PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

EMPLOYEE HEALTH BENEFIT PLAN OF MECHANICAL DEVICES COMPANY

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INTRODUCTION

This document is a description of the Employee Health Benefit Plan of Mechanical Devices Company (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against income loss during certain periods of disability and provide coverage for certain health expenses as described herein.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

Mechanical Devices Company (the Employer) fully intends to maintain this Plan indefinitely. However, the Employer reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

This document describes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges which are covered.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered by the Plan.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's right to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases; and explains the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

ELIGIBILITY, FUNDING. EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Employees.

All Active Employees of the Employer.

Eligibility Requirements for Employee Coverage.

A person is eligible for Employee coverage from the first day that he or she:

(1) is a Full-Time, Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 37 hours per week and is on the regular payroll of the Employer for that work; and

(2) is in a class eligible for coverage; and

(3) completes the Waiting Period, which is the time period from the first day of the month (not the first day of the Employee's employment) following sixty (60) consecutive days as an Employee. An Employee's coverage under the Plan begins on the first day following an Employee's satisfaction of the Waiting Period.

Eligible Classes of Dependents.

A Dependent is any one of the following persons:

(1) A covered Employee’s Spouse and children from birth to the limiting age of 26 years.

The term “Spouse” shall mean the person recognized as the covered Employee’s spouse under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children living in the same household as the Employee, adopted children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee’s household may also be included.

The phrase “child placed with a covered Employee in anticipation of adoption” refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term, “placed” means the assumption and retention by such Employee of a legal obligation for total or partial

support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a covered Employee who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

(2) A covered Dependent child who is Totally Disabled incapable of self-sustaining employment by reason of mental retardation or physical handicap, primarily dependent upon the covered Employee for support and maintenance, unmarried and covered under the Plan when reaching the limiting age. The Plan Administrator may require at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

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

If both parents are Employees, their children will be covered as Dependents of one of the parents, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

Qualified Medical Child Support Order. The Plan shall comply with the terms of a Qualified Medical Child Support Order ("QMCSO"), directing the Plan to provide benefits to one or more alternate recipients, pursuant to the procedure set forth below:

(1) An order which purports to be a QMCSO must be served on the Claims Administrator.

(2) The Claims Administrator shall, within 20 days of its receipt of the order, make a preliminary determination as to whether or not the order satisfies the requirements to be a QMCSO. In order to satisfy those requirements, an order must contain at least the following information:

(a) a clause which creates or recognizes the existence of a dependent's right to receive benefits under the Plan;

(b) the name and last known mailing address of the covered Employee with respect to whom the order is issued and each dependent covered by the order;

(c) a reasonable description of the type of coverage to be provided by the Plan to each dependent;

(d) the time period to which the order applies; and

(e) the order does not require the Plan to provide any type or form of benefit not otherwise provided under the Plan.

(3) An order which, in the judgment of the Claims Administrator, does not meet the requirements of a QMCSO shall be returned to legal counsel who prepared the order for revision. Revised orders which are resubmitted shall be considered new orders and shall be reviewed in accordance with the procedures set forth in this Section.

(4) When the Claims Administrator makes a preliminary determination that an order satisfies the requirements of a QMCSO, it shall forward the order to the Employer for review. The Employer shall make the final determination of the status of the order.

(5) The Claims Administrator shall notify all parties involved, including a designated representative of the Dependent, of the Employer's decision and of the respective parties' entitlement to benefits.

Reimbursement of benefit payments under the Plan pursuant to a QMCSO may be made to the Dependent or the Dependent's custodial parent.

FUNDING

Cost of the Plan.

Mechanical Devices Company pays the entire cost of Employee coverage under this Plan.

The covered Employees pay the entire cost for coverage for their Dependents.

Employees must sign a payroll deduction order at the time of enrollment.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions at any time.

Plan assets are held in trust in the Mechanical Devices Company Employee Benefits Trust.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application. If Dependent coverage is desired, the covered Employee is required to enroll for Dependent coverage at this time. Even if the covered Employee already has Dependent coverage, enrollment of the newborn child is required.

Enrollment Requirements for Newborn Children.

Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section “Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

For coverage of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, if the newborn child is required to be enrolled, he or she must be enrolled as a Dependent under this Plan within 31 days of the child’s birth in order for coverage to take effect from the birth.

If the child is required to be enrolled and is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

Timely Enrollment - The enrollment will be “timely” if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two parents are covered under the Plan as Employees and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

SPECIAL ENROLLMENT PERIODS

The enrollment date for anyone who enrolls under a Special Enrollment Period is the date of the special enrollment eligibility event described below. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Individuals losing other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

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

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

(c) The coverage of the Employee or Dependent who had lost the coverage

(i) was under COBRA and the COBRA coverage was exhausted, or

(ii) was not under COBRA and the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment); or employer contributions towards the coverage were terminated; or

(iii) when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual); or

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

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions described above.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause

(such as making a fraudulent claim), that individual does not have a Special Enrollment right.

(2) **Dependent beneficiaries.** If:

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

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) **Medicaid and State Child Health Insurance Programs**. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

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

(b) the Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or SCHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests

enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

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

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Enrollment Requirements of the Plan.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under the Plan stops, Plan Participants will receive a certificate of Creditable Coverage that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of the following dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option):

(1) The date the Plan is terminated.

(2) The last day of employment in which the covered Employee ceases to be in a class of Employees eligible for coverage. This includes death or termination of employment of the covered Employee. (See the COBRA Continuation Option.)

(3) The date of the covered Employee's death.

Continuation During Family and Medical Leave. In accordance with the Family and Medical Leave Act of 1993 ("FMLA"), continuation coverage under the Plan is available to covered Employees and their covered Dependents under certain specified conditions.

A covered Employee who takes a leave of absence under applicable provisions of FMLA is entitled to continued coverage under the Plan for himself and his covered Dependents. Benefits under the Plan are available to the same extent as if the covered Employee had been actively at work during the entire leave period, subject to the following terms and conditions:

(a) Coverage shall cease for a covered Employee (and his covered Dependents) for the duration of the leave if at any time the covered Employee is more than 30 days late in paying any required contribution.

(b) A covered Employee who declines coverage during the leave or whose coverage is terminated as a result of his failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same terms as prior to taking the leave, without any qualifying period, physical examination, or exclusion of pre-existing conditions.

(c) If a covered Employee who is a Key Employee does not return from leave when notified by the Employer that substantial or grievous economic injury will result from his reinstatement, the Key Employee's entitlement to Plan benefits continues unless and until the covered Employee advises the Employer that he does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.

(d) Any portion of the cost of coverage which had been paid by the covered Employee prior to the leave, must continue to be paid by the covered Employee during the leave. If the cost is raised or lowered during the leave, the covered Employee shall pay the new rates. If the leave is unpaid, the covered Employee and the Employer shall negotiate a reasonable means for paying the covered Employee's portion of the cost.

(e) If the Employer provides a new health plan or benefits or changes the health benefits or Plan while the covered Employee is on leave, the covered Employee is entitled to the new or changed plan and benefits to the same extent as if the covered Employee were not on leave.

(f) The Employer may recover its share of the cost of benefits paid during a period of unpaid leave if the covered Employee fails to return to work after the covered Employee's leave entitlement has been exhausted or expires, unless the reason the covered Employee does not return to work is due to (i) the continuation, recurrence, or onset of a serious

health condition which would entitle the covered Employee to additional leave under the FMLA; or (ii) other circumstances beyond the covered Employee's control. If a covered Employee fails to return to work because of the continuation, recurrence, or onset of a serious health condition, thereby precluding the Employer from recovering its share of the cost of benefits paid on the covered Employee's behalf during a period of unpaid leave, the Employer may require medical certification of the covered Employee's or the Covered Dependent's serious health condition. The covered Employee is required to provide medical certification within 30 days from the date of the Employer's request. If the Employer requests medical certification and the covered Employee does not provide such certification in a timely manner, the Employer may recover the costs of benefits paid during the period of unpaid leave.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of an Employee returning to work directly from COBRA coverage. This Employee does not have to satisfy the employment Waiting Period provision.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's military leave begins; or

(b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 100% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of the following dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)

(3) The date the covered Spouse loses coverage due to loss of dependency status including divorce and legal separation. (See the COBRA Continuation Option.)

(4) On the first date that the Dependent child ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Option.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) The date of the Dependent's death.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Note: The maximums listed below are the total for Preferred Provider and Non-Preferred Provider expenses. For example, if a maximum of 100 visits is listed twice under a service, the calendar year maximum is 100 visits total, which may be split between Preferred Provider and Non-Preferred Providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Person	$1000	$1500
Per Family Unit	$1750	$3000
The calendar year deductible is waived for the following: - Supplemental accident The Preferred Provider and Non-Preferred Provider deductibles are calculated on an individual basis.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Person (excluding deductible)	$2000	$3000
Per Family Unit (excluding deductible)	$3500	$6000
The Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year for Preferred Providers and 70% (instead of 50%) for Non-Preferred Providers. There is no out-of-pocket limit for the following: - Utilization Review Penalty - Plan Exclusions The Preferred Provider and Non-Preferred Provider out-of-pocket maximums are calculated on an individual basis.		
COVERED SERVICES		
Routine Preventative Care **(office visit, pap smear, prostrate screening, and mammogram)**	80%/20% over age 40 1 per calendar year maximum	50%/50% over age 40 1 per calendar year maximum
Hospital Services		
Room and Board	80%/20%	50%/50%
Intensive Care Unit	80%/20%	50%/50%
Other Inpatient	80%/20%	50%/50%
Outpatient Surgery & Diagnostic	80%/20%	50%/50%
Outpatient Pre-Admission Testing	80%/20%	50%/50%
Outpatient Urgent Care Room	80%/20%	50%/50%
Outpatient Emergency Room[1]	80%/20%	80%/20%
Inpatient Rehabilitation Facility	80%/20%	50%/50%

[1] When Supplemental Accident benefit does not apply.

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Skilled Nursing Facility	Not Covered	Not Covered
Physician Services		
Inpatient visits	80%/20%	50%/50%
Office visits, labs and x-rays	80%/20%	50%/50%
Surgery	80%/20%	50%/50%
Second Surgical Opinions	80%/20%	50%/50%
Home Health Care	80%/20% 120 visits per calendar year maximum	50%/50% 120 visits per calendar year maximum
Private Duty Nursing ($5000 calendar year max)	80%/20%	50%/50%
Supplemental Accident	100% $500 per accident maximum within 90 days	100% $500 per accident maximum within 90 days
Hospice Care	80%/20% bereavement counseling Lifetime max 6 visits	50%/50% bereavement counseling Lifetime max 6 visits
Ambulance Service	80%/20%	50%/50%
Occupational Therapy	80%/20%	50%/50%
Speech Therapy	80%/20%	50%/50%
Physical Therapy	80%/20%	50%/50%
Respiratory Therapy	80%/20%	50%/50%
Durable Medical Equipment[2]	80%/20%	50%/50%
Prosthetics	80%/20%	50%/50%
Orthotics	80%/20%	50%/50%
Medical Supplies[2]	80%/20%	50%/50%
Maternity	Same as other illness	
Routine Well Newborn Care	80%/20%	50%/50%
Birthing Center	80%/20%	50%/50%
Voluntary Sterilizations	80%/20%	50%/50%
Substance Abuse	**NON COVERED**	
Mental Illness	Same as other illness	
Chiropractic Treatment/Spinal Manipulation	80%/20% 10 visits per calendar year	50%/50% 10 visits per calendar year
TMJ and Selected Jaw Joint Treatment	Non Covered	
Organ Transplants	80%/20%	50%/50%
All Other Covered Services	80%/20%	50%/50%
Prescriptions	80%/20%	
Short Term Disability Benefits Payable	60% of covered weekly earnings to a maximum of $250 For Injury……First day of Total Disability For Sickness……Eighth day of Total Disability Maximum period payable….. 13 week	

[2] Notwithstanding anything in the Plan to the contrary, durable medical equipment and supplies obtained from a Group Plan Solutions Benefit Administration prior authorized durable medical equipment and supplies provider shall be paid at 100% without application of the deductible. No benefits will be paid for services/supplies from APRIA Health Care.

Life Insurance Benefits	
Class	Life
All Fulltime Current Employees	$20,000
Dependent – Spouse	$ 2,500
Dependent - Child (14 days to 6 months)	$ 100
Dependents - Child (6 months to 19 years)	$ 1,000
Dependents - Child (Fulltime Student Status up to age 24)	$ 1,000
Dental Benefits	Please refer to the Dental Manual

Utilization Review

The Utilization Review Administrator must be notified (i) prior to an elective admission to the Hospital, (ii) within forty-eight (48) hours after admission for Emergency Treatment or obstetric care, or (iii) prior to obtaining certain outpatient treatment. Failure to do so will result in a penalty in the form of a reduction in benefits otherwise computed. The reduction shall be the lesser of (i) actual benefits available under the Plan, or (ii) $250.

Precertification (by calling 888-641-5304).
Precertification is required for inpatient hospital stay and the following outpatient elective surgery:

- Blepharoplasty
- Mammoplasty
- Mandibular reconstruction, osteotomy/jaw surgery
- Maxillary osteotomy, orthognathic jaw surgery
- PET Scans
- Rhinoplasty
- Septoplasty
- Uvulapalatopharyngoplasty /Uvulectomy (UPPP)
- Uvulopalatoplasty, laser assisted /LAUP
- Varicose vein surgery
- Excision of benign skin lesion greater than $500
- Tonsillectomy for adults 18 or over

Prior Authorization – Predetermination – (by calling 888-301-0747).
Prior Authorization is required for

- Transplants
- Skilled nursing
- Home health
- Injectable medications
- Home infusion services
- Home IV/intravenous therapy
- Hospice care
- Pulmonary rehabilitation
- Durable medical equipment
- Orthotics
- Prosthetics

Grandfathered Plan

The Plan Administrator believes the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the contact information listed in the General Plan Information Section. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Maternity Coverage

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

WHCRA Notice

Federal law requires this Plan to provide the following benefits for elective breast reconstruction in connection with a mastectomy:

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

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

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

in a manner determined in consultation with the attending Physician and the patient.

Such coverage is subject to all other Plan terms and limitations.

General Notice

It is the covered Employee's or covered Dependent's responsibility to notify the Employer or Plan Administrator within 15 days of any event which would cause such person or a family member to (i) gain or lose eligibility for coverage under the Plan, (ii) become eligible for or entitled to any Plan benefit, or (iii) lose eligibility for or entitlement to any Plan benefit; unless the Plan elsewhere specifically provides for a longer notice provision. The foregoing includes, but is not limited to, the following:

(1) Notifying the Plan Administrator of an address change within fifteen (15) days of such change; and

(2) Notifying the Plan Administrator of a name change within fifteen (15) days of such change.

This Schedule is a summary of Plan benefits. Please read the remainder of this booklet carefully for a detailed explanation of Plan benefits and limitations.

MEDICAL BENEFITS

Medical Benefits apply when covered charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

PREFERRED PROVIDER

This is a PPO Plan which contains a Network Provider Organization.

PPO Name:	PHCS
Address:	Group Plan Solutions Benefit Administration 2505 Court Street, Pekin, IL 61558
Telephone:	1-800-869-2189
Website:	www.phcs.com

This Plan has entered into an agreement with certain Hospitals, and other health care providers, which are called Preferred Providers or Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Plan Participant uses a preferred provider listed above for Preferred Provider or Network Provider services, the Covered Person will be subject to deductible and an 80% benefit level after discount. For Non-Preferred or Non-Network Provider services rendered outside the Preferred Provider or Network Provider list above, the deducible will apply and a 50% benefit level will apply and once the Non-Preferred Provider out-of-pocket maximum amount is reached then all further non-network covered services will be payable at a 70% benefit level.

The penalty does not apply to services obtained at a Non-Preferred Provider which are not available at a Preferred Provider, services provided for Emergency Treatment, or services approved in advance by the Utilization Review Administrator. The Utilization Review Administrator shall only approve the use of a Non-Preferred Provider where, in the reasonable judgment of the Utilization Review Administrator, the use of the Non-Preferred Provider will increase to a fair degree the likelihood of a successful medical outcome or the distance to the nearest Preferred Provider providing the service is determined to be a hardship. In addition, covered services obtained from a Non-Preferred Provider pathologist, anesthesiologist, radiologist, or emergency room Physician (other Physicians providing one source services to Preferred Provider Hospital/Facility are also included) shall be considered to be provided by a Preferred Provider if the services are rendered as part of treatment rendered at a Preferred Provider Hospital. In addition, covered services obtained from a Non-Preferred Provider Physician shall be considered to be provided by a Preferred Provider Physician if the Non-Preferred Provider Physician specializes in an area or specialty in which one or less Preferred Provider Physicians practice.

DEDUCTIBLE

Deductible Amount. This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Deductible Three Month Carryover. Carryover is only applicable for a Plan Participant with covered expenses incurred and applied toward the deductible after October 1st. If any covered expenses have been incurred and applied to deductible prior to October 1st, the carryover does not apply.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the covered charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Preferred Provider Covered Charges incurred by a Covered Person will be payable at 100% for the rest of the Calendar Year. Non-Preferred Provider Covered Charges will be payable at 70% for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Preferred Provider Covered Charges for that Family Unit will be payable at 100% for the rest of the Calendar Year. Non-Preferred Provider Covered Charges will be payable at 70% for the rest of the Calendar Year.

COVERED CHARGES

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(a) **Hospital Care.** The medical services and supplies furnished by a Hospital, Ambulatory Surgical Center, or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

(b) **Coverage of Pregnancy.** The Usual and Reasonable Charges incurred by a Covered Person, Covered Person's spouse, or Dependant daughter for the care and treatment of Pregnancy are covered the same as any other Sickness.

(c) **Physician Care.** The professional services of a Physician for surgical or medical services.

(1) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

(i) If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(ii) If multiple unrelated surgical procedures are performed by 2 or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If 2 or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 25% of the surgeon's Usual and Reasonable allowance.

(d) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included as follows:

(1) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(2) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

(e) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case maybe, or 4 hours of home health aide services.

(f) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than 6 months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent children). Bereavement services must be furnished within 6 months after the patient's death.

(g) **Other Medical Services and Supplies**. These services and supplies not otherwise included in the items above are covered as follows:

(1) Local Medically Necessary professional land **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(2) **Acupuncture**; services and supplies.

(3) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(4) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; (d) in a Hospital as

defined by this Plan; and (e) coverage for Phase I and Phase II only.

(5) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(6) Initial **contact lenses** or glasses required following cataract surgery.

(7) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. No benefits will be paid for services/ supplies obtained from Apria Health Care.

(8) **Laboratory studies.**

(9) Treatment of **Mental Disorders**. Care, supplies and treatment of Mental Disorders. Psychiatrists, psychologists, counselors, or any other licensed mental health practitioners may bill the Plan directly.

(10) Injury to or care of **mouth, teeth and gums**. Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(11) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(12) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue. Usual and Reasonable Charges incurred for the following named human organ transplants: kidney, cornea, skin, bone marrow, heart, lung, heart/lung, kidney/pancreas, and liver transplants same donor.

If the organ or tissue donor is a Covered Person and the recipient is not, then, the Plan will cover donor organ or tissue charges for the organ or tissue.

No transportation charges will be considered. The Plan will always pay secondary to any other coverage.

(13) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function.

(14) **Prescription** Drugs (as defined).

(15) Routine **Preventive Care**. Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

(16) The initial purchase, fitting, repair and replacement of fitted **prosthetic devices** which replace body parts.

(17) **Reconstructive Surgery**. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered covered charges.

(18) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex

(other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

(19) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.

(20) **Surgical dressings**, splints, casts and other devices used in the reduction or fractures and dislocations.

(21) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to Usual and Reasonable Charges for nursery care for the first 4 days after birth while the newborn child is Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for routine pediatric care for the first 4 days after birth while the newborn child is Hospital confined.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

(22) **Diagnostic x-rays**.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will generally be Capitalized.

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

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Covered Dependent means an eligible Dependent for whom coverage under the Plan has become effective and has not terminated.

Covered Person is a current or former Employee or Dependent who is covered under this Plan.

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

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

Employee means a person who is a current Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship. Employee may also mean a person who has retired from the Employer and is age 65 or older and has worked for the Employer on a permanent full-time basis for at least 12 years.

Employer means Mechanical Devices Company.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/ nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase Ill clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis: or

(4) if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that

identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. The definition also includes information derived from an individual's genetic tests; the genetic tests of the individual's family members (first-through fourth-degree relative); and the manifestation of a condition in the individual's family members. Genetic information also includes the individual's request for, receipt of, or participated in, clinical research for genetic services (tests, counseling and education) and PKU, BRCA1 and BRCA2 tests.

With respect to a pregnant woman (or her family members), genetic information specifically includes information about the fetus she is carrying or any embryo legally held by the individual or a family member.

Genetic information does not include information about an individual's sex or age, a manifested condition that could reasonably be diagnosed by a medical professional, or analysis of proteins or metabolites directly related to a manifested condition.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient’s attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies: and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within 6 months.

Hospital means an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall also include a facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means. **Injury** shall **not** include any condition caused by an intentional act of any Covered Person seeking coverage under the Plan.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit.' It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Key Employee means a salaried Employee eligible for leave under the Family and Medical Leave Act of 1993 who is among the highest paid 10% of all the Employees employed by the Employer within 75 miles of the Employee's worksite.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 3l-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Separation means the living apart of Spouses, in which support and maintenance are detailed in a document issued by the court.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patients condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for

the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met: merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Physician means a Doctor of Medicine (M.D.). Doctor of Osteopathy (D.O). Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, Physician Assistant and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Mechanical Devices Company Employee Health Benefit Plan, which is a benefits plan for certain employees of Mechanical Devices Company and is described in this document.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on the effective date of the Plan.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: “Caution: federal law prohibits dispensing without prescription”; injectable insulin hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Retired Employee is a former current Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization management plan.

(6) It is not, other-than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Total Disability (Totally Disabled) means: In the case of a current Employee, the complete inability to perform any and every duty of his or her occupation or of a similar

occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. Total Disability will be determined by the Employer.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is lesser than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

In addition to any limitations or exclusions stated elsewhere in the Plan, no Medical Benefits are available for:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.

(2) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness to the Covered Person which occurred as a result of the Covered Person's illegal consumption or use of alcohol. Notwithstanding the foregoing exclusion, the Plan will cover expenses for injured Covered Persons other than the Covered Person who illegally consumed or used alcohol. This exclusion does not apply if the Injury or Sickness to the Covered Person resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(3) **Complications or non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan, except complications from an abortion for a covered Employee or Spouse are covered.

(4) **Contraceptives.** Contraceptive devices or medications.

(5) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(6) **Educational or vocational testing.** Services for educational or vocational testing or training.

(7) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(8) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(9) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(10) **Eye care.** Radial keratotomy or other eye surgery to correct near or far-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(11) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(12) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(13) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(14) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting.

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

(16) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance, or as a consequence of a Covered Person's illegal consumption or use of alcohol. Expenses will be covered for injured Covered Person's other than the Covered Person who committed any Illegal acts. This exclusion does not apply if the Injury or Sickness of the Covered Person resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(17) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Persons voluntary use or ingestion of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician or used in a manner other than as prescribed (collectively "drugs"). This exclusion applies regardless of the level of impairment of the Covered Person caused by the Covered Person's use of drugs. Expenses will be covered for Injured Covered Persons other than the person's Illegal use of drugs. This exclusion does not apply if the Injury or Sickness to the Covered Person resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(18) **Infertility.** Care and treatment for infertility, artificial insemination or in vitro fertilization.

(19) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence unless Medically Necessary.

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

(21) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(22) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(23) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(24) **Not specified as covered.** Services, treatments and supplies which are not specified as covered under this Plan.

(25) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness.

(26) **Occupational.** Care and treatment of an Injury or Sickness that is occupational — that is, arises out of and occurs in the course of work for wage or profit including self-employment.

(27) **Orthotics.** Charges in connection with foot orthotics.

(28) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non hospital adjustable beds.

(29) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(30) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(31) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(32) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered herein.

(33) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury, while sane or insane (to the extent allowed by the Health Insurance Portability and Accountability Act of 1996).

(34) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.

(35) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(36) **Skilled Nursing Facility.** Charges for care, treatment, services or supplies in a Skilled Nursing Facility.

(37) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(38) **Smoking cessation.** Care and treatment for smoking cessation programs unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.

(39) **Substance Abuse.** Care and treatment for substance abuse.

(40) **Surgical sterilization.** Care and treatment for surgical sterilization reversal.

(41) **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome, with intraoral prosthetic devices, or any other procedure to alter vertical dimension.

(42) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

(43) **War.** Any loss that is due to a declared or undeclared act of war.

(44) Developmental delays, learning disorders.

(45) Services or supplies rendered by Apria Health Care.

SHORT TERM DISABILITY BENEFITS

This benefit applies when an Employee has a Total Disability that meets all of the following:

(1) Total Disability starts while the Employee is covered by the Plan as an active Employee.

(2) Total Disability is being continuously treated by a Physician.

(3) Total Disability is due to an Injury or Sickness that, in either case, is nonoccupational — that is, does not arise out of or occur in the course of work for wage or profit including self-employment.

(4) Total Disability (Totally Disabled) means the complete inability to perform any and every duty of the Employee's occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness.

The Employer shall reserve the option of requesting periodic physical examinations from either the current Physician on the case or a Physician of the Employer’s choice. Failure to provide requested Physicians’ statements will result in termination of benefits. Employees are responsible for providing the following information in a clearly understandable format:

- History regarding when symptoms first appeared or accident happened;
- Diagnosis;
- Dates of treatment;
- Nature of treatment:
- Progress;
- Prognosis:
- Suitability for rehabilitation;
- Physicians signature and tax I.D. number.

Additional information may be required based upon the individual Illness or Injury.

BENEFIT PAYMENT

Benefits will be paid for a Total Disability up to a Weekly Benefit Limit as described in the Schedule of Benefits.

Benefits are payable as described in the Schedule of Benefits.

PERIOD OF TOTAL DISABILITY

Period of Total Disability is the period of time that an Employee is Totally Disabled. New periods due to the same or related causes must be separated by return to active work for at least three weeks in a row. New periods due to different causes must be separated by return to active work for at least one day.

COVERED WEEKLY EARNINGS

Covered weekly earnings are the Employee's rate of weekly earnings from the Employer in effect at the start of the Total Disability.

Covered Weekly Earnings does **not** include these payments made by the Employer to the Employee for any of the following:

Overtime pay.

Commissions.

Income from an employer that is not Mechanical Devices Company.

Bonuses.

CLAIM PROVISIONS

Annual Information Statement.

An annual information statement must be completed each year by the covered Employee and properly signed as required by the Employer. The completed form must be submitted to the Claims Administrator. The procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of benefits under the Plan.

Benefit Claims.

(1) Discretion of Plan Administrator

All claims must be must be filed with the Claims Administrator or other appropriate entity as directed by the Plan Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with the applicable law. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan is delegated to the Claims Administrator or other appropriate entity as directed by the Plan Administrator, provided, however, that the Claims Administrator or other appropriate entity, is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

(2) When Claims Must Be Filed

Claims must be filed with the Claims Administrator within 365 days of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date will be denied.**

A Pre-Service Claim is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator in accordance with the Plan's procedures. However, a Post-Service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92 or other approved standardized method:

(a) The date of service;

(b) The name, address, telephone number and tax identification number of the provider of the services or supplies;

(c) The place where the services were rendered;

(d) The diagnosis and procedure codes;

(e) The amount of charges;

(f) The name of the Covered Person; and

(g) The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being denied or reduced.**

(3) Timing of Claim Decisions

The Claims Administrator or Plan Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-Service Claims, of decisions that a claim is payable in full) within the following timeframes:

(a) Pre-Service Claims

(i) If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.

(ii) If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Claims Administrator or Plan Administrator and the claimant (if additional information was requested during the extension period).

(b) Post-Service Claims

(i) If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.

(ii) If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Claims Administrator or Plan Administrator and the claimant.

(c) Extensions – Pre-Service Claims

This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(d) Extensions – Post-Service Claims

This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(e) Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

(4) Notification of an Adverse Benefit Determination

The Claims Administrator or Plan Administrator shall provide a claimant with a notice, either in writing or electronically containing the following information:

(a) A reference to the specific portion(s) of the Plan upon which a denial is based;

(b) Specific reason(s) for a denial;

(c) A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;

(e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

(f) The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

(g) Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request); and

(h) In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or experimental treatment), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request.

Appeals of Adverse Benefit Determinations.

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

(1) Claimants at least one 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination;

(2) Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(3) For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(4) For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

(5) That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

(6) For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

(7) That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits in possession of the Plan Administrator or the Claims Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances.

First Appeal Level.

(1) Requirements for First Appeal

The claimant must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the claimant's appeal must be addressed as follows and mailed or faxed to the Claims Administrator.

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

(a) The name of the Employee/claimant;

(b) The Employee/claimant's social security number;

(c) The group name or identification number;

(d) All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal**;

(e) A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

(f) Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

(2) Timing of Notification of Benefit Determination on First Appeal

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

(a) For Pre-Service Claims, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

(b) For Post-Service Claims, within a reasonable period of time, but not later than 30 days after receipt of the appeal.

c) The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

(3) Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Plan Administrator shall provide a claimant with notification in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

(a) The specific reason or reasons for the denial;

(b) Reference to the specific portion(s) of the Plan on which the denial is based;

(c) The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;

(d) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(f) If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;

(g) A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;

(h) A description of the Plan's review procedures and the time limits applicable to the procedures;

(i) A statement of the claimant's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and

(j) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

(4) Furnishing Documents in the Event of an Adverse Determination.

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in subsections (c) through (f) of this section (3) relating to "Manner and

Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

Second Appeal Level.

(1) Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the claimant has 60 days to file a second appeal of the denial of benefits. The claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

(2) Timing of Notification of Benefit Determination on Second Appeal

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

(a) For Pre-Service Claims within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

(b) For Post-Service Claims within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

(c) The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

(3) Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed; and (ii) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

(4) Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in subsections (c) through (f) of the section relating to

"Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

(5) Decision on Second Appeal to be Final

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one (1) year after the Plan's claim review procedures have been exhausted.**

Appointment of Authorized Representative. A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.

Facility of Payment. If a Covered Person dies while benefits provided for Hospital, nursing, medical or surgical services remain unpaid, the Claims Administrator may, at its option, make direct payments to the individual or institution on whose charges claim is based or to the surviving Spouse of the Covered Person, or if none, to his surviving child or children (including legally adopted child or children) share and share alike, or if none, to the executors or administrators of the Covered Person's estate.

Minor or Incompetency. If a Covered Person is a minor or, in the opinion of the Claims Administrator, not competent to give a valid receipt for payment of any benefit due him under the Plan and if no request for payment has been received by the Claims Administrator from a duly appointed guardian or other legally appointed representative of that person, the Claims Administrator may, at its option, make direct payment to the individual or institution appearing to the Claims Administrator to have assumed the custody or the principal support of that person.

Discharge. Any payment by the Claims Administrator in accordance with these provisions will discharge the Employer, Trust, Plan, and the Claims Administrator from all further liability to the extent of the payment made.

Time Limitations. If any time limitations provided in the Plan for giving notice of claims, furnishing proof of loss, or for bringing any action at law or in equity is less than that permitted by the applicable law, then the time limitation provided in the Plan is hereby extended to agree with the minimum permitted by the applicable law.

Claims Mistakenly Paid. The Claims Administrator shall have the right to recover any payment of claims which have been mistakenly paid on behalf of a claimant. This includes the right to recover benefits paid on the basis of claims filed which were fraudulently or intentionally misstated by the claimant. The claimant will be notified in writing and given an opportunity for review in accordance with the claims procedures herein. A payment by the Claims Administrator in accordance with the Plan is not an admission by the Employer or Claims Administrator that the Expenses Incurred with respect to which a claim for benefits is filed are eligible for benefits under this Plan.

ADMINISTRATION

Assignment. Benefits under this Plan may be assigned to a provider upon written authorization of the Covered Person.

Withholding of Benefit Payments. In the event any question or dispute shall arise as to the proper person or persons to whom any payments shall be made hereunder, the Employer may direct the Claims Administrator to withhold such payment until there shall have been made an adjudication of such question or dispute which in the Employer's sole judgment is satisfactory to it, or until the Employer and Claims Administrator shall have been fully protected against loss by means of such indemnification agreement or bond as it determines to be adequate.

Medical Examination. The Claims Administrator shall have the right, through a Physician of its choice, to examine a Covered Person as often as may be reasonable during the pendency of a claim hereunder, and the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

The Claims Administrator shall be entitled to receive any and all reports regarding such examinations or autopsies.

Right to Receive and Release Information. The Claims Administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the Plan Administrator or Claims Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, *et seq.*, or other applicable law, the Plan Administrator or Claims Administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Claims Administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the protected health information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

In addition, the Plan Sponsor hereby certifies and agrees that it will:

(1) Not use or further disclose the information other than as permitted or required by the Plan or as required by law;

(2) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(3) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(4) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(5) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(6) Make available protected health information in accordance with 45 C.F.R. 164.524;

(7) Make health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526;

(8) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

(9) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, *et seq.*;

(10) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(11) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, *et seq*. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

Facility of Reimbursement. If payments which should have been made under this Plan have been made under any other plan or plans, the Claims Administrator may, at its

sole discretion, pay to any organization making such other payments any amounts which it determines will satisfy the intent of the Plan. Amounts so paid shall be deemed benefits paid under this Plan and, to the extent of such payments, the Employer and Claims Administrator shall be fully discharged from liability under this Plan.

Right to Recovery. If the total payments made by the Claims Administrator as to any expenses at any time are more than the maximum payment then necessary to satisfy the intent of the Plan, the Claims Administrator shall have the right to recover the extra amount of such payments from one or more of the following, as the Claims Administrator will determine: any person to, or for, or with respect to whom such payments were made, any other insurance companies, and any other organizations.

COORDINATION OF BENEFITS

In addition to benefits payable under this Plan, a Covered Person may be entitled to benefits from other plans, payable on account of the same Sickness or Injury. The other plans are those which provide benefits or services for or by reason of medical or dental care or treatment, when such benefits or services are provided on a group basis, whether insured or not, by any government or tax-supported program (including Medicare) or any similar plan or program.

This provision is applicable when the total benefits that would be payable in the absence of any coordination of benefits provision under this Plan and under all plans covering an individual exceed the total expenses incurred.

One of the two or more plans involved is the Primary Plan and the other plans are Secondary Plans. The Primary Plan pays benefits first and without consideration of the other plans. The Secondary Plans then make up the difference up to the total allowable expenses incurred. No plan will pay more than it would have paid without this special provision.

The following rules apply to determine which plan is Primary and which plan is Secondary:

(1) If one plan has no coordination of benefits provision, it is automatically Primary.

(2) A plan will be Primary if it covers the individual as an Employee and Secondary if it covers the individual as a Dependent.

(3) If an individual is covered as a Dependent under two or more plans, the plan which covers the individual as a Dependent of the person whose birthday falls earlier in the year is Primary. If both individuals share the same date of birth, the plan covering the individual for the longer period of time is Primary.

(4) In the case of children of divorced parents, in the absence of court-determined responsibility, the plan covering the parent with custody is Primary. If the parent without custody has court-determined responsibility, but does not have health benefits available for children, then the plan covering the parent with custody is Primary.

(5) A plan will be Primary if it covers the individual as an Employee and Secondary if it covers the individual (a) as a former Employee, (b) as a retiree, or (c) as an individual who has elected to continue benefits under the Plan pursuant to the COBRA Continuation of Benefits Sections herein.

(6) If none of the above rules apply, a plan will be Primary if it has covered the individual for the longer period of time and Secondary if it has covered the individual for the shorter period of time.

Notwithstanding any provision herein to the contrary, if a Covered Person is eligible for Medicare, benefits otherwise payable on behalf of that Covered Person shall be reduced by the amount of benefits available from Medicare, regardless of whether such benefits are actually received from Medicare.

Information necessary to the administration of this Section will be required at the time a claim is submitted.

Coordination with Medicare and Medicaid.

(1) Medicare

This Plan will be considered the primary plan for Covered Persons who are current Employees and their covered Dependents who are nevertheless eligible for Medicare benefits if (i) such covered Employee or covered Dependents are age 65 or older and their Employer employs 20 or more Employees, or (ii) such covered Employees or covered Dependents are disabled and any Employer under this Plan employs 100 or more employees. Except to the extent required by law for end stage renal disease, Medicare shall be considered the primary plan and pay benefits first for all other Covered Persons who become eligible for Medicare, unless the covered Employee on behalf of himself and his covered Dependents reject coverage under this Plan. In the event of an election to terminate coverage, benefits will no longer be available under this Plan.

(2) Medicaid

Payment of benefits with respect to a Covered Person under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Covered Person as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act. In enrolling or in determining or making any payments under the Plan to a Covered Person, the fact that the Covered Person is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make payment for the expenses incurred constituting such assistance, payment for the expenses incurred under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Covered Person to such payment for such expenses incurred.

Case Management. In the case where the patient's condition is expected to be or is of a serious nature, the Employer or Claims Administrator, pursuant to the reasonable exercise of its discretion, may arrange for review and/or case management services from a professional qualified to perform such services. Upon the advice of such professional, the Claims Administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result can be achieved without a sacrifice to quality of patient care.

THIRD PARTY RECOVERY PROVISION

(1) Payment Conditions

(a) The Plan, in its sole discretion, may elect, but is not required, to conditionally advance payment or extended credit of medical benefits in those situations where a Sickness, Injury, or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of a Covered Person, except where the acts or omissions of the Covered Person are excluded under the Plan, where other funds are available, including but not limited to, no-fault, uninsured motorist, underinsured motorist, medical payment provisions or other insurance policies or funds (collectively referred to hereafter as "Coverage"). For purposes of this provision, "Covered Person" includes the Covered Person and the Covered Person's legal guardian, beneficiaries, heirs, attorneys or assigns).

(b) The Covered Person agrees that acceptance of the Plan's payment of medical benefits is constructive notice of this provision in its entirety and the Covered Person agrees to 100% of the Plan's conditional payment of benefits or the fullest extent of payments from any one or combination of first and third party sources in trust and without disruption except for reimbursement to the Plan or its assignee. By accepting benefits under the Plan, the Covered Person agrees that the Plan shall have an equitable lien on any funds received by the Covered Person from any source and the Covered Person further agrees said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as co-payee on any and all settlement drafts.

(c) In the event a Covered Person settles, recovers or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid as a result of said Sickness, Injury, or disability on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses, including but not limited to reasonable attorney's fees and costs incurred by the Plan as a result of the Plan's attempt to recover such monies.

(2) Subrogation

(a) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to

any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's sole discretion.

(b) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any party who caused or allegedly caused the Sickness, Injury, or disability to the extent of such conditional payment by the Plan including but not limited to reasonable attorney's fees and costs incurred by the Plan.

(c) If the Covered Person fails to make a claim against or pursue damages against:

(i) the responsible party, its insurer or any other source on behalf of that party;

(ii) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(iii) any policy or contract of insurance from any insurance company or guarantor of a third party;

(iv) workers' compensation or other liability insurance company; or

(v) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and no-fault or school insurance coverages;

The Plan may, at its sole discretion, in its own name or in the name of the Covered Person commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the fullest extent of the value of any such benefits or conditional payment advanced, paid or to be paid by the Plan. The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in their name and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of such claims. The Covered Person or his or her guardian or the estate of a Covered Person, assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all reasonable expenses from any and all sources listed above.

(3) Right of Reimbursement

(a) The Plan shall be entitled to recover 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, and without regard to whether the Covered Person is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supercedes 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. The obligation exists regardless of how classified or characterized. If the Covered Person's recovery is less than the benefits paid, then the Plan is entitled to be paid the full amount of any recovery achieved.

(b) No court costs, expert's fees, attorney's fees, filing fees or other costs or expenses of a litigation nature may be deducted from the Plan's recovery without the prior written consent of the Plan.

(c) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or any 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.

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

(e) 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, or disability.

(4) Excess Insurance

(a) If at the time of Sickness, Injury, or disability, there is available, or potentially available (based on information known or provided to the Plan, to the Covered Person) 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. The Plan's benefits shall be excess to:

(i) the responsible party, its insurer, or any other source on behalf of that party;

(ii) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(iii) any policy of insurance from any insurance company or guarantor of a third party;

(iv) any other liability insurance company; or

(v) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages.

(5) Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person, or filing of bankruptcy by the Covered Person 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.

(6) Wrongful Death Claims

In the event that the Covered Person's Sickness, Injury or disability causes the death of the Covered Person and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights still apply.

(7) Obligations

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

(i) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or attending or cooperating in trial in order to preserve the Plan's rights;

(ii) to provide the Plan with pertinent information regarding the Sickness, Injury, or disability, including accident reports, settlement information and any other requested additional information;

(iii) to take such action and execute such documents as the Plan may require to facilitate enforcement of its rights;

(iv) to do nothing to prejudice the Plan's rights;

(v) to promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received; and

(vi) to not settle or release, without the prior consent of the Plan, any claim that the Covered Person may have against any responsible party or Coverage.

(b) If the Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Sickness, Injury, or disability, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses including but not limited to reasonable attorney's fees and costs associated with the Plan's attempt to recover such monies from the Covered Person.

(8) Offset

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

(9) Minor Status

(a) In the event the Covered Person 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 any requisite court approval in order to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(b) If the minor's parents or court-appointed guardian fail or refuse 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.

(10) 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/reimbursement rights.

(11) Severability

In the event that any subsection of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining subsections of this

provision and Plan. The subsection shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal subsections had never been inserted in the Plan.

COBRA CONTINUATION OPTIONS

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), continuation coverage under the Plan is available to Qualified Beneficiaries under certain specified conditions.

For the purpose of this Section, "Qualified Beneficiary" means any beneficiary defined as such pursuant to Section 607(3) of ERISA, and generally includes any Covered Person whose coverage under the Plan would otherwise terminate upon occurrence of any of the events specified in this Section. A Qualified Beneficiary also includes a child who is born to or placed for adoption with the covered Employee during the continuation coverage elected under this Section, provided such child qualifies as an eligible Dependent.

Eligibility to Make Election. A Qualified Beneficiary may elect to continue coverage under the Plan if coverage would otherwise cease under the Plan due to:

(1) the covered Employee's death;

(2) termination of the covered Employee's employment or reduction of the covered Employee's hours (whether voluntarily or involuntarily);

(3) divorce or legal separation of the covered Employee and his Spouse;

(4) the covered Employee becoming entitled to Medicare benefits;

(5) a covered Employee's child ceasing to be an eligible Dependent; or

(6) a proceeding in bankruptcy under Title 11, United States Code, commencing on or after July 1, 1986, with respect to the Employer if the Covered Person is a retiree.

Notwithstanding the above, a Qualified Beneficiary is not entitled to elect continuation coverage if the covered Employee's termination of employment is for gross misconduct as determined by the Employer. In the case of bankruptcy proceedings as described in (6) above, a loss of coverage includes a substantial elimination of coverage with respect to a Qualified Beneficiary within one (1) year before or after the date of commencement of the proceedings.

Election Period and Procedure. The election to continue coverage must be made during the period beginning on the day when coverage would otherwise cease under the Plan and ending 60 days after the later of (i) such date, or, (ii) if applicable under the Administrative Section, the date when the Qualified Beneficiary is notified of the right to make such election. A Qualified Beneficiary's failure to comply with the procedures and requirements established by the Employer for making the election, as described herein or in the Employer's notice of election, shall constitute the failure to make an election to continue coverage as provided herein. The written waiver by a Qualified Beneficiary (or by the covered Employee or his Spouse on behalf of a Qualified Beneficiary) of the election to continue coverage shall terminate the Qualified Beneficiary's right to later

make an election, unless the Qualified Beneficiary revokes the waiver within the 60 day election period described above. However, if a waiver is revoked, continuation coverage will be effective on the date the revocation is made and will not be retroactive to the date of the event described in the Eligibility to Make Election Section.

Benefits. A Qualified Beneficiary who elects continuation coverage as provided herein shall be eligible to receive the same benefits to which a Covered Person under similar circumstances is otherwise entitled. If benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to the Qualified Beneficiary's election of continuation coverage, each Qualified Beneficiary will be entitled to benefits comparable to those available to a Covered Person under similar circumstances.

Payment for Benefits. A Qualified Beneficiary is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of Qualified Beneficiaries shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium which shall be described in the Employer's notice of election form. A Qualified Beneficiary's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the Qualified Beneficiary's termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Qualified Beneficiary shall be precluded from extending, renewing, or reelecting such continuation coverage.

Duration of Continuation Coverage. A Qualified Beneficiary electing to purchase continuation coverage under the Plan shall be eligible to continue coverage until the earliest of the following events:

(1) the date 18 months after the date of a covered Employee's termination of employment or reduction in hours;

(2) the date 36 months after the date of any other event described in the Eligibility to Make Election Section other than a covered Employee's termination of employment or reduction in hours (except that if an Employee has a termination of employment or reduction in hours entitling him to continuation coverage within 18 months of the date of his entitlement to Medicare then the period of Continuation Coverage for the Qualified Beneficiaries other than the covered Employee shall not terminate prior to the close of the 36 month period beginning on the date the covered Employee became entitled to Medicare);

(3) the date the Employer ceases to provide any health benefit plan for any of its employees;

(4) the date the Qualified Beneficiary first becomes covered after the date of his election of continuation coverage (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion

or limitation with respect to any pre-existing condition of such Qualified Beneficiary, or the date the Qualified Beneficiary becomes entitled to benefits under Medicare;

(5) the date which is the last day of the period for which the Qualified Beneficiary's Continuation Premium payments have been paid (regardless of any grace period if the Employer establishes such a period) as determined by the Employer; or

(6) in the case of a Qualified Beneficiary who is determined, under Title II or XVI of the Social Security Act ("Act"), to have been disabled at any time during the first 60 days of continuation coverage, the earlier of (i) the date 29 months after the date of the commencement of such continuation coverage, but only if the Qualified Beneficiary has provided notice of such determination under ERISA Section 606(3) within 60 days of the receipt of the determination notice under the Act and before the expiration of 18 months from the date of occurrence of the qualifying event, or (ii) the end of the month next following the date of final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

If more than one event that would entitle the Qualified Beneficiary to elect continuation coverage occurs (as described in the Eligibility to Make Election Section herein), the first occurring of such events shall be the measuring date for purposes of the maximum possible length of continuation coverage under this Section. In addition, the maximum period available for continuation coverage pursuant to the Continuation of Benefits Section is measured from the date of occurrence of the qualifying event specified in the Eligibility to Make Election Section, except where specifically indicated to the contrary.

Administration.

(1) Notice on Death, Termination, Reduction of Hours, or Entitlement to Medicare

Within 30 days of a covered Employee's death, termination of service, reduction of hours, or entitlement to Medicare, the Employer shall inform the Plan Administrator of:

(a) the Qualified Beneficiaries eligible to elect continuation coverage;

(b) the event precipitating such notice; and

(c) the date of the event.

The COBRA Notice Coordinator, at the direction of the Employer, shall then notify the Qualified Beneficiaries of their rights to elect pursuant to procedures established by the Employer and applicable law.

(2) Notice of Change in Marital Status or Dependent Status

If a Dependent ceases to be eligible for coverage under the Plan because that person becomes divorced or legally separated from the covered Employee, or if a child of a covered Employee ceases to be eligible for coverage under the Plan because he is no longer an eligible Dependent, either the covered Employee, the covered Employee's former Spouse or the covered Employee's child must notify the COBRA Notice Coordinator of these events within 60 days of their occurrence in order for the respective Qualified Beneficiary to be eligible to elect continuation coverage. The notice may be provided to the COBRA Notice Coordinator orally or in writing and must disclose:

(a) the name and Plan identification numbers of the Employee and the individuals affected by the event;

(b) the individual’s divorce, separation, or loss of status as an eligible Dependent; and

(c) the date of such event.

Notice by a Qualified Beneficiary of the occurrence of an event giving rise to an election does not act as an election to receive continuation coverage under the Plan. In the event of divorce, legal separation, or change in dependent status, the COBRA Notice Coordinator, if notified within the time period specified in this Subsection (2), shall notify the Qualified Beneficiaries of their eligibility to elect continuation coverage.

(3) Notice of Disability

If a Covered Person is determined, under Title II or XVI of the Act to have been disabled at any time during the first 60 days of continuation coverage, the Covered Person must notify the COBRA Notice Coordinator of the determination under the Act within 60 days of the latest to occur of the following:

(i) The date of the Social Security Administration disability determination (sometimes referred to as the “award letter”);

(ii) The date of the termination of employment or reduction in hours entitling the Qualified Beneficiary to COBRA continuation coverage;

(iii) The date the Qualified Beneficiary otherwise loses coverage under the Plan as a result of the termination of employment or reduction in hours; or

(iv) The date the Qualified Beneficiary is informed of the obligation to provide notice of disability as provided herein.

Notwithstanding the above, the notice of determination must be provided the COBRA Notice Coordinator before the expiration of 18 months from the date of occurrence of the termination of employment or reduction in hours. The notice must be provided to the

COBRA Notice Coordinator in writing and must disclose (i) the name and Plan identification number of the disabled Covered Person, and (ii) the determination notice provided pursuant to the Act to the disabled Covered Person. The Qualified Beneficiaries must also notify the COBRA Notice Coordinator in writing within 30 days of the date of any final determination under the Act that the Covered Person is no longer disabled. The notice shall disclose (i) the name and Plan identification number of the disabled Covered Person, and (ii) the final determination Notice provided pursuant to the Act that the person is no longer disabled.

(4) Notice of Coverage Under Group Health Plan or Entitlement to Medicare

If a Qualified Beneficiary (i) becomes covered (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary, or (ii) becomes entitled to benefits under Medicare, the Qualified Beneficiary must notify the COBRA Notice Coordinator of such event in writing within 30 days of such coverage date.

(5) General

(a) Multiple Events. If more than one event described in the Eligibility to Make Election Section occurs, the first such event occurring will determine which one of either Subsection (1) or (2) of this Section is applicable.

(b) Notices to Employer. Notices to the COBRA Notice Coordinator shall be provided to the COBRA Notice Coordinator listed on the General Plan Information Section. If no COBRA Notice Coordinator is listed on the General Plan Information Section then the Employer shall be considered the COBRA Notice Coordinator and notices shall be provided to the person or organizational unit of the Employer that customarily handles employee benefits matters of the Employer.

(c) Current Addresses. The notification of election rights under COBRA will generally be made by U.S. Mail to the Qualified Beneficiary's last known address. As a result, it is important for each Covered Person to timely provide the Employer with his current mailing address.

(d) Interpretation. In the event of any inconsistency or omission, this Section and the applicable provisions of the Plan shall be construed, interpreted, and administered in a manner which meets the minimum requirements of COBRA.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Mechanical Devices Company Employee Health Benefit Plan is the benefit plan of Mechanical Devices Company, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Mechanical Devices Company to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Mechanical Devices Company shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

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

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

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

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

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

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

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

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan’s rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived solely from the funds of the Employer.

For Dependent Coverage: Funding is derived from contributions made by the covered Employees. (FLEX PLAN)

Benefits are paid directly from the Plan by the Trust.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN EMPLOYEE RIGHTS UNDER ERISA

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:

(1) Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, 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 Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective

bargaining agreements, 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.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

(2) 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 coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

(3) 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

(4) Enforce Your Rights

If your claim for a 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.

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 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 $110 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 which is denied or ignored, in whole or in part, you may file suit 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 domestic relations order or 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.

(5) 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded health and disability plan and the administration is provided through a third party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Employee Health Benefit Plan of Mechanical Devices Company

PLAN NUMBER: 501

TAX ID NUMBER: 37-1066971

PLAN EFFECTIVE DATE: April 1, 1992

PLAN RESTATEMENT EFFECTIVE DATE: April 1, 2014

FISCAL YEAR OF THE PLAN: April 1 through March 31

EMPLOYER INFORMATION

Mechanical Devices Company
2005 GE Road
Bloomington, Illinois 61704
309-663-2843

PLAN SPONSOR AND PLAN ADMINISTRATOR

Mechanical Devices Company
2005 GE Road
Bloomington, Illinois 6I704
309-663-2343

NAMED FIDUCIARY

Mechanical Devices Company
2005 GE Road
Bloomington, Illinois 61704

AGENT FOR SERVICE OF LEGAL PROCESS

Mechanical Devices Company
2005 GE Road
Bloomington, Illinois 61704

Service of legal process may also be made upon the Plan trustee.

CLAIMS ADMINISTRATOR

Group Plan Solutions Benefit Administration, a division of
Pekin Life Insurance Company
2505 Court Street
Pekin, Illinois 61558
888-301-0747
309-478-2912 - Fax

COBRA NOTICE ADMINISTRATOR

Group Plan Solutions Benefit Administration, a division of
Pekin Life Insurance Company
Attn: COBRA Department
2505 Court Street
Pekin, Illinois 61558
888-301-0747
309-478-2912

UTILIZATION REVIEW ADMINISTRATOR

Group Plan Solutions Benefit Administration, a division of
Pekin Life Insurance Company
2505 Court Street
Pekin, Illinois 61558
24 hour Pre-Certification Number 888-641-5304
Case Management and Pre-Determination 888-301-0747

TRUST

Mechanical Devices Company Employee Benefits Trust

TRUSTEE

Linda S. Fillingham
Trustee
Mechanical Devices Company Employee Benefits Trust
2005 GE Road
Bloomington, Illinois 61704
309-663-2343

By This AGREEMENT, the Employee Health Benefit Plan of Mechanical Devices Company is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Mechanical Devices Company on or as of the day and year above written.

MECHANICAL DEVICES COMPANY

By: Linda K. Tillingham

Its: Sec Treas.

514-95.2