once a Covered Person has provided this Plan with information about other health benefits plans and health benefits under other insurance policies under which he or she has coverage, the Plan will handle the coordination. This will be done according to the "Order of Benefit Determination." The Order of Benefit Determination works as follows:

A. The plan that pays first is called the primary plan. Any other plan that covers the Covered Person is called the secondary plan. A group or individual plan or policy that does not contain a COB feature is always primary.

B. A plan that covers a person as the certificate holder or the contract holder is primary. In the two examples given, the coverage the person has through his or her employer would be primary. The coverage through a spouse's or parent's employer would be secondary. The exception to this would be when the laws and regulations governing Medicare require that the plan covering the person as a Dependent pay its benefits as primary to Medicare, but such laws and regulations also provide that the plan covering them as the certificate holder/contract holder should pay its benefits as secondary to Medicare. In such a case, the plan that is required to pay as primary to Medicare shall also pay as primary to the other coverage.

C. If a person is covered as a Dependent child of two working parents, the plan of the parent whose birthday falls earliest in the year has primary responsibility for paying the claim. The plan of the parent with the later birthday becomes the secondary plan. If both parents have the same birthday, the parent whose coverage has been in effect the longest is primary. The ages of the respective parents are not relevant. This method of coordinating benefits is commonly referred to as the "birthday rule." If divorced or separated parents (and/or their current spouses) each have group health care coverage that includes a Dependent, the order of benefit determination will be determined, as follows:

   1. the plan of the custodial parent, if any, shall pay its benefits first;
   2. the plan of the spouse of the custodial parent, if any, will pay next;
   3. the plan of the non-custodial parent, if any, will pay after the prior listed plans; and
   4. the plan of the spouse of the non-custodial parent, if any, shall pay it benefits last.

   However, if a court order establishes responsibility for payment of health care benefits with the parent who does not have custody of the Dependent and the entity that would be

obligated to pay the benefits has actual knowledge of the court order's terms, the plan of such non-custodial parent shall pay its benefits before any of the other plans listed above. If the non-custodial parent named in the court order as responsible for the health care benefits does not have any health coverage, the plan of the non-custodial parent's spouse, if any, shall pay its benefits before any of the other plans listed above.

If the court order specifies that the parents have joint custody, and neither parent is named as the primary residential custodian, or the court order requires both parents to provide health care coverage, the "birthday rule" specified above shall apply.

D. A plan that covers a person as an active employee or as a Dependent of an active employee is primary to a plan that covers a person as an inactive employee, such as a laid-off or retired employee or as a Dependent of a laid-off or retired employee.

E. There are some situations in which none of these rules apply. Here the program that has been in effect longer is primary. An example would be when a person who works two jobs has health coverage through both employers.

F. A plan or policy that covers a specific event may be primary to a plan that provides general coverage. For example, if a person is injured in an automobile accident with an uninsured motorist, his or her automobile policy's uninsured motorist's coverage would be primary to a group health plan if both policies had similar provisions regarding other insurance.

If coverage under this Plan is primary, benefits will be paid as if the Covered Person had no other coverage. But if this coverage is secondary, this Plan's payments will be calculated by subtracting the primary plan's benefits for the services and supplies covered under this Plan from the Reasonable and Customary allowance for the services and supplies. Of course, the Plan will not pay more when secondary than it would if primary. By accepting coverage under this Plan, a Covered Person agrees to do two things to enable the Plan to coordinate benefits. First, the Covered Person will supply the Plan with information about other coverage he or she has when asked. Second, if the Plan makes a payment and later finds out that the coverage under this Plan should not have been primary, the Covered Person will return the excess amount to the Plan. The Plan has the right to obtain information needed to coordinate benefits from others as well, i.e., insurance companies and other persons, for instance.

12.2 THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

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 Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(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 but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her 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 percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one (1) or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(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 Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an

asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

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

If there is more than one (1) 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 Participant(s) is/are only one (1) or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(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 Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(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.

If the Participant(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 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,

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(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 percent (100%) of the benefits paid, 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 Participant(s) is fully compensated by his or her 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 Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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, express written consent of the Plan.

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 Participant(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.

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 Participant(s).

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 sickness, injury, disease or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he/she is required to:

A. notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
B. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
C. in circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and
D. hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available, any Coverage (including but not limited to 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.

The Plan's benefits shall be excess to any of the following:

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 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 Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(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 Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' 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;
B. to provide the Plan with pertinent information regarding the sickness, 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;
F. to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
G. to not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or coverage;
H. to instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;
I. in circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
J. to make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her 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 Participant(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 Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(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 or her 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.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

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

12.3 MEDICARE BENEFITS

This provision prevents duplication of benefits for Covered Expenses when Medical Care benefits are available from Medicare. Benefits under this Plan will be reduced to the extent that the Participant or his or her Dependents are reimbursed or entitled to reimbursement for those expenses by Medicare.

Under the Tax Equity and Fiscal Responsibility Act of 1982, as amended (TEFRA), active employees and/or their spouses who are sixty-five (65) or over may choose to have the Company program as primary coverage, in which case Medicare may pay benefits on a secondary basis. Otherwise, an employee may elect to drop out of the company program and choose Medicare as primary coverage. Employees in this category who are enrolled under this Plan will remain so enrolled with this Plan as primary coverage unless an option form is on file indicating otherwise.

The Plan may also pay its benefits as primary to Medicare's in other situations, as prescribed by applicable laws and regulations.

The Plan intends to comply with the federal Social Security Act, as amended, and other applicable laws, as such apply to Medicare benefits.

12.4 ADDITIONAL RIGHTS OF RECOVERY

If payments are made under the Plan that should not have been made, the Plan may recover that incorrect payment. The Plan may recover this payment from the person to whom it was made or from any other appropriate party. If any such incorrect payment is made to the Participant, the Plan may deduct it when making future payments directly to the Participant. Once the Plan Administrator determines that a previous benefit payment should be reimbursed, in whole or in part, either due to the provisions described in Section 12.2 or because such benefit payment should not have been made in accordance with the provisions of this Plan, the Participant and/or the applicable Provider will be notified of such overpayment, and a request will be made for such Participant/Provider to reimburse the Plan. If the reimbursement is not made as requested, such amount will constitute a lien against future claim payments that would otherwise be paid on the Participant or the Covered Person's behalf. The Plan Administrator retains the right to reduce or withhold such future claim payments until the lien is satisfied.

This Plan will comply with Sections 609(b)(1), (2) and (3) of the Employee Retirement Income Security Act with regard to Covered Persons eligible for Medicaid. An Employee's or Dependent's eligibility for, or participation in, Medicaid will not affect determination of whether or not payments should be made. Under state and federal law, should a Covered Person be entitled to payment of a claim under this Plan, and all or part of that claim has been paid by Medicaid, then the state is subrogated to the Covered Person's right to payment under this Plan to the extent of the amount paid by Medicaid, and reimbursement under this Plan will be made in that amount directly to the state.

12.5 FACILITY OF PAYMENT

Whenever a Covered Person or Provider to whom payments are directed to be made is mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the Plan Administrator nor the Benefit Manager shall be under any obligation to see that a legal representative is appointed or to make payments to such legal representative, if appointed. A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator, Benefit Manager or any fiduciary shall not be liable to any person as a result of a payment made and shall be fully discharged from all future liability with respect to a payment made.

12.6 ADMINISTRATION OF THE PLAN

Except as otherwise specifically provided for in the Plan, the Plan Administrator shall have the exclusive authority to control and manage the operation and administration of the Plan and shall be Named Fiduciary of the Plan for purposes of ERISA. The Plan Administrator shall have all power necessary or convenient to enable it to exercise such authority. In connection therewith, the Plan Administrator may provide rules and regulations, not inconsistent with the provisions thereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Plan Administrator may accept service of legal process for the Plan and shall have the full discretion, power, and the duty to take all action necessary or proper to carry out the duties required under ERISA and all other applicable law.

The Plan Administrator may delegate duties involved in the administration of this Plan to such person or persons whose services are deemed necessary or convenient; provided however, that both the ultimate responsibility for the administration of this Plan and the authority to interpret this Plan shall remain with the Plan Administrator. The Employer shall indemnify any employee to whom duties are delegated by the Plan Administrator pursuant to this section from and against any liability that such employee may incur in the administration of the Plan, except for liabilities arising from the recklessness or willful misconduct of such employee.

The Plan Administrator shall be responsible for controlling and managing the operation and administration of this Plan, including, but not limited to, the power:

A. to employ one (1) or more persons or entities to render advice with respect to any responsibility the Plan Administrator has under this Plan;

B. to construe and interpret this Plan;

C. to adopt such rules, regulations, forms and procedures as from time to time it deems advisable or appropriate in the proper administration of this Plan;

D. to decide all questions of eligibility and to determine the amount, manner and time of payment of any benefits hereunder;

E. to prescribe procedures to be followed by any person in applying for any benefits under this Plan and to designate the forms, documents, evidence or such other information as the Plan Administrator may reasonably deem necessary to support an application for any benefits under this Plan;

F. to authorize, in its discretion, payments of benefits properly payable pursuant to the provisions of this Plan;

G. to prepare and to distribute, in such manner as it deems appropriate, information explaining the Plan;

H. to apply consistently and uniformly to all Covered Persons in similar circumstances its rules, regulations, determinations and decisions;

I. to prepare and file such reports and to complete and to distribute such other documents as may be required to comply fully with the provisions of ERISA and all other applicable laws, and all regulations promulgated thereunder; and

J. to retain counsel (who may, but need not, be counsel to the Company), to employ agents and to provide for such clerical, medical, accounting, auditing and other services as it may require in carrying out the provisions of the Plan.

The Plan Administrator shall be the sole judge of the standards of proof required in any case. In the application and interpretation of this Plan document, the decision of the Plan Administrator shall be final and binding on the Participants, Dependents, and all other persons. The Plan Administrator shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan document and all other written documents. Any such determination and any such construction adopted by the Plan Administrator in good faith shall be binding upon all of the parties hereto and the beneficiaries thereof and may not be reversed by a court of competent jurisdiction unless the court finds the determination to be arbitrary and capricious.

12.7 NON-ALIENATION AND ASSIGNMENT

The Plan shall not be liable for any debt, liability, contract or tort of any employee or Covered Person. The Plan shall pay all benefits due and payable for Covered Expenses directly to the Covered Person who incurred the Covered Expenses, and no Plan benefits shall be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation or any other voluntary or involuntary alienation or other legal or equitable process not transferable by operation of law; provided however, that a Covered Person to whom benefits are otherwise payable may assign benefits to a Hospital, Physician or other service Provider; provided further, that any such assignment of benefits by a Covered Person to a Hospital, Physician or other service Provider shall be binding on the Plan only if:

A. the Plan Administrator or Benefit Manager is notified of such assignment prior to payment of benefits;

B. the assignment is made on a form provided by, or approved by, the Plan Administrator or the Benefit Manager; and

C. the assignment contains such additional terms and conditions as may be required from time to time by the Plan Administrator or Benefit Manager.

12.8 FAILURE TO ENFORCE

Failure to enforce any provision of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at another time, nor will such failure affect the right to enforce any other provision.

12.9 FIDUCIARY RESPONSIBILITIES

No fiduciary of the Plan shall be liable for any acts or omission in carrying out his, her or its responsibilities under the Plan, except as may be provided under ERISA and other applicable laws. Each fiduciary under the Plan shall be responsible only for the specific duties assigned to such fiduciary under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary, except as may be otherwise provided in ERISA and other applicable laws.

12.10 DISCLAIMER OF LIABILITY

The Plan is not responsible for the efficiency or integrity of any health care Provider delivering services or supplies utilized by the Participant. The Plan is not liable in any way for the effect of delivery of such services or supplies, the results of actions taken as a result of such services or supplies being limited or not covered by the Plan, nor any limitations imposed on the cost sharing responsibility of the Plan.

Nothing contained herein shall confer upon a Covered Person any claim, right or cause of action, either at law or at equity, against the Plan, Plan Administrator, Benefit Manager, or any Employer for the acts or omissions of any health care Provider from whom a Covered Person receives care, or for the acts or omission of any Physician from whom the Covered Person receives care under the Plan, or for any acts or omissions of any Provider of services or supplies under this Plan. Neither the Plan, nor the Plan Administrator, nor the Benefit Manager have any responsibility for or control over the actions of any Preferred Provider networks offering services and/or supplies under the Plan.

12.11 ADMINISTRATIVE AND CLERICAL ERRORS

The benefits payable to or on behalf of a Participant or Dependent under this Plan will not be decreased nor increased due to administrative or clerical errors made by the Employer, the Plan Administrator, the Utilization Review Service or the Benefit Manager. If written application for coverage for an eligible employee or Dependent is submitted by the employee/Participant within the applicable time frame specified in Article V, any subsequent administrative or clerical error made by the Employer, the Plan Administrator or the Benefit Manager shall not act to delay the effective date of such person's coverage beyond the date such coverage would otherwise become effective if such application was processed in a timely manner. In addition, any such error made in claims processing, utilization review or other administrative functions shall not affect the benefits payable to or on behalf of a Covered Person under this Plan. The Plan Administrator may require proof of an error described in this provision. The Plan Administrator shall have the sole responsibility to determine when an error is an "administrative or clerical" error and will be the sole judge of any proof required.

12.12 RESCISSION OF COVERAGE

A rescission of coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide an individual with coverage, just as if he or she never had coverage under the Plan. Such coverage can only be rescinded if the individual (or a person seeking coverage on an individual's behalf) perform an act, practice, or omission that constitutes fraud; or unless the individual (or a person seeking coverage on the individual's behalf) make an intentional misrepresentation of material fact, as prohibited by the terms of this Plan. Coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by an employer.

Such individual will be provided with thirty (30) calendar days' advance notice before coverage is rescinded. Such individual has the right to request an internal appeal of a rescission of his or her coverage. Once the internal appeal process is exhausted, such person has the additional right to request an independent external review.

ARTICLE XIII

PRIVACY

13.1 PRIVACY OF HEALTH INFORMATION

This provision is intended to bring this Plan into compliance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder. Health Information transmitted or maintained by the Plan will be subject to the provisions described in this article.

13.2 USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Protected Health Information will only be disclosed or used by the Plan under one (1) of the following conditions:

A. with the specific consent of the individual who is the subject of the Protected Health Information, provided that the Plan obtains any required authorization;

B. for payment of claims submitted to the Plan, or for utilization review activities as described in Article VI, including, but not limited to, the review of any grievances or appeals involved in such activities that are generated by the Covered Person or his or her authorized representatives; or

C. for other reasonable purposes necessary to operate the Plan, to the extent that such Protected Health Information is required for such purposes, including:

   1. quality assessment and improvement activities;
   2. evaluation of Plan performance;
   3. underwriting and premium rating and other activities relating to the procuring, renewal or replacement of stop loss or excess loss insurance;
   4. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
   5. business planning and development of the Plan;
   6. business management and general administrative activities of the Plan, including, but not limited to, enrollments, billing, customer service and the resolution of internal grievances; and
   7. other health care operations listed under 45 C.F.R. § 164.501.

No other use or disclosure of Protected Health Information is permitted by this Plan.

13.3 DISCLOSURES OF HEALTH INFORMATION TO THE COMPANY

The Plan Administrator will disclose, or permit the disclosure of, Health Information to the Company only as described below:

A. for any of the purposes and under the conditions described in Section 13.2;

B. as Summary Health Information, if requested by the Company for the following purposes:

   1. obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
   2. modifying, amending or terminating the Plan; or

C. for informational purposes regarding whether an individual is participating in the Plan, provided such information is only used by the Company for the purpose of performing Plan administrative functions.

Prior to any disclosure of Health Information to the Company, such entity must agree:

A. not to use or further disclose the information other than as permitted or required by this section, or as required by law;

B. that it will ensure that any agents, including subcontractors, employed by the Company or Plan Administrator for Plan administration or other Plan purposes to whom it provides Protected Health Information, including, but not limited to, the Benefit Manager, any Utilization Review Service or pharmacy benefit manager, agree to the same restrictions and conditions that apply to the Company with respect to such information;

C. not to use or disclose the Protected Health Information for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the Company;

D. that it will report to the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for in this section of which it becomes aware;

E. that it will make available Protected Health Information to the subject of such information, and allow amendment to such information as described in Section 13.4 and Section 13.5;

F. that it will provide an accounting in accordance with 45 C.F.R. § 164.528, upon the request of the subject of Protected Health Information, of the disclosure of such information by the Plan made within six (6) years of the request, except information exempted from such accounting under that section;

G. that it will make available its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan to the Secretary of the United States Department of Health and Human Services for the purpose of determining compliance by the Plan with the privacy provisions of HIPAA;

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

I. that it will provide for adequate separation between the Plan and the Plan Sponsor by implementing the following procedures:

   1. access to Protected Health Information will only be provided to the following Company employees:
      a. the President;
      b. the Human Resources/Payroll Manager;
      c. the Compliance Manager; and
      d. the Accounting Manager;
   2. that access to and use by such employees or other persons as described above will be limited to the plan administration functions that the Company performs for the Plan; and
   3. any non-compliance by such named individuals with the privacy provisions of this Plan will be addressed in accordance with the Company's established employee discipline and termination procedures.

13.4 ACCESS OF COVERED PERSONS TO PROTECTED HEALTH INFORMATION

A Covered Person or other individual has the right of access to inspect and obtain a copy of Protected Health Information about such person as long as such information is maintained by the Plan, except for:

A. psychotherapy notes;

B. information compiled in reasonable anticipation, or for use in, a civil, criminal or administrative proceeding or action; or

C. as such information is otherwise exempted from disclosure under 45 C.F.R. § 164.524.

Any such request must be made to the Plan Administrator a writing signed by the Covered Person whose information is being requested. The Plan Administrator will notify the Covered Person, in writing, as to whether such request is approved or denied, and, if approved, will provide access to the information in accordance with 45 C.F.R. § 164.524(c), including the imposition of reasonable fees for the costs of providing such access.

13.5 AMENDMENT RIGHTS

A Covered Person or other individual has the right to have the Company amend Protected Health Information or other information about such individual as long as such information is maintained by the Plan. The Plan Administrator will deny such a request if:

A. the information was not created by the Plan, unless the individual provides a reasonable basis to believe that the originator of the Protected Health Information is no longer available to act on the requested amendment;

B. the information is not currently maintained in any record by the Plan;

C. the information would not be available for inspection under the reasons cited in Section 13.4; or

D. the information in the Plan's records is accurate and complete.

Any request for amendment of Protected Health Information must be provided in writing to the Plan Administrator and signed by the Covered Person or individual who is the subject of the information with an explanation as to why such person believes the information is inaccurate, incomplete or incorrect. The Plan Administrator will notify the Covered Person, in writing, as to whether such request is approved or denied, and, if approved, will make the necessary corrections to the information in accordance with 45 C.F.R. § 164.526(c). The Plan Administrator will make reasonable efforts to inform all entities that it has knowledge of such entity's receipt of any information that has been corrected. If the request is denied, the individual may submit a written statement disagreeing with the denial that includes the basis of such disagreement. The Plan Administrator may prepare a written rebuttal of such statement. The statement of disagreement, and the rebuttal, if any, will be included in any future disclosure of the information. Even if no statement of disagreement is submitted, the individual may request that the request for amendment and denial be included with any future disclosures of the information.

13.6 SECURITY OF PROTECTED HEALTH INFORMATION

The Company will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information (ePHI) that is created, received, maintained or transmitted on behalf of the Plan, including reasonable and appropriate security measures between the Company and the Plan to support the requirements of Section 13.3. The Company will further ensure that any agent, including a subcontractor, to whom it provides access to ePHI agrees to implement reasonable and appropriate security measures to protect the information, and will report any security incident of which it becomes aware to the Plan Administrator.

ARTICLE XIV

STATEMENT OF ERISA RIGHTS

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

A. **Receive Information About Your Plan and Benefits**:

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

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

B. **Continue Group Health Plan Coverage:**

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation rights.

C. **Prudent Actions by Plan Fiduciaries:**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

D. **Enforce Your Rights:**

1. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have 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.

2. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to one hundred ten dollars ($110.00) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit, once the other appeal rights listed in this Plan are exhausted, in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan Fiduciaries

misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

E. **Assistance with Your Questions:**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Outreach, Education, and Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.