PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

LTX, INCORPORATED MEDICAL BENEFIT PLAN

(MEDICAL, PRESCRIPTION DRUG AND VISION)

AMENDED AND RESTATED AS OF:
January 1, 2011

Group No.: 10717

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INTRODUCTION

In the event of any conflict between this document and any other document or oral communication, this document will control.

This is the LTX, Incorporated Medical Benefit Plan for Medical, Vision, and Prescription Drugs ("the Plan"), amended and restated as of January 1, 2011.

The Plan Sponsor reserves the right to terminate or amend the Plan at any time and for any reason.

The Plan will pay benefits only for the eligible expenses incurred while this coverage is in force. Benefits are not payable for eligible expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

As used in this document, the word year refers to a calendar year. All annual benefit maximums and deductibles accumulate during the calendar year. The word Lifetime as used in this document refers to the period of time that a Plan Participant under the LTX, Incorporated Medical Benefit Plan is covered.

The LTX, Incorporated Employee Benefit Plan believes it 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 your 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 dollar 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 507-282-6715. 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.

Defined terms are capitalized and defined in the Defined Terms section. This document is divided into the following sections:

Schedule of Medical, Prescription Drug and Vision Benefits. Provides a description of the Plan's benefits.

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

Eligibility and Commencement of Coverage Provisions. Explains eligibility and when coverage begins under the Plan.

Annual Enrollment Period. Explains when a Plan Participant can change plan and enrollment options.

Termination of Coverage and Extension of Coverage Provisions. Explains when a Plan Participant's coverage would end and when a Plan Participant may extend coverage under the Plan.

Medical Management. Explains the Medical Management Program, which protects a Covered Person from significant health care expenses and helps to provide quality care.

This section should be read carefully since each Plan Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Medical Benefits. Provides a description of medical benefits provided under the Plan.

Plan Exclusions. Lists services, treatment and charges incurred that are not covered by the Plan.

Prescription Drug Benefit. Explains benefits provided under the independent drug program.

Vision Benefits. Provides a description of vision benefits provided under the Plan.

Filing a Claim. Explains how to submit a claim for consideration of benefits under the Plan.

Claims Procedure. Explains the procedures for filing a claim and the claim appeal process.

Coordination of Benefits. Explains the Plan benefit payment order when a Covered Person is covered under more than one plan providing benefits.

Other Important Plan Provisions. Explains other important Plan provisions.

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

COBRA Continuation Options. Explains continuation options available under the Plan.

Responsibilities for Plan Administration. Explains the responsibilities of the Plan Sponsor.

Health Information Privacy and Security. Summary of the Plan's HIPAA Privacy Policy and Security.

General Plan Information. Provides general Plan information.

SCHEDULE OF BENEFITS

MEDICAL, PRESCRIPTION DRUG AND VISION BENEFITS

The following Schedule of Benefits describes the benefits of the Plan. Additional Plan provisions, which may affect benefit payment, can be found in the Benefit Description sections.

All benefits described in the Schedule of Medical, Prescription Drug and Vision Benefits are subject to the exclusions and limitations described in the Plan Exclusion Section.

Required Precertification: The following services must be precertified or reimbursement from the Plan may be reduced or not available:

Hospitalizations
Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility stays
Inpatient Mental Disorder/Substance Use Disorder treatments
Inpatient Surgical Procedure

The Plan does not require precertification for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

For precertification call: Meritain Health Medical Management at 800-242-1199.

Detailed information regarding precertification requirements and penalties for failure to comply can be found in the Medical Management section.

Participating Provider Organization (PPO)

The Plan includes an arrangement with a Participating Provider Organization (PPO). Each employee has been assigned a PPO that services the employee's worksite location. The PPO name, address and phone number will be printed on the employee's identification card.

The assigned PPO will apply to all Family members regardless of where the individual Family members may reside.

The Plan Sponsor will provide each employee with information regarding his or her PPO.

The PPO has an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. These Participating Providers have agreed to charge reduced fees to Covered Persons covered under the Plan. The Plan saves money because services are performed at a lower cost, the provider gains new clientele, and the Plan Participant receives a cost effective benefit.

Therefore, when a Covered Person uses a Participating Provider, the Covered Person will receive a higher payment from the Plan than when a Non-Participating Provider is used.

It is the Covered Person's option to select a Participating or Non-Participating Provider.

It is the Covered Person's responsibility to verify a provider's current participation as a Participating Provider by calling the PPO number on the ID card or by accessing the website, Mymeritain.com.

Deductibles Payable by Plan Participants

Deductibles are dollar amounts that the Covered Person or all Covered Person's in a Family must pay before the Plan will consider expenses for reimbursement. The In-Network deductible accrues toward the Out-of-Network deductible and the Out-of-Network deductible accrues toward the In-Network deductible.

An individual deductible is the amount of covered expenses a Covered Person must pay during each calendar year before the Plan will consider expenses for reimbursement. The Family deductible, if applicable, applies collectively to all Covered Persons in a Family each calendar year. When the Family deductible is satisfied, no further deductible will be applied for

any covered Family member during the remainder of that calendar year. However, covered expenses incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next calendar year as well as the current calendar year.

Out-of-Pocket Maximums

An out-of-pocket maximum is the maximum amount of covered expenses a Covered Person must pay during a calendar year before the Plan payment percentage increases. The In-Network out-of-pocket maximum accrues toward the Out-of-Network out-of-pocket maximum and the Out-of-Network out-of-pocket maximum accrues toward the In-Network out-of-pocket maximum.

The individual out-of-pocket maximum applies separately to each Covered Person. When a Covered Person reaches his or her out-of-pocket maximum, the Plan will pay 100% of additional covered expenses for that individual during the remainder of that calendar year.

The Family out-of-pocket maximum applies collectively to all Covered Persons in the same Family. When the Family out-of-pocket maximum is satisfied, the Plan will pay 100% of covered expenses for any Covered Person in the Family during the remainder of that calendar year.

The Plan will pay the designated percentage of covered charges until the applicable out-of-pocket maximum is reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year.

The following expenses do not count toward the out-of-pocket maximum and are never paid at 100%:

Precertification penalties
Excess of Usual and Customary Charges
Prescription drug copays

Continuity of Care

New members who are currently receiving care from a provider or specialist who does not participate with the Claims Processor, you may request to remain with this provider, and continue to receive care for a special medical need or condition, for a reasonable period of time before transferring to a participating provider as required under the terms of your coverage with this Plan.

If the relationship between your participating primary care clinic or Physician and the Claims Processor ends, rendering your clinic or provider nonparticipating with the Claims Processor, and the termination was not for cause, you may request to continue to receive care for a special medical need or condition, for a reasonable period of time before transferring to a participating provider as required under the terms of your coverage with this Plan.

The Claims Processor will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a Physician certifies that your life expectancy is 180 days or less. The Claims Processor will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days:

(1) An acute condition;
(2) A life-threatening mental or physical Illness;
(3) A physical or mental disability rendering you unable to engage in one or more major life activities provided that the disability has lasted or can be expected to last for at least one year, or that has a terminal outcome;
(4) A disabling or chronic condition in an acute phase or that is expected to last permanently;
(5) You are receiving culturally appropriate services from a provider with special expertise in delivering those services; or
(6) You are receiving services from a provider that are delivered in a language other than English.

Continuation through the postpartum period (6 weeks post delivery) for a pregnancy beyond the first trimester.

SCHEDULE OF MEDICAL BENEFITS

DEDUCTIBLE PER CALENDAR YEAR		MAXIMUM OUT-OF-POCKET PER CALENDAR YEAR	
In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
$2,000 per Covered Person	$2,000 per Covered Person	$4,000 per Covered Person	$4,000 per Covered Person
$4,000 per Family	$4,000 per Family	$8,000 per Family	$8,000 per Family

MAXIMUM LIFETIME BENEFIT
(per Covered Person)
Unlimited

MAXIMUM ANNUAL BENEFIT
(per Covered Person)
$1,000,000

Participating Provider vs. Non-Participating Provider Benefit Level

Covered services rendered by a Participating Provider will be paid at the Participating Provider benefit level. Covered services rendered by a Non-Participating Provider will be paid at the Non-Participating Provider benefit level. The Participating Provider benefit level will be paid for Non-Participating Provider services when a:

- Covered Person has a Medical Emergency requiring immediate care
- Covered Person receives services by a Non-Participating Provider (e.g., anesthesiologists, radiologists, pathologists, etc.) who is under agreement with a Participating facility
- Participating Provider submits a specimen to a Non-Participating laboratory
- Non-Participating Provider provides services at a Participating Facility
- Covered Person receives services from a Participating surgeon who uses a Non-Participating Assistant Surgeon

However, all other limitations, requirements and provisions of the Plan will apply including the Usual and Customary provision of the Plan. This exception does not apply in the event of consultations and other situations in which the Covered Person and/or the provider selected had the opportunity to select a Participating Provider, and exercised the right to receive services from a Non-Participating Provider.

Referrals by a Participating Provider to a Non-Participating Provider will be considered at the Non-Participating Provider benefit level.

Maximums

The maximums listed below in any one box are the total for Participating and Non-Participating Provider expenses. For example, if a maximum of 60 days is listed in two boxes under a benefit, the calendar year maximum is 60 days total which may be split between Participating and Non-Participating Providers.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (U&C Applies)	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Preventive Care			
Routine Well Care (age 6 and over)	100% no deductible	Not Covered	Includes but is not limited to: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests, hearing tests, STD screening, osteoporosis screening, cholesteral/lipid profile, thyroid screening, urinalysis, diabetes screening, hemoglobin-CBC, surveillance tests for ovarian cancer (CA-125) tumor marker, trans-vaginal ultrasound, pelvic exam.
Routine Well Child Care (up to age 6)	100% no deductible	Not Covered	Includes but is not limited to: office visits, routine physical examination, laboratory blood tests, x-rays, hearing tests and developmental assessments until age 6.
Routine Immunizations/ Vaccinations/Flu Shots	100% no deductible	Not Covered	Includes Gardasil.
Colonoscopy or Sigmoidoscopy			Age 50 and over. Includes all related charges.
First Colonoscopy or Sigmoioscopy age 50 or Over (routine or non- routine)	100% no deductible	Not Covered	
Thereafter			
Routine - Age 50 and Over	100% no deductible	Not Covered	
Non-Routine - Age 50 and Over	80% after Deductible	Not Covered	
Routine Eye Exams (up to age 18)	100% no deductible	Not Covered	Includes refractions and office visits.
X-ray & Laboratory Services			
Pre-Admission and Pre-Surgical Testing, within 7 days of a scheduled Inpatient Hospital admission.	80% after deductible	60% after deductible	
Diagnostic Charges (X-ray and Laboratory)	80% after deductible	60% after deductible	
Hospital Services, Specialized Treatment Facilities and Services			
Inpatient Hospital Services, including Room and Board	80% after deductible room and board limited to the semi-private room rate	60% after deductible room and board limited to the semi-private room rate	The Plan's payment will be reduced if the requirements of the Medical Management section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (U&C Applies)	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Intensive Care Unit	80% after deductible room and board limited to the ICU/CCU room rate	60% after deductible room and board limited to the ICU/CCU room rate	The Plan's payment will be reduced if the requirements of the Medical Management section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Routine Well Newborn Care	80% after deductible	60% after deductible	
Outpatient Hospital	80% after deductible	60% after deductible	
Birthing Center	80% after deductible	60% after deductible	
Home Health Care	80% after deductible	60% after deductible	
Hospice Care	80% after deductible	60% after deductible	Includes bereavement counseling.
Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility	80% after deductible room and board limited to the facility's semi-private room rate	60% after deductible room and board limited to the facility's semi-private room rate	The Plan's payment will be reduced if the requirements of the Medical Management section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum. If you are unable to obtain a bed in an In-Network Skilled Nursing Facility within a 50 mile radius of your home due to full capacity, you may be eligible to receive services at an Out-of-Network facility at the In-Network level of benefits.
Ambulance Service	80% after deductible	60% after deductible	
Emergency Room, including all related services performed during the same visit. Follow-up treatment will not be considered under the Emergency Room benefit.	80% after deductible	60% after deductible	Meritain Health Medical Management must be notified at 800-242-1199 within 48 hours of the admission, even if the Covered Person is discharged within 48 hours of the admission.
Urgent Care Facility	80% after deductible	60% after deductible	
Medical and Surgical Physician Services			
Allergy Serum and Injections	80% after deductible	60% after deductible	
Spinal Manipulation/ Chiropractic Care	80% after deductible 20 visits calendar year maximum	60% after deductible 20 visits calendar year maximum	
Inpatient Surgery (includes anesthesiologists)	80% after deductible	60% after deductible	The Plan's payment will be reduced if the requirements of the Medical Management section of the Plan are not followed. his penalty does not apply to the out-of-pocket maximum.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (U&C Applies)	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Outpatient Surgery (Includes anesthesiologists)	80% after deductible	60% after deductible	
Surgery Performed in a Physician's Office	80% after deductible	60% after deductible	
Inpatient Physician Visits	80% after deductible	60% after deductible	
Occupational Therapy	80% after deductible	60% after deductible	
Physical Therapy	80% after deductible	60% after deductible	
Speech Therapy	80% after deductible	60% after deductible	
Physician's Office Visits	80% after deductible	60% after deductible	Includes diagnostic services performed in the Physician's office.
Retail Clinics	100% no deductible	100% no deductible	
Jaw Joint Conditions/ Temporomandibular Joint Disorder	80% after deductible	60% after deductible	
Home Infusion Therapy	80% after deductible	60% after deductible	
All Other Covered Medical and Surgical Expenses	80% after deductible	60% after deductible	
Durable Medical Equipment, Supplies, Prosthetics and Orthotics			
Durable Medical Equipment	80% after deductible	60% after deductible	
Medical Supplies	80% after deductible	60% after deductible	
Prosthetics and Orthotics	80% after deductible	60% after deductible	
Prescription Drugs Not Eligible Under Prescription Drug Program	80% after deductible	60% after deductible	This benefit applies to prescription drugs, medicines or supplies dispensed through a Physician's office and take-home prescription drugs from a Hospital. This does not cover prescription drugs, medicines or supplies that are eligible under the Prescription Drug Program.

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (U&C Applies)	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Mental Disorders and Substance Use Disoders			
Mental Disorders			Inpatient: The Plan's payment will be reduced if the requirements of the Medical Management Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Inpatient	80% after deductible	60% after deductible	
Outpatient	80% after deductible	60% after deductible	
Emergency Care (ambulance and emergency room)	80% after deductible	80% after In-Network deductible, subject to In-Network Out-of-Pocket Maximum	
Prescription Drugs Not Eligible Under Prescription Drug Program	80% after deductible	80% after In-Network deductible, subject to In-Network Out-of-Pocket Maximum	
Substance Use Disorders			Inpatient: The Plan's payment will be reduced if the requirements of the Medical Management Program section of the Plan are not followed. This penalty does not apply to the out-of-pocket maximum.
Inpatient	80% after deductible	60% after deductible	
Outpatient	80% after deductible	60% after deductible	
Emergency Care (ambulance and emergency room)	80% after deductible	80% after In-Network deductible, subject to In-Network Out-of-Pocket Maximum	
Prescription Drugs Not Eligible Under Prescription Drug Program	80% after deductible	80% after In-Network deductible, subject to In-Network Out-of-Pocket Maximum	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

BENEFIT DESCRIPTION	
Pharmacy Option (31-day supply)	**Copays**
Generic Drugs	20% (minimum $25)
Formulary Brand Name Drugs	20% (minimum $25)
Non-Formulary Brand Name Drugs	30% (minimum $40)
Curascript Specialty Drugs (30-day supply)	$30
Mail Order Prescription Drug Option (90-day supply)	**Copays**
Generic Drugs	$50
Formulary Brand Name Drugs	$50
Non-Formulary Brand Name Drugs	$80

"Dispensed As Written" Drug Provision

The Plan requires that retail pharmacies dispense Generic drugs when available unless the Physician specifically prescribes a Brand Name drug and marks the script "dispense as written." Should a Covered Person choose a Brand Name drug rather than the Generic equivalent when the Physician allowed a Generic drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Brand Name drug, in addition to the Brand Name drug copayment and the Covered Person's share of the prescription's drug cost does not apply toward the out-of-pocket maximum.

Details regarding Prescription Drug Benefits are in the Prescription Drug Benefits section.

SCHEDULE OF VISION CARE BENEFITS

BENEFIT DESCRIPTION	BENEFIT
Vision Benefits are limited to the following:	
Eye Exam (age 18 and over), per Covered Person, per Calendar Year	100% up to $30 per exam; one per calendar year
Frame-Type Lenses, Per Pair, in a Calendar Year Period:	
Single vision	$24
Bi-focal	$36
Tri-focal	$48
Lenticular	$99
Contact lenses	$45
Contact lenses when visual acuity cannot be corrected to 20/70 vision in the better eye by use of conventional type lenses, but can be improved to 20/70 with contact lenses	$188
Frames, Per Pair, in a Calendar Year Period	$21

Details regarding Vision Benefits are in the Vision Benefits section.

DEFINED TERMS

The following terms, when capitalized in the Plan, have the special meanings indicated.

Active Employee is an employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer, as determined by the Employer.

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.) and does not provide for overnight stays.

Assistant Surgeon is a Physician who actively assists the Physician in charge of a case in performing a surgical procedure. Depending on the type of surgery to be performed, an operating surgeon may have one or two Assistant Surgeons. The need for an Assistant Surgeon is dictated by the technical aspects of the surgery involved.

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

Brand Name means a trade name medication.

Cosmetic means care and treatment performed primarily to improve one's appearance, and does not promote the proper function of the body or prevent or treat an Illness, Injury or disease.

Covered Person is an employee or dependent who is covered under the Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits; long-term care benefits if provided under a separate policy; coverage that is limited to a specified disease or Illness; Hospital indemnity or other fixed dollar indemnity insurance if provided under a separate policy, certificate or contract of insurance; coverage only for accidents; disability income insurance; liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; or, coverage for on-site medical clinics. Days in a waiting period from a prior plan during which an employee has no other coverage are not considered Creditable Coverage under the Plan, nor are these days taken into account when determining a Significant Break In Coverage.

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.

Diagnostic Charges means charges for x-ray or laboratory examinations made or ordered by a Physician in order to detect a medical condition.

Disability means the inability to perform all the duties of the Covered Person's occupation as the result of a non-occupational Illness or Injury. For an unemployed Covered Person, Disability means the inability to perform the normal duties of a person of the same age.

Disability (Disabled) for an Active Employee means 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 Illness or Injury. Disability will be determined by the attending Physician.

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.

Employer is the Plan Sponsor and any other entity, with the consent of the Plan Sponsor that adopts the Plan.

Enrollment Date is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

Experimental/Investigational means medical treatments, procedures, technology, supplies or drugs which:

(1) Have not been approved by the Federal Food and Drug Administration for the particular condition at the time the service, medical treatment, procedure, technology, supply or drug is provided; or

(2) Is the subject of ongoing Phase I, II, or III clinical trial as defined by the National Institute of Health, National Cancer Institute or the FDA; or

(3) There is documentation in published U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity or efficacy of the service, medical treatment, procedure, technology, supply or drug; or

(4) The patient has been asked to sign or has signed a release or other document indicating that treatment is Experimental or Investigational or other term of similar meaning.

In determining any of the above, the Plan will rely on recognized medical sources such as, but not limited to, the American Medical Association, including the Council of Technology Assistance Program and the Council on Medical Special Services; the National Institute of Health; Medicare; the Food and Drug Administration and other accepted medical authorities and sources.

Family is an employee who is a Covered Person and his or her dependents who are Covered Persons.

Formulary means a list of prescription medications specified as such by the Plan Sponsor.

Generic drug means any Food and Drug Administration approved Generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being Generic.

Home Health Care Agency is an organization that provides Home Health Care Services and Supplies; is federally certified as a Home Health Care Agency; and is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan is a formal written plan made by the patient's attending Physician. It must state the diagnosis and 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; laboratory services by or on behalf of the Hospital; and services of a registered dietician.

Hospice Agency is a public or private organization, licensed and operated according to the law, primarily engaged in providing Hospice Care Services and Supplies for palliative, supportive, and other related care for a Covered Person diagnosed as terminally ill with a medical prognosis that life expectancy is 6 months or less.

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 six months.

Hospital is 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 requirements: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; 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.

"Hospital" also includes:

(1) 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.

(2) A facility operating primarily for the treatment of Substance Use Disorder if it meets these requirements: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Use Disorder.

Illness means a non-occupational bodily disorder, disease, physical sickness, Mental Disorder or Substance Use Disorder. Illness includes Pregnancy, childbirth, miscarriage, as defined by the Employer.

Infertility means incapable of producing offspring.

Injury means a non-occupational accidental physical injury caused by an unexpected external means.

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 and which 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.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is used in the Plan in reference to benefit maximums and limitations and is understood to mean while covered under the Plan beginning January 1, 2009.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means an Illness or Injury which occurs suddenly and unexpectedly, requiring immediate medical care and use of the most accessible Hospital equipped to furnish care to prevent the death or serious impairment of the Covered Person.

Such conditions include but are not limited to suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, emergency medical care rendered in accident cases and other acute conditions.

Medically Necessary means the treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

"Proven" means the care is not considered Experimental/Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA), for treatment.

"Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, injury, illness or a clinical condition.

"Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the LTX, Incorporated Medical Benefit Plan.

All criteria must be satisfied. When a Physician merely recommends or approves certain care does not mean that it is Medically Necessary.

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 the International Classification of Diseases, published by U.S. Health and Human Services.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Non-Participating (Out-of-Network) Provider means a Hospital, Physician or other health care provider that has not entered into a contractual agreement with the Plan's Participating Provider Organization (PPO).

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a Covered Person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Participating (In-Network) Provider means a Hospital, Physician or other health care provider that has a contractual agreement with the Plan's Participating Provider Organization (PPO).

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician (Health care Provider) 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, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, Nutritionist/Dietician 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 Participant is any employee or dependent who is covered under the Plan.

Plan Sponsor is LTX, Incorporated, as further identified under General Plan Information.

Plan Year refer to the General Plan Information page.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under the Plan.

Pregnancy is not considered a Pre-Existing Condition. Also, any Plan exclusion does not apply to Covered Persons under age 19.

Pregnancy is childbirth and conditions associated with Pregnancy, including Complications of Pregnancy.

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.

Qualified Medical Child Support Order (QMCSO) is a judgment or decree by a court of competent jurisdiction or order issued through an administrative process established under state law that has the force and effect of state law that requires the Plan to provide coverage to the children of an employee pursuant to a state domestic relations law.

A medical child support order must meet certain requirements specified in the law in order to be considered "qualified."

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

Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Illness or Injury.

Significant Break in Coverage is a period of 63 consecutive days during all of which the individual does not have any Creditable Coverage, except that a waiting period is not taken into account in determining a Significant Break in Coverage.

Skilled Nursing Facility, including an extended care facility and a rehabilitation facility, is a facility that fully meets all of the following:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. 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 a full-time registered nurse.
(4) It maintains a complete medical record on each patient.
(5) It has an effective utilization review plan.
(6) It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.
(7) It is approved and licensed by Medicare.

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

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.

Spouse means the person of the opposite sex recognized as the covered employee's husband or wife under the laws of the state where the covered employee lives.

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases, published by U.S. Health and Human Services.

Temporomandibular Joint Syndrome (TMJ) is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Urgent Care Facility means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

Usual and Customary Charge is a charge which is not more 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 that care or supply in the same area, as determined by the Plan Sponsor. The nature and severity of the condition being treated will be considered. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

If the actual charge billed is less than the Usual and Customary Charge as defined above, the lesser charge billed will be deemed to be the Usual and Customary Charge.

ELIGIBILITY AND COMMENCEMENT OF COVERAGE PROVISIONS

ELIGIBILITY

Eligible Classes of Employees. An employee of the Employer who is a United States citizen and non-citizen with a valid work visa and is a full-time employee regularly scheduled to work at least 32 hours per week for the Employer (as determined by the Employer) and is on the regular payroll of the Employer.

Waiting Period for Employee Coverage. An employee must complete the waiting period of 90 days as an Active Employee. Please see section titled Effective Date of Coverage to determine when coverage begins after the waiting period. For the purpose of this provision, an employee shall not be treated as absent from work if the absence is because of a health condition. The waiting period is counted toward the Pre-Existing Conditions exclusion provision of the Plan.

The Employer may waive the waiting period for newly hired Executives, Directors or Managers.

Should an employee of the Employer change to full-time status, any waiting period required to be eligible for coverage under the LTX, Incorporated Medical Benefit Plan will be calculated from the employee's date of hire. If the employee has been employed with the Employer longer than the required waiting period, coverage would begin on the first day of the month following the date the employee changed to full-time status.

Notwithstanding the foregoing, the term employee shall not include:

(1) Any employee of the Employer who is a member of a collective bargaining unit covered under a collective bargaining agreement unless the collective bargaining agreement provides for the employee's participation in the Plan, or

(2) Any leased employee of the Employer, or

(3) Any person who is not classified by the Employer as a common law employee of the Employer, regardless of whether or not such person is later reclassified by a court or any regulatory agency as a common law employee of the Employer, or

(4) Any person classified by the Employer as a temporary employee of the Employer (as determined by the Employer).

Effective Date of Employee Coverage. When the enrollment requirements are met, an eligible employee's coverage is effective on the first day of the month following the waiting period. In the case of a Special Enrollment Situation or Status Change, coverage will be effective on the date of the event, provided the enrollment application is received within 31 days of the event.

An employee must be an Active Employee (as defined by the Plan) for coverage to begin.

The Employer may waive the waiting period for newly hired Executives, Directors or Managers and coverage may become effective on the date of hire.

Eligible Classes of Dependents. A dependent is any one of the following persons:

(1) A covered employee's Spouse, unless legally separated.

(2) A covered employee’s Dependent Child until the end of the calendar month in which he/she attains age 26, provided such child does not have coverage available through another employer-sponsored group health plan, other than one available through his or her parent’s employer.

(3) A covered employee’s Dependent Child age 26 or older, who is unable to be self supporting by reason of mental or physical handicap and is incapacitated, provided the child suffered such incapacity prior to the end of the month in which he/she attained age 26. The child must be unmarried, primarily dependent upon the covered employee for support, and not eligible for any other type of health coverage (other than Medicaid or Medicare).

The Plan Sponsor may require subsequent proof of the child's disability and dependency, including a Physician's statement certifying the child's physical or mental incapacity.

(4) A child for whom the covered employee is required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Sponsor at no cost.

The term "Spouse" shall mean the person of the opposite sex recognized as the covered employee's husband or wife under the laws of the state where the covered employee lives. The Plan Sponsor may require documentation proving a legal marital relationship.

The term "Dependent Child" shall mean a covered employee's natural born son, daughter, stepson, stepdaughter, legally adopted child (or a child placed with the covered employee in anticipation of adoption), eligible foster child, or a child for whom the covered employee is legal guardian (coverage for an eligible foster child or a child for whom the Employee is legal guardian will remain in effect until such child no longer meets the age requirements of an eligible dependent under the terms of the Plan, regardless of whether or not such child has attained age 18, or any other applicable age of emancipation of minors).

For purposes of this section, the following terms shall have the following meanings:

"eligible foster child" means an individual who is placed with the covered employee by an authorized placement agency.

"legal guardian" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree, or other order of any court of competent jurisdiction.

An unmarried grandchild shall also be considered an eligible Dependent Child; provided the employee provides more than ½ of such child's support and resides with the employee for more than ½ of the calendar year.

The Plan Sponsor may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

The following are excluded as dependents: any Spouse 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 the Plan changes status from employee to dependent or dependent to employee, and the person is covered continuously under the Plan, during and after the change in status, credit will be given toward deductibles and all amounts applied to Plan maximums.

If both mother and father are employees of the Employer, their children will be covered as dependents of the mother or father, but not of both.

Effective Date of Dependent Coverage. Dependent coverage is effective on the day that the Eligibility Requirements are met; the employee is covered under the Plan; and all enrollment requirements are met. In the case of a Special Enrollment Situation or Status Change, coverage will be effective on the date of the event, provided the enrollment application is received within 31 days of the event.

PRE-EXISTING CONDITIONS – Does not apply to Covered Persons under age 19

NOTE: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if a Covered Person has Creditable Coverage from another health plan.

A Covered Person may request a certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage.

After Creditable Coverage has been taken into account, and the Plan has determined that a Pre-Existing Conditions Limitation applies to a Covered Person, the Covered Person will be notified by the earliest date that the plan, acting in a reasonable and prompt fashion, can provide the notice.

Except as otherwise provided in the Plan, covered charges incurred under Medical Benefits for Illnesses or Injuries that are determined to be Pre-Existing Conditions are excluded for the first 12 consecutive months after the Covered Person's Enrollment Date.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within 6 months prior to the Covered Person's Enrollment Date under the Plan.

The Pre-Existing Condition exclusion of the Plan does not apply to Pregnancy, or to a Covered Person under age 19.

All questions about the Pre-Existing Condition Limitation and Creditable Coverage provisions should be directed to the Plan Sponsor at: 507-282-6715.

ENROLLMENT

Enrollment Requirements. An employee must enroll for coverage by completing, signing and timely submitting an enrollment application along with the appropriate payroll deduction authorization. If the employee wishes to enroll eligible dependents, the enrollment application and payroll deduction authorization must include dependent information.

Enrollment Requirements for Newborn Children. A newborn child must be enrolled as a dependent under the Plan within 31 days of the child's birth in order for coverage to take effect from the date of birth.

If the child is not enrolled within 31 days of birth, the child may only enroll during the annual open enrollment period. The enrollment will be considered a Late Enrollment.

TIMELY INITIAL ENROLLMENT

Initial enrollment is considered "timely" if the completed enrollment form is received by the Plan Sponsor no later than 31 days after the person becomes eligible for coverage under the Plan, initially, under a Special Enrollment Situation or during the annual open enrollment.

When two employees (husband and wife) are covered under the Plan and the employee covering the dependent children is no longer eligible for coverage under the Plan, dependent coverage may continue under the other Covered employee with no waiting period. However, coverage must be continuous from one employee to the other.

SPECIAL ENROLLMENT SITUATION/STATUS CHANGE

An employee or dependent may be eligible to enroll for coverage under the Plan during a Special Enrollment Period. There are two types of Special Enrollment Periods, as described below. For either type of Special Enrollment, an employee who has a Special Enrollment Right (for the employee or one or more dependents) may elect coverage under any Plan option that is available to an employee during an initial enrollment opportunity, as long as the employee (or dependent) is otherwise eligible for that Plan option.

(1) **Special Enrollment Rights Because of Loss of Other Coverage.** An employee or dependent is eligible for coverage under the Plan, but chose not to enroll in the Plan, because he or she was covered at the time coverage under the Plan was previously offered may enroll later if one of the following conditions is met:

(a) The other coverage was not COBRA coverage and that coverage terminates because of a Loss of Eligibility, (as described below);

(b) The other coverage was not COBRA coverage and an employer’s contributions towards the coverage cease; or

(c) The coverage of the employee or dependent was under COBRA and the COBRA coverage is exhausted.

A “Loss of Eligibility” includes a loss of eligibility because of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment or a reduction in the number of hours of employment. A Loss of Eligibility also occurs if the other coverage is provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, if the employee or dependent no longer lives or works in the applicable services area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected employee or dependent). “Exhaustion of COBRA coverage” occurs when COBRA coverage ceases for any reason other than a failure of the employee or dependent to pay premiums on a timely basis or for cause. Exhaustion of COBRA coverage occurs when COBRA coverage ceases because an employer or other responsible party fails to remit premiums on a timely basis. For COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, exhaustion of COBRA coverage also occurs if coverage ceases because the employee or dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available). In addition, exhaustion of COBRA coverage occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits and no other COBRA coverage is available to the individual.

The Plan Sponsor may require the employee to state in writing at the time coverage is offered that other health coverage was the reason for declining enrollment in the Plan (for the employee or a dependent). If the Plan Sponsor imposes such a requirement and informs the employee of the requirement, the employee or dependent will not be eligible for Special Enrollment based on the loss of coverage unless the employee provided the required statement at the time coverage was declined.

The employee or dependent must request enrollment in the Plan during the Special Enrollment Period, which ends 31 days (1) the other coverage terminates, (2) employer contribution's cease, or (3) COBRA coverage is exhausted, whichever applies. Coverage will be effective no later than the first day of the first month that begins after the Plan Sponsor receives a completed request for enrollment..

An individual does not have a Special Enrollment Right if the employee or dependent loses other coverage because of a failure to pay premiums or required contributions or if the other coverage is terminated for cause (such as for making a fraudulent claim).

(2) Special Enrollment Rights Because of Marriage, Birth or Adoption.

(a) An otherwise eligible employee (i.e., an employee who is not a current participant but who has completed any waiting period and any other eligibility requirements under the Plan) may enroll himself or herself in the Plan during the Special Enrollment Period described below if an individual becomes a dependent of the employee through marriage, birth, adoption or placement for adoption.

(b) An active Participant may enroll an individual who becomes or is his or her spouse (determined under federal law) during the Special Enrollment Period described below if either (1) the individual becomes the Participant’s spouse or (2) the individual is the Participant’s spouse and a child becomes a dependent of the Participant through birth, adoption or placement for adoption.

(c) An otherwise eligible employee may elect to enroll in the Plan the employee and an individual who becomes or is his or her spouse (determined under federal law) during the Special Enrollment Period described below if (1) the employee and the individual become married or (2) the employee and the individual already are married and a child becomes a dependent of the employee through birth, adoption or placement for adoption.

(d) An active Participant may enroll an individual in the Plan during the Special Enrollment Period described below if the individual becomes a dependent of the Participant through marriage, birth, adoption or placement for adoption.

(e) An otherwise eligible employee may elect to enroll the employee and an individual who becomes a dependent of the employee (including the employee’s spouse) in the Plan, if the individual becomes a dependent of the employee through marriage, birth, adoption or placement for adoption.

For purposes of paragraphs (a) through (e) above, “marriage” is limited to marriages that are recognized for purposes of federal law.

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

Coverage for an employee or dependent who enrolls in the Plan because of a marriage, birth or adoption Special Enrollment Right will be effective:

(a) In the case of marriage, no later than the first day of the first month beginning after the date the Plan Sponsor receives a completed request for enrollment electing coverage for the employee or dependent, if the completed request for enrollment is submitted within 31 days after the marriage;

(b) In the case of a dependent's birth, on the date of birth if the completed request for enrollment is submitted within 31 days of the birth; or

(c) In the case of a dependent's adoption or placement for adoption, on the date of the adoption or placement for adoption if the completed request for enrollment is submitted within 31 days of the date of the adoption or placement for adoption.

(3) **Change in Status.** An employee or dependent may also enroll in the Plan as a result of an election that is permitted by LTX, Incorporated Section 125 plan, if any, because of a change in status.

(4) **Dependents Residing Outside the United States of America.** If an otherwise eligible dependent is not enrolled in the Plan because he or she does not reside in the United States, the employee is permitted to enroll the dependent in the Plan. Coverage will be effective on the date of relocation, provided the request for enrollment in the Plan is received within 31 days after the dependent relocates to the United States of America. This rule does not apply to coverage provided through a Section 125 plan. For coverage provided through a Section 125 Plan, the employee will be able to enroll the dependent under these circumstances only if a Special Enrollment Right applies or a Change in Status election is permitted under the terms of the Section 125 Plan.

(5) **Special Enrollment Due to Coverage Under Medicaid or Under a State Children’s Health Insurance Program (CHIP)**

If an employee or eligible dependent did not enroll in the Plan when initially eligible, but was otherwise eligible to enroll, they will be permitted to later enroll in the Plan under one of the following circumstances:

(a) The employee or eligible dependent was covered under Medicaid or CHIP at the time of initial enrollment and such coverage subsequently terminates; or

(b) The employee or eligible dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP subsequent to the time they were initially eligible.

The employee or dependent must request enrollment in the Plan within sixty (60) days after coverage under Medicaid or CHIP terminates or within sixty (60) days after their eligibility for a premium assistance subsidy under Medicaid or CHIP is determined, whichever is applicable.

ACQUISITIONS

All Eligible Employees (including any Eligible Dependents) acquired through a contract with LTX, Incorporated are hereby eligible for coverage under this Plan effective on the date of the contract. The waiting period and the Pre-Existing Condition Limitation will be waived provided they were covered under the Employer-sponsored plan which is immediately replaced by this Plan. All other provisions of this Plan will apply.

Any deductible amounts satisfied with the Employer-sponsored plan immediately replaced by this Plan will be credited toward satisfaction of this Plan's deductible requirements.

ANNUAL ENROLLMENT PERIOD

Plan Participants will receive information regarding the annual re-enrollment period from the Employer.

OPEN ENROLLMENT

During the open enrollment period, established by the Plan Sponsor, eligible employees and their eligible dependents who are not currently enrolled in the Plan will be allowed to enroll in the Plan. However, all enrollment applications must be received prior to the open enrollment effective date.

Benefit choices made during the open enrollment period will become effective January 1st and remain in effect until the next January 1st unless the employee experiences a Special Enrollment Situation or Status Change (refer to Special Enrollment Situation/Status Change subsection).

TERMINATION OF COVERAGE AND EXTENSION OF COVERAGE PROVISIONS

When Employee Coverage Terminates. Employee coverage terminates on the earliest of the following dates:

(1) The date all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Employer.

(2) The date the covered employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered employee.

(3) The date the employee reports to active military service.

(4) The beginning of the period for which a required contribution has not been paid.

(5) The date the employee (or any person seeking coverage on behalf of the employee) performs an act, practice, or omission that constitutes fraud.

(6) The date the employee (or any person seeking coverage on behalf of the employee) makes an intentional misrepresentation of a material fact.

Continuation During Periods of Disability, Personal Leave of Absence or Layoff. A covered employee may remain eligible if Active, full-time work ceases due to a Disability which is certified by a Physician, personal leave of absence or layoff. Continuance of coverage will end as follows:

For Disability leave: The end of the 6 months that follows the date on which the covered employee last worked as an Active Employee. Disability leave is concurrent with the Family and Medical Leave (as defined by the Family Medical Leave Act of 1993 (FMLA).

For personal leave of absence: The end of the 6 months that follows the date in which the covered employee last worked as an Active Employee.

Layoff: The end of the 6 months that follows the date on which the covered employee last worked as an Active Employee.

Continuation of coverage will be coverage which was in force on the last day the covered employee worked as an Active Employee. However, if benefits reduce for Active Employees in the same eligible class, benefits will also reduce for the continued person.

Continuation During Family and Medical Leave (FMLA)

During any leave taken under the Family and Medical Leave Act, the employee may maintain coverage under the Plan on the same conditions as coverage would have been provided if the covered employee had been continuously employed during the leave period.

If the employee fails to return to work after the Family and Medical Leave Act, the Employer has the right to recover its contributions toward the cost of coverage during the Family and Medical Leave Act.

If coverage under the Plan terminates during the Family and Medical Leave Act, coverage will be reinstated for the employee and his or her covered dependents if the employee returns to work at the end of the Family and Medical Leave Act.

Rehiring a Terminated Employee. If an employee who was previously covered by this Plan is re-hired within 6 months after termination of employment, coverage will become effective on the date of re-employment and the waiting period will be waived. However, the Pre-Existing Conditions limitation and Creditable Coverage provisions will apply to Covered Persons under age 19.

If an employee who was previously covered by this Plan is re-hired more than 6 months after termination of employment, the employee will be considered a new employee and will be subject to all provisions of this Plan.

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 that were covered under the Plan at the time of leaving for military service.

(1) The maximum period of coverage of an employee and the employee's dependents under such an election shall be the lesser of:

(a) The 24 month period beginning the date on which the employee's absence begins; or

(b) The period beginning on the day the employee's military service absence begins and ending on the day after the date on which the employee returns to employment with the employer or fails to apply for or return to a position of employment with the Employer within the time limit that applies under USERRA.

(2) An employee who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except an employee on active duty for 31 days or less cannot be required to pay more than the employee's share, if any, for the coverage.

(3) Continuation coverage provided under USERRA counts as COBRA continuation coverage as long as the notice requirements of COBRA are satisfied in connection with the USERRA leave.

(4) An employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the employee resumes employment within the time limit that applies under USERRA. No waiting period or pre-existing condition exclusionary period will apply to an employee returning from USERRA leave (within the applicable time period) unless the waiting period or exclusionary period would have applied to the employee if the employee had remained continuously employed during the period of military leave.

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 enroll, see the section entitled COBRA Continuation Options):

(1) The date all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Employer.

(2) The date that the employee's coverage under the Plan terminates for any reason including death.

(3) The date the dependent reports to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained in the employees on Military Leave provision of the Plan.

(4) The date a covered Spouse ceases to be a dependent.

(5) The date the Spouse reports to active military service.

(4) On the date a Dependent Child ceases to be a dependent as defined by the Plan.

(6) The first day of the period for which the required contribution has not been paid.

(7) The date the dependent (or any person seeking coverage on behalf of the dependent) performs an act, practice, or omission that constitutes fraud.

(8) The date the dependent (or any person seeking coverage on behalf of the dependent) makes an intentional misrepresentation of a material fact.

Retroactive Termination of Coverage

Except in cases where an employee or other Covered Person fails to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan for any Covered Person unless the Covered Person (or a person seeking coverage on behalf of that person) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least thirty days advance written notice to each Participant or Dependent who would be affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

MEDICAL MANAGEMENT PROGRAM

Medical Management Phone Number

Meritain Health Medical Management at 800-242-1199

The Covered Person or a family member must call this number to receive certification of certain health care services. This call must be made at least 5 days in advance of services being rendered or within 48 hours after an admission due to a Medical Emergency.

Penalties for failure to follow Medical Management procedures will not accrue toward the out-of-pocket maximum.

MEDICAL MANAGEMENT

Medical Management is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

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

Hospitalizations
Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility stays
Inpatient Substance Use Disorder/Mental Disorder treatments
Inpatient Surgical Procedure

(2) Retrospective review of Medical Necessity of the listed services;

(3) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(4) Certification of services and planning for discharge from a Medical Care Facility.

This program is not intended to diagnose or treat medical conditions, guarantee benefits, validate eligibility or to be a substitute for the medical judgment of the attending Physician or other health care provider.

The Covered Person will not be required to obtain precertification from the Plan for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, the following provisions should be read carefully.

PRECERTIFICATION

Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives the other listed medical services, Medical Management will, in conjunction with the attending Physician, be required to certify the care as Medically Necessary. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

Medical Management is set in motion by a telephone call from the Covered Person or a family member. Meritain Health Medical Management must be called, **at least 5 days before** the listed medical services are scheduled to be rendered, with the following information:

- The name of the Covered Person and relationship to the covered employee
- The name, Social Security number and address of the covered employee
- The name of the Employer
- The name and telephone number of the attending Physician

- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery

If there is a Medical Emergency admission to the Medical Care Facility, the Covered Person, a family member, Medical Care Facility or attending Physician must contact Meritain Health Medical Management **within 48 hours** of the first business day after the admission.

Medical Management will determine the number of days of Medical Care Facility confinement or use of other listed medical services that is Medically Necessary. When the required review procedures outlined above are followed, benefits will be unaffected, and the Plan Participant and the Plan avoid expenses related to unnecessary health care.

FAILURE TO FOLLOW REQUIRED REVIEW PROCEDURES

A retrospective review is conducted by the Meritain Health Medical Management program to determine if the services provided without the Covered Person following the procedures met all other Plan provisions and requirements.

If the review concludes that the services were Medically Necessary and would have been approved had the required phone call been made, benefits will then be reduced by 20% to a maximum reduction of $1,000%. However, any charges not deemed Medically Necessary will be denied.

The amount the Covered Person pays when Meritain Health Medical Management review procedures are not followed does not apply to the Plan's out-of-pocket maximum.

CONCURRENT REVIEW, DISCHARGE PLANNING

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are part of Medical Management. Medical Management will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time that was initially precertified, the attending Physician must request the additional services or days.

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) Performed on an outpatient basis within seven days of a Hospital confinement;
(2) Related to the condition which causes the confinement; and
(3) Tests performed in an outpatient setting instead of diagnostic tests performed while Hospital confined.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. The plan of care may include some or all of the following:

-- personal support to the patient;
-- contacting the family to offer assistance and support;
-- monitoring Hospital, Skilled Nursing Facility, extended care facility or rehabilitation facility;
-- determining alternative care options; and
-- assisting in obtaining any necessary equipment and services.

Once agreement has been reached, the Plan will reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient chooses not to participate.

Examples of Illnesses or Injuries that would be appropriate for Case Management include, but are not limited to:

- Terminal Illnesses
  - Cancer
  - AIDS
- Chronic Illnesses
  - Multiple Sclerosis
  - Renal Failure
  - Obstructive Pulmonary Disease
  - Cardiac Conditions
- Accident Victims Requiring Long-Term Rehabilitative Therapy
- Newborns with High Risk Complications or Multiple Birth Defects
- Diagnosis Involving Long-Term IV Therapy
- Illnesses Not Responding to Medical Care

HEALTHY MERITS[sm]

Healthy Merits[sm] is aimed at reducing the health risks of certain participants. These participants have been identified via health risk assessments or on-site wellness programs as individuals that may be in need of assistance based on information collected. Wellness involves making guided, personal changes toward a healthier lifestyle. Healthy Merits[sm] supports employees and their families by giving them the tools and personal support they need to make these changes.

Wellness Management

Managed Metrics begins with voluntary on-site member health assessments including blood chemistry profiles, blood pressure and cholesterol levels, body mass index, health risk assessment and coronary risk analysis.

Disease Management

This program seeks to manage a Covered Person's chronic health-conditions that have the potential for complications and high-dollar costs. Through the Disease Management Program, personalized care plans are developed for individual members based on their own health information and identified risks.

Educational Tools and Resources

Tools and resources are offered to members to help the Covered Person better comprehend their health conditions and understand how to lessen their chances of developing costly, life threatening Illnesses.

MEDICAL BENEFITS

The following is a description of the medical benefits provided under the Plan. The Plan provides benefits only with respect to covered services and supplies which are Medically Necessary in the specific treatment of a covered Illness or Injury, unless specifically mentioned otherwise in Covered Medical Expenses.

DEDUCTIBLE

Three Month Deductible Carryover. Covered charges incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next calendar year.

Deductible for a Common Accident. This provision applies when two or more Covered Persons in a Family are injured in the same accident.

These Covered Persons will not be required to satisfy separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the calendar year in which the accident occurred will be required as a unit for charges arising from the accident.

BENEFIT PAYMENT

Each calendar year, except as otherwise provided in the Plan, benefits will be paid for covered charges of a Covered Person that are in excess of the deductible, but less than the Usual and Customary Amount, if applicable. Payment will be made at the percentages shown as the reimbursement percentage in the Schedule of Benefits.

MAXIMUM BENEFIT AMOUNT

The maximum benefit amount is shown in the Schedule of Medical Benefits. The maximum benefit amount is the total amount of benefits that will be paid under the Plan for all covered charges incurred by a Covered Person.

COVERED MEDICAL EXPENSES

Covered charges are the Usual and Customary Charges, where applicable, incurred for the following services and supplies:

A charge is considered incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care**. Covered medical services and covered supplies furnished by a Hospital or Ambulatory Surgical Center. Covered Hospital charges will be payable as shown in the Schedule of Medical Benefits. This benefit includes Hospital expenses for covered dental services if the attending Physician certifies that care in a Hospital is Medically Necessary to safeguard the health of the patient.

Room and board, including non-routine nursery care, not to exceed the cost of a semiprivate room or other accommodations if the attending Physician certifies Medical Necessity. If a private room is the only accommodation available, the Plan will cover an amount equal to the prevailing semiprivate room rate in that facility.

Charges for an Intensive Care Unit (ICU) and Coronary Care Unit (CCU) stay are payable as described in the Schedule of Medical Benefits and based on the Hospital's ICU or CCU charge.

(2) **Pregnancy.** The care and treatment of a Pregnancy is covered the same as any other Illness for all Covered Persons. This benefit includes services and supplies furnished by a Birthing Center, as shown in the Schedule of Medical Benefits.

The Plan 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 Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

The Plan covers one home health care visit within 4 days of discharge from the Hospital if either the mother or the newborn child is confined for a period less than the 48 hours (96) hours mentioned above. This limit is not applied to the maximum visit limit for Home Health Care.

(3) **Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility Admissions**. The room and board and nursing care furnished by a Skilled Nursing Facility, extended care facility and rehabilitation facility will be payable when approved by Medical Management, as outlined in the Schedule of Medical Benefits. In order to be eligible, the following must occur:

(a) The Covered Person is confined as a bed patient in the facility;
(b) Admitted within 30 days after a Hospital admission of at least 3 consecutive days for the same Illness;
(c) The attending Physician certifies that confinement is needed for further care of the condition that caused the Hospital confinement; and
(d) The attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility, extended care facility or rehabilitation facility.

Covered charges for a Covered Person's care in these facilities are limited to the facility's semiprivate room rate.

(4) **Physician Care.** Inpatient, outpatient, office or home professional services of a Physician for surgical or medical services to treat an Illness or Injury will be payable as shown in the Schedule of Medical Benefits. Inpatient care includes services by an attending Physician or non-attending Physician. This benefit also includes the following:

(a) Testing and treatment of Attention Deficit Disorder (ADD) and/or Attention Deficit Hyperactivity Disorder (ADHD).

(b) Second surgical opinion (and/or second medical opinion) and necessary third surgical/medical opinions.

(c) E-Visits.

(d) Multiple surgical procedures, subject to the following provisions:

Two (2) or more surgical procedures performed during the same session through the same incision, natural body orifice or operative field. The amount eligible for consideration is the Usual and Customary charge for the largest amount billed for one procedure plus 50% of the sum of Usual and Customary charges for all other procedures performed; or

Two (2) or more surgical procedures performed during the same session through different incisions, natural body orifices or operative fields. The amount eligible for consideration is the Usual and Customary charge for the largest amount billed for one procedure plus 50% of the sum of Usual and Customary charges billed for all other procedures performed.

(e) Assistant Surgeon, if required. The Assistant Surgeon's covered charge will not exceed 25% of the surgeon's Usual and Customary allowance, if applicable.

(5) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be supported by a certification and a treatment plan from the attending Physician.

Benefit payment for Home Health Care services is subject to the Home Health Care limit, (up to 4 hours equal one visit), as outlined in the Schedule of Medical Benefits.

(6) **Hospice Care Services and Supplies.** Covered 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 Covered Person is not expected to live more than 6 months and has placed the Covered Person under a Hospice Care Plan and only as outlined in the Schedule of Medical Benefits. A Hospice Care Plan primarily provides palliative, supportive, respite, and other related care. Respite care is limited to not more than 5 consecutive days at a time up to a maximum of 15 days during the episode of Hospice Care.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's covered Spouse and/or covered dependent children.

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

(a) **Allergy services** includes allergy testing, preparation of serum and allergy injections as outlined in the Schedule of Medical Benefits.

(b) **Ambulance transportation** provided by a professional ambulance service for local land or air transportation for a Medical Emergency will be payable as shown in the Schedule of Medical Benefits. A charge for this service will be considered a covered charge only if the service is to the nearest Hospital or emergency care facility where necessary treatment can be provided. Benefits are also provided for transportation from one Medical Care Facility to another, when Medically Necessary.

(c) **Amniocentesis** only when the attending Physician certifies that the procedure is Medically Necessary and limited to one per Pregnancy.

(d) **Anesthetic services** when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a covered surgical procedure.

(e) **Blood** and blood derivatives that are not donated or replaced. Administration of these services is also considered an eligible expense.

(f) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered under the supervision of a Physician and in a Medical Care Facility as defined by the Plan.

(g) **Chemotherapy and radiation treatment** with radioactive substances. The materials and services of technicians are included.

(h) **Circumcision**.

(i) **Contact lenses,** eyeglasses, eye examinations, professional fees for fitting of the lenses, vision therapy and orthoptics are covered for diagnosis and treatment of an Illness or Injury. Contact lenses or eyeglasses are also covered when needed to replace the human lens lost due to cataract surgery and other intraocular surgeries. Benefits for contact lenses or eyeglasses are limited to the initial prescription only.

(j) **Diabetes outpatient self-management training** and education, including medical nutrition therapy.

(k) **Durable Medical Equipment**, including oxygen and oxygen equipment, if deemed Medically Necessary will be payable as shown in the Schedule of Medical Benefits. A statement is required from the prescribing Physician describing how long the equipment is expected to be Medically Necessary. This statement will determine whether the equipment will be rented or purchased. Benefits are limited to the fair market value of the equipment at the time of purchase. If the equipment is purchased, benefits include expenses related to necessary repairs and maintenance. Initial replacement equipment will be covered if the replacement equipment is required due to a change in the Covered Person's physical condition; or, purchase of new equipment will be less expensive than repair of existing equipment.

(l) **Foot treatment.** Treatment for the following foot conditions: (a) weak, unstable or flat feet; (b) bunions, when an open cutting operation is performed; (c) non-routine treatment of corns or calluses; (d) toenails when at least part of the nail root is removed; (e) any Medically Necessary surgical procedure required for a foot condition; or (f) initial purchase, fitting and repair of foot orthotics, orthopedic or corrective shoes, and supportive appliances for the feet when determined to be Medically Necessary by the attending Physician.

(m) **Hearing examinations**, hearing aids, or related supplies, only when loss of hearing is due to a covered Illness or Injury other than Sensorineural hearing loss. Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other procedures (maximum of one hearing aid per ear every 3 years). Routine hearing exams are covered under the Preventive Care benefit.

(n) **Home infusion therapy** when ordered by a Physician and includes the following:

(i) Solutions and pharmaceutical additives, pharmacy compounding and dispensing services.
(ii) Durable Medical Equipment.
(iii) Ancillary medical supplies.
(iv) Nursing services to: (a) train you or your caregiver; or (b) monitor your home infusion therapy.
(v) Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy.
(vi) Other eligible home health services and supplies provided during the course of home infusion therapy.

Not covered. There is no coverage for nursing services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer therapy. Services that do not involve direct patient contact, such as delivery charges and recordkeeping.

(o) Medically Necessary services for care and treatment of **jaw joint conditions,** including Temporomandibular Joint Syndrome (TMJ), craniomandibular disorder and other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other related to that joint, including surgical and non-surgical treatment for or prevention thereof, will be payable as shown in the Schedule of Medical Benefits.

(p) **Kidney dialysis.**

(q) Diagnostic **laboratory studies** will be payable as shown in the Schedule of Medical Benefits.

(r) **Mental Disorders and Substance Use Disorders**. Care, supplies, treatment and emergency care of Mental Disorders and Substance Use Disorders will be payable as shown in the Schedule of Medical Benefits.

Smoking cessation programs. Smoking deterrents are covered under the Prescription Drug Benefits section.

(s) Surgical treatment of **Morbid Obesity**, limited to one surgical procedure per Lifetime. Non-surgical treatment of Morbid Obesity is not covered.

(t) 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:

(i) Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth.
(ii) Repair and related x-rays due to Injury to sound natural teeth. This repair must be made within 12 months from the date of the Injury.
(iii) Surgery needed to correct Injuries to the jaw, cheeks, lips, tongue, floor and roof of the mouth.
(iv) Surgery needed to correct frenulum or frenum, cleft lip and palate. Benefit includes necessary orthodontic services.
(v) Excision of benign bony growths of the jaw and hard palate.
(vi) External incision and drainage of cellulitis.
(vii) Incision of sensory sinuses, salivary glands or ducts.
(viii) Removal of impacted teeth.
(ix) Medical and dental treatment of cleft lip and palate for a dependent child up to age 19 (including orthodontia).
(x) Anesthesia and Hospital charges for dental care provided to: (a) a covered child under age 5; (b) a Covered Person who is severly disabled; or (c) a Covered Person who has a medical condition that requires hospitalization or general anesthesia for dental treatment.

Charges will not be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, unless otherwise specified, dental services to treat an Injury from biting or chewing, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(u) **Nutritional supplements**. Physician prescribed nutritional supplements or other enteral supplementation necessary to sustain life, including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) when prescribed by a Physician.

Amino acid-based elemental formula for patients with the following conditions: (i) cystic fibrosis; (ii) amino acid, organic acid and fatty acid metabolic and malabsorption disorders; (iii) IgE – medicated allergies to food proteins, limited to patients 5 years of age and under; (iv) food protein – induced enterocolitis syndrome; (v) eosinophilic esophagitis; (vi) eosinophilic gastroenteritis; (vii) eosinophilic colitis.

No coverage is provided for solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding, or as provided above.

(v) **Occupational therapy** by a licensed occupational therapist will be payable as shown in the Schedule of Medical Benefits. Therapy must be ordered by a Physician to restore body function lost due to an Injury, Illness or surgery. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(w) **Organ transplant** expenses.

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: (i) evaluating the organ or tissue; (ii) removing the organ or tissue from the donor.

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

(x) **Orthotics** that are the original fitting, adjustment and placement of appliances such as braces, casts, splints, crutches, cervical collars, head halters, or other appliances to aid in their function when impaired will be payable as shown in the Schedule of Medical Benefits. Replacement of such devices is only covered if the replacement is necessary due to a change in the physical condition of the Covered Person. This benefit includes expenses for penile implants when necessary due to a covered Illness or Injury.

(y) **Palliative care.** Outpatient palliative care for Covered Persons with a new or established diagnosis of a progressive, debilitating Illness which may limit the Covered Person's life expectancy to 2 years or less. The services must be in the scope of the provider's license to be covered. Palliative care does not include Hospice or respite care.

(z) **Physical therapy** provided by a licensed physical therapist will be payable as shown in the Schedule of Medical Benefits. Therapy must be in accord with a Physician's exact orders as to the type, frequency and duration of therapy and for conditions which are subject to significant improvement through short-term therapy. Eligible expenses do not include maintenance therapy.

(aa) **Pre-admission and pre-surgical testing** within 7 days of a scheduled inpatient Hospital admission, as outlined in the Schedule of Medical Benefits.

(bb) **Prescription Drugs,** medicines or supplies dispensed through the Physician's office, and take-home prescription drugs from a Hospital, for which the patient is charged, are covered under the Medical Benefits section of the Plan, as outlined in the Schedule of Medical Benefits and not under the Prescription Drug Program Benefits.

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

(dd) The initial purchase, fitting and repair of fitted **prosthetic devices**, artificial limbs and artificial eyes, which replace body parts will be payable as shown in the Schedule of Medical Benefits. Replacement of such devices is only covered if the replacement is necessary due to a change in the physical condition of the Covered Person, or, replacement is less expensive than repair of the existing device.

(ee) **Reconstructive surgery.** Correction of abnormal congenital conditions, birth abnormalities resulting in the malformation or absence of a body part, or conditions caused by an accidental Injury or covered Illness, or elimination or maximum feasible treatment of port wine stains.

Reconstructive mammoplasties will also be considered covered charges. Mammoplasty benefits will include reimbursement for:

(i) Reconstruction of the breast on which a mastectomy has been performed,
(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
(iii) Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

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

(ff) **Repiratory therapy.**

(gg) **Sleep disorders.** Care, treatment, services and supplies for sleep disorders.

(hh) **Speech therapy** provided by a licensed speech therapist will be payable as shown in the Schedule of Medical Benefits. 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 Covered Person; (ii) an Injury; or (iii) an Illness.

(ii) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or a D.C. Eligible expenses do not include maintenance treatment. Benefits are limited as outlined on the Schedule of Medical Benefits.

(jj) **Sterilization** procedures.

(kk) **Supplies** such as surgical dressings and other medical supplies, but limited as follows:

(i) Insulin infusion pumps, limited to one in every 5 years, and related supplies; and
(ii) Jobst/compression garments, limited to 4 per year.

(ll) **Well Newborn Nursery/Physician Care Charges**.

Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room and board charges and other normal routine care.

This coverage is only provided if the newborn is properly enrolled.

Physician Care. Benefits are limited to charges incurred by a newborn child while the newborn child is Hospital confined as a result of the child's birth, including circumcision.

(mm) Diagnostic **x-rays**, including ultrasounds only if the attending Physician certifies that the procedure is Medically Necessary, will be payable as shown in the Schedule of Medical Benefits.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs Benefits are shown in the Prescription Drug Program section.

Note: All exclusions related to Vision Benefits are shown in the Vision Plan section.

For all Medical Benefits shown in the Schedule of Medical Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an elective abortion. This exclusion does not apply to terminated pregnancies, This exclusion does not apply to terminated pregnancies, including those for covered dependent daughters, when the life of the mother is endangered by the continued Pregnancy, in the case of fetal abnormality, or when the Pregnancy is the result of documented rape or incest. If complications arise after the performance of any abortion, any expenses incurred to treat those complications will be eligible, whether the abortion was eligible or not.

(2) **Acupuncture**, except for the treatment of chronic pain when treatment is provided through a comprehensive pain management program or for the prevention and treatment of nausea associated with surgery, chemotherapy or Pregnancy.

(3) **Administrative costs.** Administrative costs of completing claim forms, itemized bills, medical reports or for providing records, mailing and/or shipping expenses, expenses for broken appointments or expenses for telephone calls.

(4) **Adoption expenses.**

(5) **Artificial heart or other organ.** Artificial heart or other organ and any expenses related to its insertion or maintenance.

(6) **Autopsies.**

(7) **Blood pressure monitoring devices.**

(8) **Child-birth classes.**

(9) **Communication devices**, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.

(10) **Complications of non-covered surgery or treatment.** Care, services or treatment required as a result of complications from any non-covered surgery or treatment if the complications occur within 12 months of the non-covered surgery or treatment.

(11) **Cosmetic.** Services and supplies which are considered Cosmetic. Repair of scars and blemishes on skin surfaces.

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

(13) **Developmental delay services**, except when Medically Necessary and provided by an eligible health care provider.

(14) **Diagnostic testing.** Admission for diagnostic tests that can be performed on an outpatient basis.

(15) **Educational or vocational testing.** Services for educational or vocational testing, training, care for learning disorders or behavioral problems whether or not services are rendered in a facility that also provides medical and/or Mental Disorder treatment, except as specified in Covered Medical Benefits. Physical, occupational, and speech therapy services for or related to learning disabilities and disorders, except when Medically Necessary and provided by an eligible health care provider.

(16) **Excess charges.** Expenses in excess of the Usual and Customary Charge.

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

(18) **Experimental and/or Investigational.** Expenses for treatment, procedures, devices, drugs or medicines which are determined to be Experimental and/or Investigational; clinical trials (except as specified); research or studies; or for any services or supplies that are not considered legal in the United States of America.

(19) **Eye surgery.** Radial keratotomy or other eye surgery to correct refractive disorders, except as specified under Covered Medical Expenses.

(20) **Fetal tissue transplantation.**

(21) **Foot care.** Treatment of routine foot care, unless needed because of a metabolic or peripheral-vascular disease.

(22) **Genetic testing** of genetic information and counseling. Gene therapy as a treatment for inherited or acquired disorders.

(23) **Governmental agency**. Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

(24) **Growth hormone**. Services for or related to growth hormone, except that replacement therapy is eligible for conditions that meet Medical Necessity criteria as determined by the Claims Processor prior to receipt of the services.

(25) **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.

(26) **Hearing aids.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be listed as covered under Covered Medical Expenses.

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

(28) **Injections.** Charges for injections which can be self-administered.

(29) **Illegal act.** Expenses which are incurred while a Covered Person is engaged in an act that is illegal under federal or state law, or as a result of their illegal act, including but not limited to, participation in a riot or other act of civil disobedience, driving while intoxicated or commission of felonies or misdemeanors. This exclusion will not apply to injuries and/or illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(30) **Impotence.** Care, treatment, services or supplies in connection with treatment for impotence.

(31) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization. Impregnation procedures, such as but not limited to artificial insemination, in-vitro fertilization, embryo and fetal implantation and G.I.F.T. (gamete intrafallopian transfer) are also excluded.

(32) **Internet communications**. internet or similar network communications for the purpose of: scheduling medical appointments; refilling or renewing existing prescription medications; reporting normal medical test results; providing education materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for an onsite medical office visit.

(33) **Medical records**. Charges for furnishing medical records or reports.

(34) **Medically Necessary.** Expenses for goods or services, not Medically Necessary.

(35) **Modifications** to home, vehicle, and/or the workplace, including vehicle lifts and ramps.

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

(37) **Non-emergency Hospital admissions on Friday/Saturday.** Care, treatment and services 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.

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

(39) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; and care, 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 Illness.

(40) **Not covered.** Expenses for services provided to an individual who was not a Covered Person at the time such services were rendered, regardless of when it is discovered that the individual was not a Covered Person.

(41) **Not specified as covered.** Non-traditional services, treatments and supplies which are not specified as covered under the Plan, such as, but not limited to holistic, rolfing, hypnosis, homeopathic, biofeedback and naturopathic services.

(42) **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 Illness. Refer to Covered Medical Expenses for Plan provisions regarding care and treatment of Morbid Obesity.

(43) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, television, telephone, guest meals, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings (except as specified), nonprescription drugs and medicines, first-aid supplies, non-hospital adjustable beds, heating pads, hot water bottles, waterbeds, hot tubs, swimming pools, or any other equipment that could be used in the absence of an Illness or Injury.

(44) **Plan exclusions.** Charges excluded by the Plan as noted in this document.

(45) **Private duty nursing.** Services for or related to private duty nursing, except as specified under the Home Health Care and Hospice Care benefits.

(46) **Recreational therapy.** Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages) or educational therapy (defined as special education classes, tutoring, and other non medical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including, but not limited to, health club memberships, aerobic conditioning, therapeutic exercises, work-hardening programs, massage therapy, etc., and all related material and products for these programs.

(47) **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.

(48) **Removal of breast implants or other prosthetic implants.** Removal of implants are not covered if the implants were: (1) inserted in connection with Cosmetic surgery, regardless of the reason for removal; or (2) not inserted in connection with Cosmetic surgery, but the removal is not Medically Necessary. Includes all expenses for or related to such removal.

(49) **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, or, replacement is less expensive than repair of the existing device.

(50) **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, Illness or Pregnancy-related condition which is known or reasonably suspected, including routine eye examinations, including refractions, lenses for the eyes and exams for their fitting, unless such care is specifically covered in the Schedule of Medical Benefits.

Services for or related to routine physical exams for purposes of medical research, obtaining employment or insurance, or obtaining or maintaining a license of any type, unless such physical examination would normally have been provided in the absence of the third party request.

(51) **Self-inflicted Injury**. Expenses for Injury or Illness arising out of attempted suicide or an intentional self-inflicted Injury. This exclusion will not apply if self-inflicted injuries result from a medical condition such as depression and the benefits for such injuries are normally covered under the Plan.

(52) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under the Plan or after coverage ceased under the Plan.

(53) **Services outside of the United States of America.** Care, treatment or supplies rendered outside the United States of America or its territories, except for covered charges related to an Injury or a Medical Emergency. These services will be considered at the out of network benefit level.

(54) **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.

(55) **Surgical sterilization reversal.** Expenses related to reversal of surgical sterilization.

(56) **Surrogate parenting.** Expenses related to surrogate parenting.

(57) **Televideo.** Charges made by a professional for televideo conferencing services, email, and Physician/patient telephone consultation, except eligible E-Visits as specified as covered.

(58) **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.

(59) **Vocational rehabilitation**, except when Medically Necessary and provided by an eligible health care provider. Services for or related to functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits.

(60) **War.** Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism, whether declared or undeclared, or while in the armed forces of any country or international organization.

(61) **Worker's Compensation.** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation.

Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.

PRESCRIPTION DRUG BENEFITS

Prescription Drug Program

This Prescription Drug Program is an independent program, separate from medical coverage. Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. In order to receive the full benefit of the Prescription Drug Program, a Covered Person must use participating pharmacies and present his or her ID card. Express Scripts, Inc. is the administrator of the Prescription Drug Program.

"Dispensed As Written" Drug Provision

The Plan requires that retail pharmacies dispense Generic drugs when available unless the Physician specifically prescribes a Brand Name drug and marks the script "dispense as written." Should a Covered Person choose a Brand Name drug rather than the Generic equivalent when the Physician allowed a Generic drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Brand Name drug, in addition to the Brand Name drug copayment and the Covered Person's share of any prescription's drug cost does not apply toward the out-of-pocket maximum.

Copays

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the Schedule of Prescription Drug benefits. The copayment amount is not a covered charge under the Medical Benefits and does not apply to the Medical Benefits out-of-pocket. Any one pharmacy prescription is limited to a 31-day supply. Any one mail order prescription is limited to a 90-day supply.

Direct Reimbursement

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the Covered Person must pay the pharmacist the full amount for the prescription. In order for reimbursement to occur, the Covered Person must complete a direct reimbursement form, obtained from the Employer, attach the receipt and submit it to the following address:

Express Scripts, Inc.
P.O. Box 66583
St. Louis, MO 63166
Attn: Claims Department

The Covered Person will be reimbursed the amount that would have been paid to a participating pharmacy, less the applicable copayment.

Mail Order Drug Benefit

The mail order drug benefit is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

Covered Prescription Drugs

(1) Prescriptions covered under the Plan include drugs bearing the legend "Caution: Federal law prohibits dispensing without a prescription," except as specified in Prescription Drugs Not Covered.

(2) Insulin, glucose monitors, insulin syringes and other diabetic supplies when prescribed by a Physician.

(3) Oral contraceptives.

(4) Smoking deterrents, including over-the-counter with a Physician’s prescription.

(5) Off-label drugs used for cancer treatment as specified by law.

Expenses Not Covered

The Plan will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants or dietary supplements.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Contraceptives.** Contraceptive injections, patches, implants, IUD, diaphragm, devices, etc.

(5) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(6) **Drugs used for Cosmetic purposes.** Charges for drugs used for Cosmetic purposes, such as anabolic steroids, or medications for hair growth or removal.

(7) **Experimental/Investigational.** Experimental/Investigational drugs and medicines, even though a charge is made to the Covered Person.

(8) **FDA.** Any drug not approved by the Food and Drug Administration.

(9) **Fertility drugs.** A charge for fertility medication.

(10) **Growth hormones.** Drugs to enhance physical growth or athletic performance or appearance.

(11) **Immunization.** Immunization agents or biological sera.

(12) **Impotence.** A charge for impotence medication.

(13) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

(14) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital or institution confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(15) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(16) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(17) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(18) **Non-legend drugs.** A charge for FDA-approved drugs prescribed for non-FDA-approved uses.

(19) **No prescription.** Over the counter medications, with the exception of insulin, insulin syringes and insulin-related diagnostic materials.

(20) **Refills.** Any refill requested more than one year after the date ordered by the Physician.

(21) **Vitamins**. Vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

VISION BENEFITS

Vision care benefits apply when a Covered Person incurs services for vision care that is recommended and approved by a Physician or Optometrist.

BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Vision Care Benefits.

VISION CARE CHARGES

Vision care charges are the Usual and Customary Charges for the vision care services and supplies shown in the Schedule of Vision Care Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Vision Care Benefits for each vision care service or supply. As listed below:

(1) **Vision examinations** by a Physician or Optometrist which include care history, visual acuity (clearness of vision), external examination and measurement; interior examination with ophthalmoscope; pupillary reflexes and eye movements; retinoscopy (shadow test); subjective refraction; coordination measure (far and near); medicating agents for diagnostic purposes; and, analysis of findings with recommendations and prescription if required.

(2) **Glass or plastic lenses** prescribed by a Physician or Optometrist.

(3) **Frames** to hold prescribed lenses.

(4) **Contact lenses** as an alternative to conventional lenses.

PLAN LIMITATIONS

The Plan will not provide benefits for any of the items listed below. This list is intended to give a general description of expenses for services and supplies not covered by the Plan. There may be expenses in addition to those listed below which are not covered by the Plan.

(1) **Prior to effective date.** Care, treatment or supplies for which a charge was incurred before a person was covered under the Plan.

(2) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.

(3) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than the Plan.

(4) **No prescription.** Charges for lenses ordered without a prescription.

(5) **Orthoptics.** Charges for orthoptics (eye muscle exercises).

(6) **Replacement.** Charges for lost, stolen or broken lenses and/or frames, unless within the frequency limitations.

(7) **Sunglasses**, prescription or non-prescription.

(8) **Safety lenses or goggles**.

(9) **Medical or surgical treatment of the eye**.

FILING A CLAIM

HOW TO SUBMIT A CLAIM

The following general steps should be followed in order to submit a claim for Medical and Prescription Drugs:

(1) Obtain a claim form from the Human Resource Department, the Plan Sponsor or on-line at mymeritain.com.

(2) Complete the employee section of the form. Answer all questions, even if the answer is "none" or "N/A" (not applicable), including the section referring to other insurance ("COB"). A separate claim form must be completed for each Covered Person for whom benefits are being requested.

(3) The Physician or other provider must complete the provider's portion of the form.

(4) Attach bills for services rendered. Documentation must include:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number and federal tax identification number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of service
- Charges
- If another plan is the primary payor, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claim form sent to the Plan.

(5) Mail the completed claim form and attached documentation to the Claims Processing Office or at the address listed below:

Meritain Health
P.O. Box 27267
Minneapolis, Minnesota 55427-0267

Questions regarding the claim can be addressed by calling the following toll-free number:

800-925-2272

WHEN CLAIMS MUST BE SUBMITTED

Claims must be filed with the Claims Processor within 365 days of the date the service was incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed after 365 days of the date the service was incurred will be declined.

The Claims Processor will determine if sufficient information has been submitted for appropriate consideration of the claim. If not, additional information may be requested.

CLAIMS PROCEDURE

The Plan's claims procedures are intended to reflect the Department of Labor's claims procedures regulations, and should be interpreted accordingly. In the event of any conflict between the summary and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this summary automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to the claimant.

Initial claims for Plan benefits are made to the Plan Administrator or, if applicable, the Insurer providing that benefit. The Plan Administrator, (or Insurer, if applicable) will review the claim itself or appoint an individual or an entity to review the claim, following these procedures:

(1) **Urgent Care Claims**. If the claimant's claim is for urgent care health benefits, the reviewer will notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the reviewer will notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the claimant. The claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The reviewer will notify the claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

(2) **Concurrent Care Claims**. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, the reviewer will notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by a claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the reviewer will notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

(3) **Other Health Benefit Claims**. In the case of a health benefit claim not described above:

(a) For a pre-service health benefit claim, the reviewer will notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. If, due to matters beyond the control of the Plan, the reviewer needs additional time to process a claim, the reviewer may extend the time for notifying the claimant of the Plan's benefit determination for up to 15 days, provided that the reviewer notifies the claimant within 15 days after the Plan receives the claim, of those special circumstances and of when the reviewer expects to make its decision. However, if such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(b) For a post-service health benefit claim, the reviewer will notify the claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the reviewer needs additional time to process a claim, the reviewer may extend the time for notifying the claimant of the Plan's benefit determination on a one-time basis for up to 15 days, provided that the reviewer notifies the claimant within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment of services which the claimant has already received.

(4) **Calculation of Time Periods**. For purposes of the time periods relating to the Plan's initial benefit determination, the period of time during which an initial benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to a claimant's failure to submit all information necessary, the period for making the determination is "frozen" from the date the notification is sent to the claimant until the date the claimant responds to the request for additional information.

(5) **Manner and Content of Denial of Initial Claims**. If the reviewer denies a claim, it must provide to the claimant, in writing or by electronic communication:

(a) The specific reasons for the denial;

(b) A reference to the Plan provision or insurance contract provision upon which the denial is based;

(c) A description of any additional information or material that the claimant must provide in order to perfect the claim;

(d) An explanation of why the additional material or information is necessary;

(e) Notice that the claimant has a right to request a review of the claim denial and information on the steps to be taken if the claimant wishes to request a review of the claim denial along with the time limits applicable to a request for review;

(f) A statement of the participant's right to request an external review or, if applicable, to bring a civil action under a Federal law called "ERISA" following any denial on review of the initial denial;

(g) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the claimant and without charge); and

(h) If the adverse benefit determination is based on the Plan's Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to the claimant's medical circumstances, or (b) a statement that the same will be provided upon request by the claimant and without charge.

NOTE: For an adverse benefit determination concerning a health claim involving urgent care, the information described in this Section may be provided to the claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished to the claimant no later than 3 days after the oral notification.

Internal Review of Initially Denied Claims

If a claimant submits a claim for Plan benefits and it is initially denied under the procedures described above, the claimant may request a review of that denial under the following procedures.

(1) **Health Benefit Claims**. A claimant for health benefits has one hundred eighty (180) days following receipt of a notification of an adverse initial benefit determination within which to request a review of the adverse initial benefit determination. In such cases, the review will meet the following requirements:

(a) The Plan will provide a review that does not afford deference to the adverse initial benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse initial benefit determination that is the subject of the appeal, nor is a subordinate of the individual who made the adverse initial determination.

(b) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial benefit determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the adverse initial benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

(c) The Plan will identify to the claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse initial benefit determination, without regard to whether the advice was relied upon in making the adverse initial benefit determination.

(d) In the case of a requested review of a denied adverse initial benefit determination involving urgent health care, the review process shall meet the expedited deadlines described below. The claimant's request for such an expedited review may be submitted orally or in writing by the claimant and all necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

(e) The reviewer will afford the claimant an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim for benefits and to submit issues and comments relating to the claim for benefits in writing to the Plan Administrator (or Insurer, if applicable). The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

All requests for review of initially denied claims (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 1380
Amherst, NY 14226-1380

(2) **Deadline for Internal Review of Initially Denied Claims**.

(a) **Urgent Health Benefit Claims**. For urgent care health benefit claims, the reviewer will notify the claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimaint’s request for review of the adverse initial benefit determination by the Plan.

(b) Other Health Benefit Claims.

(i) For a pre-service health claim, the reviewer will notify the claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after receipt by the Plan of the claimant's request for review of the adverse initial benefit determination.

(ii) For a post-service health claim, the reviewer will notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after receipt by the Plan of the claimant's request for review of the adverse initial benefit determination.

(c) Calculation of Time Periods. For purposes of the time periods specified in this Section, the period of time during which a benefit determination on review is required to be made begins at the time relating to the Plan's review of adverse initial benefit determination is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination or review accompanies the request for review.

(3) Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims. Upon completion of its review of an adverse initial benefit determination, the reviewer will give the claimant, in writing or by electronic notification, a notice containing:

(a) Its decision;

(b) The specific reasons for the decision;

(c) The relevant Plan provisions or insurance contract provisions on which its decision is based;

(d) A statement that the claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claimant's claim for benefits;

(e) A statement describing the claimant’s right to bring an action for judicial review under ERISA Section 502(a).

(f) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to the claimant upon request;

(g) If the adverse determination on review is based on a Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such an explanation will be provided without charge upon request; and

(h) 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, if your benefit is an insured benefit, your State insurance regulatory agency."

Expedited External Review

If the request for an external review is for an "urgent care claim", the claimant may request an expedited external review. The following requirements apply to an expedited external review:

(1) Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review and notify the claimant in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.

(b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, the claimant will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the four-month deadline described in (1) above.

(2) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (i.e. telephone, facsimile, etc.), all information and materials relevant to the final internal adverse benefit determination.

(3) The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require, and no later than seventy-two hours after receipt of the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to the claimant and the Plan as confirmation of the decision within forty-eight hours after the date of the notice. The notice will contain the following information:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code, and the corresponding meaning for each, and the reason for the previous denial;
(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;
(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
(e) A statement that the determination is binding except that other remedies may be available under State or Federal law to either the group health plan or to the claimant;
(f) A statement that judicial review may be available to the claimant; and

Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 27

Plan's Failure to Follow Procedures

If the Plan fails to follow the claims procedures described above, a claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Sponsor has been rendered (or deemed rendered).

COORDINATION OF BENEFITS

Coordination of benefits is the order of payment when charges are eligible under two or more benefit plans. Coordination of benefits also occurs when the Covered Person is covered by the Plan and Medicare.

The plan that pays first according to the rules will pay as if there was no other coverage. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

Benefit Plan. The Plan will coordinate the medical benefits with the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.
(2) Blue Cross and Blue Shield group plans.
(3) Group practice and other group prepayment plans.
(4) Federal government plans or programs, including Medicare.
(5) Other plans required or provided by law. This provision does not include any benefit plan or Medicaid that, by its terms, does not allow coordination.
(6) No-fault auto insurance.

Allowable Charge. The Plan will consider only covered charges under the Plan as Allowable Charges.

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

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

No-Fault Limitations. When medical payments are available under vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. The Plan will always be considered secondary and coordinate with benefits provided or required by any no-fault insurance statute whether or not a no-fault policy is in effect.

Benefit Plan Payment Order. When two or more benefit plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

(1) Benefit plans that do not have a coordination of benefits provision will pay first.

(2) Benefit plans with a coordination of benefits provision will pay benefits up to the Allowable Charge as follows:

(a) The benefit plan which covers the person directly (that is, as an employee, member or subscriber) will determine benefits thereunder before benefits are considered under a benefit plan which covers the person as a dependent.

(b) The benefit plan which covers a person as an employee who is neither laid-off nor retired will determine benefits before a benefit plan which covers that person as a laid-off or retired employee. The benefit plan which covers a person as a dependent of an employee who is neither laid-off nor retired will determine benefits thereunder before benefits are considered under a benefit plan which covers a person as a dependent of a laid-off or retired employee.

(c) The benefit plan which covers a person as an employee who is neither laid-off nor retired will determine benefits before benefits are considered under a benefit plan which covers that person as a laid-off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(d) The benefit plan which covers a person as an employee who is neither laid-off nor retired or a dependent of an employee who is neither laid-off nor retired will determine benefits before benefits are considered under a benefit plan which covers the person as a COBRA beneficiary.

(e) When a child is covered as a dependent and the parents are not separated or divorced, the following rules will apply:

(i) The benefit plan of the parent whose birthday falls earlier in a year will determine benefits before benefits are considered under a benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefit plan which has covered the patient for the longer period of time will determine benefits before benefits are considered under the benefit plan which covers the other parent.

(f) When a child's parents are divorced or legally separated, the following rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will determine benefits before benefits are considered under the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. First, the benefit plan of the parent with custody determine benefits. Next, the benefit plan of the stepparent that covers the child as a dependent will determine benefits. Finally, the benefit plan of the parent without custody will determine benefits.

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

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the benefit plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

(g) When a child's parents were never married to each other, the rules as set out above in letter (e), will apply as long as paternity has been established.

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

(3) Medicare will pay primary, secondary or last, as specified in applicable law.

(4) If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and the Plan will pay second.

OTHER IMPORTANT PLAN PROVISIONS

Assignment of Benefits. No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an Alternate Recipient, in the manner described in ERISA Section 609(a) and in the Plan's QMCSO Procedures.

Inability to Locate Recipient. If the Plan Sponsor is unable to make payment to any Covered Person or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Covered Person or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of such Covered Person or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Covered Person or other person shall be forfeited eighteen (18) months after the date such payment first became due.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

As a condition to receiving benefits under the Plan, Covered Person(s), including all dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the Injury or Illness giving rise to the benefits occurs through the act or omission of another person.

Alternatively, if a Covered Person receives any full or partial recovery, by way of judgment, settlement or otherwise, from another person or business entity, the Covered Person agrees to reimburse the Plan, in first priority, for any benefits paid by the Plan (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by the Plan, from any monies received, with the balance, if any, retained by the Covered Person).

The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including Plan expenses. Furthermore, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery together with all other previous or anticipated recoveries fully compensates the Covered Person for any damages the Covered Person may have experienced.

This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the Covered Person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the Covered Person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the Covered Person.

The Plan may enforce its reimbursement or subrogation rights by requiring the Covered Person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the Covered Person's claim without prior express written authorization by the Plan. The Plan will not be subject to any "make whole" or other subrogation rules.

COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan offer covered employees and their covered spouses and dependent children the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This section is intended to inform you, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in regulations issued by the Department of the Treasury and the Department of Labor. This section is intended to reflect the law and does not grant or take away any rights that apply under applicable law. Instructions on COBRA rights and procedures, as well as election forms and other information, will be provided by the Plan Sponsor to Covered Persons who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at specific rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The continuation coverage is identical to the coverage under the Plan that the Qualified Beneficiary had immediately before the Qualifying Event, or, if the coverage has been changed, the coverage is identical to the coverage provided to similarly situated Active employees who have not experienced a Qualifying Event.

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

(1) Any individual who, on the day before a Qualifying Event, is covered under the Plan as either a covered employee, the Spouse of a covered employee, or a dependent child of a covered employee, and who loses coverage under the Plan because of the Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage.

In addition, if the Qualifying Event is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to an Employer, a covered retired employee (who retired from employment with that Employer) and any individual who is covered under the Plan as the Spouse, surviving Spouse or dependent child of such a retired employee may also be Qualified Beneficiaries. Those individuals are qualified beneficiaries only if (1) for the employee, he or she retired on or before the date of substantial elimination of coverage and (2) for any other individuals, they were beneficiaries under the Plan on the day before the bankruptcy proceeding commenced.

An individual is not a Qualified Beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, for the reason described in the preceding sentence, an individual is not a Qualified Beneficiary, then a Spouse or dependent child of the individual is not a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if an employee, a Spouse or a dependent child would lose coverage (i.e., would cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage.

For a covered employee, the following may be a Qualifying Event:

(1) The termination (other than because of the employee's gross misconduct), or reduction of hours, of a covered employee's employment.

For a covered Spouse, in addition to (i), the following may be Qualifying Events:

(2) The death of a covered employee.

(3) The divorce or legal separation of a covered employee from the employee's Spouse.

(4) A covered employee's entitlement to Medicare.

For a covered dependent child, in addition to events (i)-(iv) above, the following may be a Qualifying Event:

(5) A dependent child's ceasing to satisfy the Plan's requirements for coverage as a dependent child (e.g., attainment of the maximum age for dependency under the Plan).

Finally, for a covered retired employee (or a Spouse, surviving Spouse, or dependent who has coverage as the Spouse, surviving Spouse or dependent of a retired employee), the following may also be a Qualifying Event:

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered retired employee retired at any time.

If the Qualifying Event causes the employee, or the Spouse or a dependent child of the covered employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (the persons losing such coverage become Qualified Beneficiaries under COBRA. In addition, if a bankruptcy Qualifying Event causes a former employee (who retired on or before the date of a substantial elimination of coverage), or such a former employee's Spouse, surviving Spouse or dependent child to experience a substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), that former employee, Spouse, surviving Spouse or dependent child becomes a Qualified Beneficiary under COBRA. Any increase in contribution that must be paid by a covered employee, former employee or the Spouse, surviving Spouse or a dependent child of the covered employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if a covered employee does not return to employment at the end of the FMLA leave. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date. Note that the covered employee and covered Family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. Availability of COBRA continuation coverage is conditioned upon the timely election of such coverage. The election period begins on the date of the Qualifying Event and ends 60 days after the later of (1) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or (2) the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered employee or Qualified Beneficiary responsible for informing the Plan Sponsor of the occurrence of a Qualifying Event? Yes, in some cases. Each covered employee or Qualified Beneficiary is responsible for notifying the Plan Sponsor of the occurrence of a Qualifying Event that is:

(1) A dependent child's ceasing to be a dependent child under the Plan.

(2) The divorce or legal separation of the covered employee.

A Qualified Beneficiary (or the covered employee or Spouse) must notify the Plan Sponsor within 60 days after the later of the date one of these Qualifying Events occurs.

This notice must be provided, along with any required documentation to:

Plan Sponsor
COBRA Qualifying Event
LTX, Incorporated
1515 Industrial Drive Northwest
Rochester, Minnesota 55901
507-282-6715

The notice must be provided in writing in a letter addressed to the Plan Sponsor. The notice must include:

(1) The covered employee's name, address, phone number and health plan ID number.

(2) The name, address, phone number and health plan ID number for any dependent child or Spouse whose eligibility is affected by the qualifying event.

(3) A description of the Qualifying Event (or a notice of a disability determination or termination of disability status, as described below) and the date on which it occurred.

(4) The following statement: "By signing this letter, I certify that the Qualifying Event described in this letter occurred on the date described in this letter." If the notice concerns a disability determination or a change in disability status, as described below, this statement is not required.

(5) The signature of the person sending the letter.

The Qualified Beneficiary (or the covered employee or Spouse) must also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date of the divorce or the date the legal separation began. If a Qualified Beneficiary or anyone else has a question about what type of documentation is required, he or she should contact the Plan Sponsor.

In addition to accepting a letter with the information described above, the Plan Sponsor, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered employee or a covered Spouse or dependent child may obtain a copy by requesting it from the Plan Sponsor at the address provided in this notice.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Sponsor within 60 days after the later of (1) the date of the Qualifying Event or (2) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Sponsor, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? COBRA continuation coverage ends on the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other group health plan that does not include an exclusion or limitation with respect to any pre-existing condition that would affect the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary is first entitled to Medicare. This date does not apply for anyone who became a Qualified Beneficiary because of a bankruptcy proceeding.

(6) For a Qualified Beneficiary who is entitled to a disability extension, the later of:

(a) The first day of the first month that is later than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) The last day of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA participants, (for example, for fraud.)

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(1) If the Qualifying Event is a termination of employment or reduction of hours of employment, except as provided in paragraphs (ii) and (iii) below, the maximum coverage period ends 18 months after the Qualifying Event.

(2) If the Qualifying Event is a termination of employment or reduction of hours of employment and the Qualified Beneficiary is entitled to a disability extension, the maximum coverage period ends 29 months after the Qualifying Event if there is a disability extension (unless the disability ends before the end of that 29- month period).

(3) If a covered employee becomes entitled to Medicare before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered employee ends on the later of:

(a) 36 months after the date the covered employee becomes entitled to Medicare; or

(b) 18 months (or up to 29 months, if there is a disability extension) after the date of the covered employee's termination of employment or reduction of hours of employment.

(4) For a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is a retired covered employee (or a surviving Spouse who was participating in the Plan as a surviving Spouse on the day before the bankruptcy Qualifying Event) ends on the date of the covered retired employee's (or surviving Spouse's) death. The maximum coverage period for a Qualified Beneficiary who is the Spouse or dependent child of the covered retired employee ends 36 months after the death of the covered retired employee.

(5) For a Qualified Beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(6) For any Qualifying Event other than those described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the maximum coverage period may be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to last longer than 36 months after the date of the first Qualifying Event.

However, no event is a second Qualifying Event unless that event would have been an initial Qualifying Event if it had occurred for an active covered employee. For example, an employee's entitlement to Medicare cannot be a second Qualifying Event for a Spouse or a dependent child unless an active employee's entitlement to Medicare would have been an initial Qualifying Event, i.e., unless an employee's entitlement to Medicare would have resulted in a loss of coverage for the Spouse or dependent child.

A Qualified Beneficiary (or a covered employee or Spouse) must notify the Plan Sponsor of a second Qualifying Event within 60 days after the later of the date of the Qualifying Event or the date the Qualified Beneficiary would lose coverage because of the Qualifying Event. To submit this notice, the Qualified Beneficiary must follow the procedures described above under "**Is a covered employee or Qualified Beneficiary responsible for informing the Plan Sponsor of the occurrence of a Qualifying Event?**"

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered employee's employment is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary (or a covered employee or Spouse) must also provide the Plan Sponsor with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. To submit this notice, the Qualified Beneficiary must follow the procedures described above under "**Is a covered employee or Qualified Beneficiary responsible for informing the Plan Sponsor of the occurrence of a Qualifying Event?**"

If a Qualified Beneficiary becomes entitled to a disability extension and then there is a final determination by the Social Security Administration, under title II or XVI of the Social Security Act, that the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary (or the covered employee or someone else must notify the Plan Sponsor of that determination within 30 days after the date of the final determination. The notice should take the form of a letter as described above under "**Is a covered employee or Qualified Beneficiary responsible for informing the Plan Sponsor of the occurrence of a Qualifying Event?**"

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, the Plan will require the payment of an amount equal to 102% of the actual cost of coverage except the Plan will require the payment of an amount equal to 150% of the actual cost of coverage for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes.

What is Timely Payment for payment for COBRA continuation coverage? For regular monthly payments, Timely Payment means a payment made by the first day of the month in question (the "due date") or within a 30 day grace period beginning on that due date.

Notwithstanding the above paragraph, the Plan will not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

Special Additional Continuation Coverage Election Period for "TAA-Eligible Individuals". In addition to the other COBRA rules described in the Plan, there are some special rules that apply if an individual is classified as a "TAA-eligible

individual" by the U.S. Department of Labor. (This applies only if the individual qualifies for assistance under the Trade Adjustment Assistance Reform Act 2002 because he or she became unemployed as a result of increased imports or the shifting of production to other countries.)

If an individual who is classified by the Department of Labor as a TAA-eligible individual does not elect continuation coverage when he or she first loses coverage, he or she may qualify for an election period that begins on the first day of the month in which the individual becomes a TAA-eligible individual and lasts up to 60 days. However, in no event does this election period last later than 6 months after the date of the individual's TAA-related loss of coverage. If a TAA eligible individual elects continuation coverage during this special election period, continuation coverage would begin at the beginning of that election period, but, for purposes of determining the maximum required COBRA coverage period, the coverage period will be measured from the date of the original Qualifying Event, i.e., the TAA-related loss of coverage.

The Trade Adjustment Assistance Act also provides for a tax credit that may apply to some expenses for continuation coverage. An affected individual should consult with a financial advisor if he or she has questions about the tax credit.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN SPONSOR. The Plan Sponsor shall be the named fiduciary for purposes of ERISA. Except as to those functions reserved to the Plan Sponsor or an Insurer, the Plan Sponsor shall control and manage the operation and administration of the Plan.

The Plan Sponsor shall administer the Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of the Plan that the Plan Sponsor 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 interpretation of the Plan and those of fact relating to the Plan. The decisions of the Plan Sponsor will be final and binding on all interested parties.

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

SELF-FUNDED NATURE OF PLAN

For Employee and Dependent Coverage: Funding is derived from the funds of the Plan Sponsor and contributions made by the covered employees.

All Plan benefits are paid from the Employer's general assets. No trust or other separate fund is maintained in connection with the Plan.

The level of any employee contributions will be set by the Plan Sponsor.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract of employment. Nothing contained in the Plan shall be deemed:

(1) To give any employee the right to be retained in the employ of the Employer; or

(2) To affect the right of the Employer to discipline or discharge any employee at any time.

ADMINISTRATIVE ERROR

If, due to an administrative error, an overpayment occurs in a reimbursement amount from the Plan, the Plan retains a contractual right to recover the overpayment. The person or institution receiving the overpayment will be required to return the overpayment. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING, MODIFYING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination. If the Plan is amended or modified, expenses incurred prior to the modification or amendment of the Plan will be considered as provided under the terms of the Plan prior to its amendment or modification.

The Employer by action evidenced in writing reserves the right, at any time, without prior notice, to amend, suspend or terminate the Plan in whole or in part. In the event of the dissolution, merger, consolidation or reorganization of the Plan Sponsor, the Plan automatically will terminate unless it is continued by a successor to the Plan Sponsor.

PARTICIPANT'S RIGHTS UNDER ERISA

Plan Participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

(1) Examine, without charge, at the Plan Sponsor's office and at other specified locations, such as worksites, and union halls, if applicable, all Plan documents and copies of all documents governing the Plan, including benefit contracts and collective bargaining agreements, if any, and a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the employee Benefits Security Administration.

(2) Obtain, upon written request to the Plan Sponsor, copies of documents governing the operation of the Plan, including benefit contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The employee may have to pay a reasonable charge to the Plan Sponsor to cover the cost of photocopying.

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

Prudent Action By Plan Fiduciaries. In addition to creating rights for Plan Participants, ERISA imposes duties upon the individuals who are responsible for the operation of the employee benefit Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

A Participant May Enforce Rights. If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Sponsor to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Sponsor.

If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

Assistance With Questions. If the Plan Participant has any questions about the Plan, he or she should contact the Plan Sponsor. If the Plan Participant has any questions about this statement or his or her rights under ERISA, or if the Plan Participant needs assistance in obtaining documents from the Plan Sponsor, that Plan Participant should contact either the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. The Plan Participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HEALTH INFORMATION PRIVACY

SCOPE OF SECTION

This Section is intended to provide for the Plan's compliance with all applicable requirements of the final Regulations issued by the Department of Health and Human Services pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, including the Regulations entitled Standards for Privacy of Individually Identifiable Health Information (the “Privacy Regulations”) and the Regulations entitled Health Insurance Reform: Security Standards (the “Security Standards”).

The Plan will comply with all applicable requirements of the Privacy Regulations, as provided in this Section and in the Privacy Regulations and as interpreted pursuant to any subsequent authoritative guidance issued by the Department of Health and Human Services. If there is any conflict between the requirements of the Privacy Regulations and any provision of this Plan, the Privacy Regulations will control. Also, any amendment or revision or authoritative interpretation of the Privacy Regulations is incorporated into the Plan as of the effective date of that guidance.

Notwithstanding the preceding, this Section applies only to those plans that provide health benefits and that are subject to the Privacy Regulations, as determined by the Plan Sponsor.

PROTECTED HEALTH INFORMATION

For purposes of this Section, “Protected Health Information” has the same meaning as provided for that term in the Privacy Regulations and is limited to information that is Protected Health Information with respect to the Plan.

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

The Plan will disclose Protected Health Information to the Plan Sponsor only as follows:

(1) **Summary Health Information**. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose Protected Health Information that is summary health information to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of:

(a) Obtaining premium bids from insurance issuers for providing health insurance coverage under the Plan; or

(b) Modifying, amending or terminating the Plan.

For purposes of this subsection, "summary health information" means information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan, from which certain identifying details have been removed, as provided in section 164.504(a) of the Privacy Regulations.

(2) **Enrollment Information**. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose to the Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health option or HMO offered by the Plan.

(3) **Other Disclosures to Plan Sponsor**. Except as provided in subsections (a) or (b) above, or under the terms of an applicable individual authorization, the Plan may disclose Protected Health Information to the Plan Sponsor and may permit the disclosure of Protected Health Information by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the Protected Health Information to administer the Plan.

The Plan Sponsor, by signing this document, certifies that it:

(a) Will not use or further disclose Protected Health Information other than as permitted or required by the Plan or as required by law;

(b) Will ensure that any agents 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;

(c) Will 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;

(d) Will report to the Plan any use or disclosure, of which it becomes aware, of the information that is inconsistent with the uses or disclosures permitted under the Plan;

(e) Will make Protected Health Information available to the individual who is the subject of that information in accordance with Section 164.524 of the Privacy Regulations;

(f) Will consider requested amendments to an individual's Protected Health Information in accordance with Section 164.526 of the Privacy Regulations;

(g) Will make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with Section 164.528 of the Privacy Regulations;

(h) Will 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 Regulations;

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

(j) Will ensure that the adequate separation of the Plan and the Plan Sponsor as required in this Section is established.

(4) **Prohibited Disclosures**. The Plan will not disclose Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

SEPARATION OF HEALTH PLANS AND PLAN SPONSOR

The Plan is a legal entity separate from the Plan Sponsor. The Plan Sponsor has designated and trained certain employees of the Plan Sponsor as the only employees of the Plan Sponsor who will have access to Protected Health Information.

The Plan Sponsor will work with the Plan's designated Privacy Official to establish effective policies and procedures for identifying, investigating, remedying and disciplining any alleged instances of noncompliance with the requirement that employees of the Plan Sponsor who have access to Protected Health Information use that Protected Health Information only for the purposes specified in this Section.

PRIVACY NOTICE

The Plan will comply with the applicable requirements of the Privacy Notice issued by the Plan pursuant to the requirements of the Privacy Regulations and the Plan's Privacy Notice is incorporated into the Plan by this reference. If the Privacy Notice is revised, the Plan will comply with the revised Privacy Notice as of the effective date of the revision. A revised Privacy Notice is incorporated into the Plan as of the effective date of each revision without the need for further amendment of the Plan.

HIPAA SECURITY REGULATIONS

The Plan Sponsor, by adopting this document, certifies that it will:

(1) Reasonably and appropriately safeguard electronic Protected Health Information created, received, maintained, or transmitted to or by the Plan Sponsor or the Employer on behalf of the Plan;

(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 the adequate separation required by §164.504(f)(2)(iii) of the Privacy Regulations is supported by reasonable and appropriate security measures;

(4) Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect that information; and

(5) Report to the Plan any security incident of which it becomes aware.

BREACH REPORTING.

The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

OTHER ADMINISTRATIVE SIMPLIFICATION REGULATIONS

Notwithstanding any other provision of the Plan, the Plan will comply with all applicable requirements of the Administrative Simplification regulations issued by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, as they become applicable to the Plan and the Plan shall be construed to be consistent with such requirements.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan administered by the Employer.

PLAN NAME

LTX, Incorporated Medical Benefit Plan

PLAN NUMBER: 505

TAX ID NUMBER: 41-0908878

PLAN EFFECTIVE DATE AS AMENDED AND RESTATED: January 1, 2011

PLAN YEAR: The 12-month period for the Plan Sponsor preceding December 31, unless otherwise stated.

EMPLOYER INFORMATION

LTX, Incorporated
1515 Industrial Drive Northwest
Rochester, Minnesota 55901
507-282-6715

AGENT FOR SERVICE OF LEGAL PROCESS

LTX, Incorporated
1515 Industrial Drive Northwest
Rochester, Minnesota 55901
507-282-6715

CLAIMS PROCESSOR

Meritain Health
P.O. Box 27267
Minneapolis, Minnesota 55427-0267
800-925-2272

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #3
TO THE
LTX, INCORPORATED
EMPLOYEE BENEFIT PLAN
Group No. 10717

This Summary of Material Modification and Amendment describes changes to the LTX, Incorporated Employee Benefit Plan effective January 1, 2011. These changes are **effective as of June 1, 2014,** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

LTX, Incorporated (the "Plan Sponsor") is amending the LTX, Incorporated Employee Benefit Plan (the "Plan") as follows:

*The Plan is amended to add a **Participating Employer**. As such, the **Plan Number** and **Tax ID Number** sections are deleted and replaced as follows, and a **Participating Employer** section is added to the **General Plan Information** section:*

GENERAL PLAN INFORMATION

PLAN NUMBER: LTX, Incorporated: 505
Lawrence Leasing, Inc.: 506

TAX ID NUMBER: LTX, Incorporated: 41-0908878
Lawrence Leasing, Inc.: 41-1709172

PARTICIPATING EMPLOYER

Lawrence Leasing, Inc.
860 Bench Street
Red Wing, MN 55066
507-282-6715

All other provisions of this Plan shall remain unchanged.

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #2
TO THE
LTX, INCORPORATED
EMPLOYEE BENEFIT PLAN
Group No. 10717

This Summary of Material Modification and Amendment describes changes to the LTX, Incorporated Employee Benefit Plan effective January 1, 2011. These changes are **effective as of the dates indicated below** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

LTX, Incorporated (the "Plan Sponsor") is amending the LTX, Incorporated Employee Benefit Plan (the "Plan") as follows:

EFFECTIVE SEPTEMBER 23, 2013

HIPAA Privacy and Security Practices

*To comply with the amended HIPAA Privacy and Security Practices effective September 23, 2013, the **Health Information Privacy** section is hereby deleted and replaced with the sections outlined in **Exhibit A**.*

EFFECTIVE JANUARY 1, 2014

Patient Protection and Affordable Care Act (the "Affordable Care Act")

This Summary of Material Modification and Amendment to the LTX, Incorporated Employee Benefit Plan (the "Plan") is adopted to comply with certain provisions of the Patient Protection and Affordable Care Act (the "Affordable Care Act").

1: Prohibition on Pre-Existing Conditions

*No pre-existing condition limitation shall apply to any covered individual. As such, the **Pre-Existing Conditions** section under **Eligibility and Commencement of Coverage Provisions** is hereby deleted. All references to Pre-Existing Conditions throughout the Plan are hereby deleted and not replaced. The following provision is added under the **Other Important Plan Provisions** section of the Plan to read as follows:*

OTHER IMPORTANT PLAN PROVISIONS

Certificates of Creditable Coverage. The Plan will automatically provide a Certificate of Creditable Coverage to anyone who loses coverage under the Plan before December 31, 2014. In addition, until December 31, 2014 (or later, to the extent required under applicable law), a Certificate of Creditable Coverage will be provided upon request at any time while the individual is covered under the Plan and up to 24 months after the individual loses coverage under the Plan.

The Plan will make reasonable efforts to collect information about any Dependents and to include that information on the Certificate of Creditable Coverage, but the Plan will not issue an automatic Certificate of Creditable Coverage for Dependents until the Plan has reason to know that a Dependent has lost coverage under the Plan.

All questions about the Certificate of Creditable Coverage may be directed to the Plan Administrator. Refer to the General Plan Information page.

2: Limitation of 90 Day Waiting Period

The eligibility waiting period has been reduced to 60 days. As a result, any eligible Employee (as defined by the terms of the existing Plan Document and Summary Plan Description) will be eligible to enroll for coverage under this Plan as of the first of the month coinciding with or immediately following the date he or she satisfies the waiting period provided all required election and enrollment forms are properly submitted to the Plan Administrator. As such, the first paragraphs under ***Waiting Period for Employee Coverage*** *and under* ***Effective Date of Employee Coverage*** *subsections under* ***Eligibility and Commencement of Coverage Provisions*** *are hereby deleted and replaced the following:*

ELIGIBILITY AND COMMENCEMENT OF COVERAGE PROVISIONS

ELIGIBILITY

Waiting Period for Employee Coverage. An employee must complete the waiting period of 60 days as an Active Employee. Please see section titled Effective Date of Coverage to determine when coverage begins after the waiting period. For the purpose of this provision, an employee shall not be treated as absent from work if the absence is because of a health condition.

Effective Date of Employee Coverage. When the enrollment requirements are met, an eligible employee's coverage is effective on the first of the month coinciding with or immediately following the waiting period. In the case of a Special Enrollment Situation or Status Change, coverage will be effective on the date of the event, provided the enrollment application is received within 31 days of the event.

As a result of this reduced waiting period, if an otherwise eligible Employee is currently in a waiting period on the Effective Date, and the Employee has currently satisfied at least 60 days of the prior waiting period, that Employee is eligible to enroll in coverage under the Plan, with coverage to be effective on the first day of that Plan Year provided all required election and enrollment forms are properly submitted to the Plan Administrator in accordance with the Plan's normal enrollment procedures.

3: Extension of Dependent Coverage to Age 26

The Plan will provide coverage to a Dependent Child generally until age 26 (or a later age if otherwise specified in the Plan Document and Summary Plan Description) regardless of whether or not he or she is eligible for coverage under another employer-sponsored group health plan. As such, number (2) under the ***Eligible Classes of Dependents*** *subsection under* ***Eligibility and Commencement of Coverage Provisions*** *is hereby deleted and replaced the following:*

ELIGIBILITY AND COMMENCEMENT OF COVERAGE PROVISIONS

ELIGIBILITY

Eligible Classes of Dependents. A dependent is any one of the following persons:

(2) A covered employee's Dependent Child until the end of the calendar month in which he/she attains age 26.

RENEWAL CHANGES EFFECTIVE JANUARY 1, 2014

1: Spouse Coverage

*Number (1) under the **Eligible Classes of Dependents** subsection under **Eligibility and Commencement of Coverage Provisions** is hereby deleted and replaced the following:*

ELIGIBILITY AND COMMENCEMENT OF COVERAGE PROVISIONS

ELIGIBILITY

Eligible Classes of Dependents. A dependent is any one of the following persons:

(1) A covered employee's Spouse, unless legally separated.

A Spouse of an employee who is eligible for coverage under their employer-sponsored health plan will not be eligible for coverage under this Plan. If a Spouse loses eligibility under the employer-sponsored health plan or the employer terminates the health plan, the Spouse may enroll for coverage under this Plan subject to the Special Enrollee provisions. There is no coverage for a Spouse who is eligible for coverage under their employer-sponsored health plan, regardless if they elect coverage or not under that plan.

2: Vision benefit

*The **Schedule of Vision Care Benefits** is hereby deleted and replaced with the following:*

SCHEDULE OF VISION CARE BENEFIS

BENEFIT DESCRIPTION	BENEFIT
Vision Benefits are limited to the following:	
Eye Exam (age 18 and over), per Covered Person, per Calendar Year	100% up to $30 per exam; one per calendar year
Frame-Type Lenses, Per Pair, in a Calendar Year Period (under age 18)	50%
Frames, Per Pair, in a Calendar Year Period (under age 18)	50%
Frame-Type Lenses, Per Pair, in a Calendar Year Period: (age 18 and over)	
Single vision	100% up to $24
Bi-focal	100% up to $36
Tri-focal	100% up to $48
Lenticular	100% up to $99
Contact lenses	100% up to $45
Contact lenses when visual acuity cannot be corrected to 20/70 vision in the better eye by use of conventional type lenses, but can be improved to 20/70 with contact lenses	100% up to $188
Frames, Per Pair, in a Calendar Year Period (Limit does not apply to Cover Person under age 18)	100% up to $21

Details regarding Vision Benefits are in the Vision Benefits section.

All other provisions of this Plan shall remain unchanged.

EXHIBIT A

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

(1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

(2) Modifying, amending or terminating the Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document, certifies that it agrees to:

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

(2) Ensure that any agents, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

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

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with section 164.524 of the privacy standards;

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;

(7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI 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 PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

(a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.

(b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

(1) The Plan documents have been amended to incorporate the above provisions; and

(2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information
Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

"Underwriting purposes" is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); (3) the application of any preexisting condition exclusion under the Plan; and (4) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

In accordance with HIPAA's standards for security (the "security standards"), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

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

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

(3) Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI.

(4) Report to the Plan any Security Incident of which it becomes aware.

(5) The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the security standards.

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #1
TO THE
LTX, INCORPORATED
EMPLOYEE BENEFIT PLAN
Group No. 10717

This Summary of Material Modification and Amendment describes changes to the LTX, Incorporated Employee Benefit Plan effective January 1, 2011. **These changes are effective as of January 1, 2012** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

LTX, Incorporated (the "Plan Administrator") is amending the LTX, Incorporated Employee Benefit Plan (the "Plan") as follows:

*The "Participating Provider Organization (PPO)" section in the **Schedule of Benefits** is hereby deleted and replaced with the following;*

SCHEDULE OF BENEFITS

Aetna PPO Participating Provider Organization

The Plan includes an arrangement with Aetna PPO as the Participating Provider Organization (PPO).

The Plan Administrator will provide each Employee with information regarding Aetna PPO.

Aetna PPO has an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. These Participating Providers have agreed to charge reduced fees to Covered Persons covered under the Plan at a lower cost, the provider gains new clientele, and the Plan Participant receives a cost effective benefit.

Therefore, when a Covered Person uses a Participating Provider, the Covered Person will receive a higher benefit from the Plan than when a Non-Participating Provider is used.

It is the Covered Person's option to select a Participating or Non-Participating Provider.

It is the Covered Person's responsibility to verify a provider's current participation as a Participating Provider by calling the PPO number on the ID card or by accessing the website, www.myMERITAIN.com

*The "Maximum Annual Benefit" in the **Schedule of Medical Benefits** is hereby deleted and replaced with the following:*

SCHEDULE OF MEDICAL BENEFITS

MAXIMUM ANNUAL BENEFIT
(per Covered Person)
Effective January 1, 2012: $1,250,000
Effective January 1, 2013: $2,000,000
Effective January 1, 2014: Unlimited

The definition of "Participating (In-Network) Provider is hereby deleted and replaced with the following:

DEFINED TERMS

Participating (In-Network) Provider means a Hospital, Physician or other health care provider that has a contractual agreement with Aetna PPO, the Plan's Participating Provider Organization (PPO).

All references to Express Scripts, Inc. as the Prescription Manager are hereby deleted and replaced with Scrip World/CVS Caremark in lieu thereof. The section "Direct Reimbursement" under ***Prescription Drug Benefits*** *is hereby deleted and replaced with the following:*

PRESCRIPTION DRUG BENEFITS

Direct Reimbursement

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the Covered Person must pay the pharmacist the full amount for the prescription. In order for reimbursement to occur, the Covered Person must complete a direct reimbursement form, obtained from the Employer, attach the receipt and submit it to the Prescription Manager at the following address:

Scrip World/CVS Caremark
P.O. Box 52010
Phoenix, AZ 85072-2010
866-475-7589
www.caremark.com

The Covered Person will be reimbursed the amount that would have been paid to a participating pharmacy, less the applicable copayment.

All other provisions of this Plan shall remain unchanged.