HEALTH INSURANCE HANDBOOK

2014

Contents

HEALTH INSURANCE HANDBOOK PURPOSE

This handbook is provided to give employees a general description of MESA's health insurance benefits and provide pertinent information required by law. No handbook can be so inclusive as to cover every circumstance that may arise. Additionally, MESA may abide by other policies or procedures not described herein, such as policies listed in MESA's Benefits Summary Plan Description. This handbook also contains information that is not applicable to every position or employee. If you have a question about anything in this handbook, please contact Human Resources, who would be happy to explain anything that may be of concern.

This handbook is subject to change at any time. The most recent version of the handbook will be posted on MESA's SharePoint site. The posted handbook is the applicable version and it is the employee's responsibility to check for updates and familiarize himself or herself with this version. Additionally, MESA's Benefits Summary Plan Description has more comprehensive and detailed information about many of these programs and policies. If you have a question regarding access to the online copy of this handbook, please contact Human Resources, who would be glad to show you where to find it.

HEALTH INSURANCE BENEFIT PLAN REVIEW

MESA's Plan is administered by HealthCare Solutions Group, Inc.

- An employee is eligible to enroll when he has completed thirty days of full-time employment.
- Must enroll within thirty days from the first of the month following eligibility date.
- Can only enroll or make changes within thirty days after a qualifying event, such as marriage, loss of coverage elsewhere, birth, or adoption.

Routine Physical Exams:

PPO: Plan pays 100% (no deductible)
Non-PPO: Plan pays 60% (no deductible)

This applies to employee and spouse only.
This applies on the following schedule: 25-39 – one exam every three years; 40-49 – one exam every other year; 50+ – one exam a year.

Routine Female Exams:

PPO: Plan pays 100% (no deductible)
Non-PPO: Plan pays 60% (no deductible)

Well-baby Care (up to 18 mo.):

PPO: Plan pays 100% (no deductible)
Non-PPO: Plan pays 60% (deductible)

Immunizations (up to 16 yrs.):

PPO: Plan pays 100% (no deductible)
Non-PPO: Plan pays 100% (no deductible)

Nicotine Cessation:

PPO: Plan pays 100% up to $500 (no deductible)
Non-PPO: Plan pays 100% up to $500 (no deductible)

Physician Office Visits (incl. Specialists and Urgent Care):

PPO: $20 co-pay for office visit charge (all other expenses subject to deductible and co-insurance)
Non-PPO: Deductible and co-insurance applies

DEDUCTIBLES

PPO and Non-PPO: Employee - $500; Spouse - $500; Child - $250 (deductible limit per family - $1,000)

Participation in the annual Personal Health Assessment Program will result in a $250 credit toward Employee and Spouse deductibles, as well as the Family deductible.

CO-INSURANCE LEVELS

PPO: 80%
Non-PPO: 60%

OUT-OF-POCKET MAXIMUMS

PPO: Individual – $2,000; Family – $4,000
Non-PPO: Individual – $4,000; Family – $8,000

Prescription Drug Benefits:

Retail (34-day supply): Generic – $10 co-pay; Brand name – greater of $30 or 20%
Mail order (90-day supply): Generic – $20 co-pay; Brand name – $60 co-pay
Specialty (30-day supply): 20% up to $500 co-pay

DENTAL BENEFITS

Deductible: $50
Calendar year maximum: $1,500
Lifetime Orthodontia Maximum: $1,500

Percentage Payable:

Preventative: 100%
Basic: 80% following deductible
Major: 50% following deductible
Orthodontia: 50% following deductible

VISION BENEFITS

Calendar year maximum: $250
Eligible expenses covered 100% with no deductible

NON-OCCUPATIONAL DISABILITY BENEFIT

Maximum weekly benefit: 60% of basic earnings, not to exceed $2,500
Maximum benefit period: 26 weeks
Elimination period: injury – 14 days; illness – 14 days
When on Disability for over 90 days, regular benefits coverage is cancelled.

Please see Human Resources for additional benefit information.

FLEXIBLE SPENDING ACCOUNTS

1. What is a health Flexible Spending Account (FSA)?
Health FSAs are benefit plans that employers can sponsor to allow their employees to be reimbursed on a tax-favored basis for certain medical expenses that are not covered by the employer's major medical plan. An estimated 14 million families participate in health FSAs. Health FSAs may be offered in conjunction with other employer-provided benefits as part of a cafeteria plan. They are commonly funded by employees through voluntary salary reduction contributions, and employers may also contribute. Contributions to an FSA are not includible in the employee's income, and reimbursements from an FSA that are used to pay qualified medical expenses are not taxed.

2. How do FSAs work?
Generally, employees decide before the beginning of the plan year how much money they want to contribute to the FSA. Throughout the year, they can draw from this account for qualified medical expenses that are not covered by their employer's main health plan. This can include copays, deductibles, and various medical services and products – from dental and vision care to eyeglasses and hearing aids. For the past 30 years, health FSAs have been subject to a "use-or-lose" rule, meaning that any funds left unused at the end of the year are forfeited.

3. What's changed and how does this help consumers?
A recent notice by the IRS in 2013 makes health FSAs more consumer friendly by relaxing the use-or-lose rule. This will enable employers, for the first time, to permit employees to use up to $500 of unused health FSA amounts in the next year, instead of forfeiting the unused amounts. Notably, most forfeitures are less than $500. Individuals can now participate in a health FSA without the risk of losing all of their unused contributions. This also cuts back on wasteful year-end FSA healthcare spending by limiting the risk of forfeiture, and in turn, reducing the incentive to spend down as year-end approaches in order to avoid losing unused funds. Some plan sponsors may be eligible to take advantage of the option to adopt a carryover provision as early as plan year 2013.

4. What are the disadvantages of a FSA?
Because you are reducing your social security contribution, there could be an effect on your future social security benefit. Although these reductions usually are not significant amounts, you need to be aware of them.

5. What is the disadvantage to the employer?
The employer pays the cost of administering these plans. In general, the payroll tax savings offset the cost of administering such plans.

6. What is the tax advantage?
The amount that a participant elects to contribute to a FSA is deducted from pay before taxes. The amount of money goes into an account where it is available for reimbursement of claims for eligible expenses. Because the money comes out of pay before taxes, taxable income decreases and employees pay less in Federal, State, Local and Social Security taxes.

7. Who can participate in a FSA?
All eligible employees, their spouses and IRS eligible dependents can participate. Eligible employees would be full-time employees who have completed thirty days of service.

8. What is the maximum I can contribute to my account?
MESA's annual maximum is $2,500 per family.

9. Can I change the amount I elect to contribute to these accounts?
You can only change the amount you contribute annually, prior to the beginning of each plan year. During the plan year you may change your contribution only if you experience a change in family status.

10. How do I file for reimbursement?
If you are a participant with HealthCare Solutions Group and have no secondary carrier, your out-of-pocket expenses for medical services can automatically apply to your FSA. If you have medical, dental, or secondary coverage with another carrier, you will have to file a request for reimbursement with appropriate documentation about the services rendered and what the other carrier paid in benefits.

11. Do I need receipts in order to receive reimbursement?
Health care claims should be accompanied by an Explanation of Benefits from your secondary carrier along with the corresponding receipts. If HealthCare Solutions Group is your only insurance carrier for all means of reimbursement, then no explanation or filing is necessary.

12. Can the FSA reimburse my health care provider?
No, the FSA cannot make a payment on your behalf. All reimbursements must go directly to the participant.

13. Can I claim my contribution or my spouse's contribution to health insurance through my FSA?
No, premiums are not eligible FSA expenses. However, premiums for programs offered by an employer may be a separate pre-tax deduction.

14. Do I have to keep track of how much is in my account during the year?
No, HealthCare Solutions Group will do it for you. You will receive a statement of your account balance with each reimbursement. Statements are also sent the last quarter of the year to advise you of your account balances. This is an added step to help plan your expenses and reduce the amount of unused funds at the end of the year.

17. If I leave my job, may I still participate in the FSA program?
You can continue your Flexible spending account under COBRA. You would continue to make contributions in your Flexible spending account, but on an after tax basis.

18. How often will a participant receive reimbursement?
HealthCare Solutions Group will make reimbursements weekly.

19. If I have a question regarding my spending account whom do I call?
Contact the Customer Service Department of HealthCare Solutions Group at (800) 749-1422.

If you have any questions about MESA's options in Flexible Spending Accounts, or whether an account is right for you, please see Human Resources.

CHRONIC CARE MANAGEMENT PROGRAM

HealthCare Solutions Group appreciates the opportunity to serve as your group health plan administrator through MESA. We are pleased to announce the addition of the *HSG Chronic Care Management Program* to your benefit program. This valuable benefit demonstrates MESA'S continued dedication to provide the tools necessary to improve the health of you and your family.

Our goal is simple – to help make a difference in the lives of our customers and to provide the inspiration and support they need to actively manage their chronic or potentially chronic conditions. Your health is important to us, and *HSG* is here to assist you in developing an understanding and provide personalized solutions to help you manage your condition. Your program delivers the following services:

- One-on-one management by a qualified registered nurse
- Patient advocate to reduce risk and improve health
- Periodic follow-up to address needs or concerns
- Assist with understanding your condition and recommended test and treatments
- Assist with understanding how your medical plan can help you manage your condition
- Monitor your clinical progress with follow-up calls to your physician(s)
- Coordinate recommended home care needs

This generation of our population are not only living longer, but working longer than any generation this country has ever seen. Your health is an important asset, and *HSG* is a trusted center of decision support services regarding your health care needs.

HSG will periodically contact our customers to help improve your understanding and assist you in achieving your long-term self-management goals. *HSG* also welcomes you to call Gail Henrichs, our care management nurse director, to discuss your condition and needs to achieve a better quality of life. Gail can be reached using our toll free number (1-800-749-1422), or you may contact Gail via email at ghenrichs@hsg.com.

In today's confusing health care landscape and economic climate, now more than ever before, our customers are in need of guidance and understanding of their health care conditions. We look forward to serving you.

Sincerely,

HealthCare Solutions Group, Inc.
Care Management Team
800-749-1422
ghenrichs@hsg.com

MATERNITY MANAGEMENT PROGRAM

MESA and the Maternity Management Team at Healthcare Solutions Group (HSG) are dedicated in helping you get the information and support you need for a healthier pregnancy.

This free service includes:

- One-on-one consultations by a qualified registered nurse
- Individualized approach to help you reduce risk and maintain your health
- Periodic follow-up calls to address your needs or concerns
- Assistance with understanding of recommended test and treatments
- Help you understand your health care plan
- Monitor the plan of care established by your obstetrical specialist

A confidential and free enrollment begins when you call HSG at (800) 749-1422, Monday through Friday from 8:30 a.m. – 5:00 p.m. Please ask for the Maternity Management Team, or contact us via email at ghenrichs@hsg.com.

Sincerely,

Gail Henrichs
Maternity Management Coordinator

ONE CALL MEDICAL PROGRAM

Through our efforts to bring you quality care at an affordable price, we are pleased to share with you information about a new program now available for members and eligible dependents covered by the ***MESA Products, Inc. Employee Benefit Plan.***

In recent years, the use of advanced radiology testing has increased significantly. The cost of covering those tests has increased dramatically as well. To ensure that diagnostic tests, such as MRI (Magnetic Resonance Imaging) and CAT (Computed Axial Tomography) scans remain affordable, a national network of discounted radiology providers will be accessible to our group.

One Call Medical is the nation's leading provider of quality radiology testing with 15 years of experience. They offer the largest network of qualified radiology providers in the nation. The radiology network includes more than 2,900 imaging centers, servicing all 50 states.

Because of their competitive pricing, YOU CAN SAVE MONEY by PAYING LESS FOR THESE SERVICES scheduled through One Call Medical. Services provided through One Call Medical will be paid at 100% instead of 80% once your Deductible has been met. YOU

The ***One Call Medical*** program is simple to use. It is strictly voluntary with no additional enrollment required. Before you or a covered family member are scheduled for an MRI or CAT scan, you or your provider can simply call OCM's toll-free telephone number, (888) 458-8746, provided on your new ID card. They will help you find the most convenient provider in your area, and schedule the test for you. During this telephone call you may ask questions regarding the test and what to expect during the procedure. You may also request help with understanding your plan coverage for the procedure.

Make the most of your health care plan by choosing from a comprehensive radiology network of imaging centers while at the same time feel confident you are managing the cost of your health care.

SURGICAL MANAGEMENT PROGRAM

The Mesa Products, Inc. Employee Benefit Plan would like to share information with you regarding a new partnership with specialty surgical centers and hospitals. Mesa consistently strives to create innovative approaches to meet the needs of their membership and stay ahead of the ever-changing challenges of creating convenient and affordable access to health care.

The development of this surgical management partnership is centered-around a culture of quality, service, efficiency, and affordability for plan sponsors as well as their health plan members. As a result, the use of these specialty surgical centers and hospitals for scheduled surgeries will reduce the out-of-pocket expenses associated with hospital facility and anesthesiology charges.

The current responsibility through an In-Network Hospital provider is the annual plan deductible of $500 ($250 with PHA) plus your Out-of-Pocket expense up to $2,000. **If you choose to utilize one of these facilities, the Out-of-Pocket expense for the facility and anesthesia charges will be waived.** ***(Surgeon charge and any other related charge will apply to normal plan benefits.)***

The surgical management facility partners and locations are as follows:

Tulsa Spine & Specialty Hospital • 6901 S. Olympia Avenue • Tulsa, OK 74137

Oklahoma Surgical Hospital • 2408 East 81st Street • Tulsa, OK 74137

The program is simple to use. Although these are physician-owned facilities, there are many other non-affiliated physicians that can and many times prefer to provide surgical services at these facilities. During your consultation for a scheduled surgery, we suggest that you ask if your physician can perform his or her services at one of these facilities. In addition, **Medical Care Analysts** will contact you upon the physician's notification of a scheduled surgery to assist you with your surgical facility options. You may also contact Medical Care Analysts at 1-888-711-9060 should you have any questions or need assistance in determining whether these facilities can accommodate your type of scheduled surgery. Medical Care Analysts contact information is also provided on the back of your medical identification card.

Should the need for surgery arise, make the most of your health care plan by considering one of these facilities and feel confident that you are managing the cost of your health care.

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

On April 7, 1986, a federal law was enacted (Public law 99272, Title X) requiring that most employers sponsoring Employee Health Plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. (Both you and your spouse should take the time to read this notice carefully.) If you are an employee of MESA Products, Inc. covered by Mesa Products, Inc. Employee Benefit Plan, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by MESA Products, Inc. Employee Benefit Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under Mesa Products, Inc. Employee Benefit Plan for any of the following four reasons:

(1) The death of your spouse;
(2) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with Mesa Products, Inc.;
(3) Divorce or legal separation from your spouse; or
(4) Your spouse becomes entitled to Medicare causing a loss of coverage.

In the case of a dependent child of an employee covered by MESA Products, Inc. Employee Benefit Plan, he or she has the right to continuation coverage if group health coverage under the MESA Products, Inc. Employee Benefit Plan is lost for any of the following reasons:

(1) The death of the employee;
(2) A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with;
(3) The employee's divorce or legal separation;
(4) The employee becomes entitled to Medicare causing a loss of coverage; or
(5) The dependent child ceases to be a "dependent child" under the Mesa Products, Inc. Employee Benefit Plan.

Under the law, **the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the MESA Products, Inc. Employee Benefit Plan within 60 days of the date of the event**. Mesa Products, Inc. has the responsibility to notify the Plan Administrator of the employee's death , termination, reduction in hours of employment or Medicare entitlement.

Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want continuation coverage.
If you do not choose continuation coverage on a timely basis, your group health insurance coverage will end. Not choosing continuation coverage may cause a break in your continued coverage, and any such break of more than sixty-three days may cause loss of coverage portability.

If you choose continuation coverage, MESA Products, Inc. is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or

family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended for affected individuals to 36 months from termination of employment if other events (such as a death, divorce, legal separation, or Medicare entitlement) occur during that 18 month period. Also, if you or your spouse gives birth to or adopts a child while on continuation coverage, you will be allowed to change your coverage status to include the child.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. The 18 months may be extended to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security disability purposes) as of the termination or reduction in hours of employment, or within sixty days thereafter. **To benefit from this extension, a qualified beneficiary must notify the Plan Administrator of that determination within 60 days and before the end of the original 18 month period**. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

However, the law also provides that continuation coverage may be cut short for any of the following five reasons:

(1) MESA Products, Inc. no longer provides group health coverage to any of its employees;
(2) The premium for continuation coverage is not paid on time;
(3) The qualified beneficiary becomes covered under another Employee Health Plan;
(4) The qualified beneficiary becomes entitled to Medicare;
(5) The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Employee Health Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Under the law, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

If you have any questions about COBRA, or if you have changed marital status, or you or your spouse have changed addresses, please contact Opal Smith at (800) 749-1422.

NOTICE OF HIPAA PRIVACY PRACTICES

FOR THE GROUP HEALTH PLANS OF
MESA PRODUCTS, INC.
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of

May 1, 2014

1. Introduction: This Notice is being provided to all covered employees and dependents in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the self-insured group health plans of Mesa Products, Inc. (the "Sponsor"). If you participate in a fully insured group health plan of the Sponsor (e.g., dental, vision, cancer or other voluntary insurance policies), then the insurance company for that plan is required to provide you with a separate notice regarding the insurance company's privacy practices.

2. General Rule: The group health plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about: the Plan's uses and disclosures of Protected Health Information (PHI); your privacy rights with respect to PHI; the Plans duties with respect to your PHI; your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and the person or office to contact for further information about the Plan's privacy practices.

3. Protected Health Information: The term "protected health information" or "PHI" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment And Health Care Operations: A group health plan and its Business Associates may use PHI without your authorization to carry out treatment, payment and health care operations of the group health plan. An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan. Examples of "payment" activities include billing, claims management, and medical necessity reviews. Examples of "health care operations" include disease management and case management activities.

The group health plan and its Business Associates may also disclose PHI to the designated person listed below, known as the HIPAA privacy officer, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

Privacy Officer:
Jami Lummus - Human Resources

Privacy Team:
Terry May - President
Patrick Hobbs - Controller

5. Uses And Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose PHI for reasons unrelated to treatment, payment or health care operations without your authorization. The Plan will not use or disclose your PHI for marketing and the Plan will not sell your PHI, unless you provide a written authorization to do so. If you authorize a disclosure of PHI, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Officer identified in section 22.

6. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

7. Uses And Disclosures For Which Authorization Or Opportunity To Object Is Not Required: A group health plan and its Business Associates may use and
disclose your PHI without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities;
- When required for judicial or administrative proceedings;
- When required for law enforcement purposes;
- When required to be given to a coroner or medical examiner or funeral director;
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

8. Minimum Necessary Standard: When using or disclosing PHI or when requesting PHI from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own PHI; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

9. Disclosures Of Summary Health Information: A group health plan may use or disclose summary health information to the Sponsor for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history and other information of participants generally without identifying information specific to any one individual.
10. Disclosures Of Enrollment Information: A group health plan may disclose to the Sponsor information on whether an individual is enrolled in or has disenrolled in the plan.

11. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your PHI to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

12. Disclosures To Family Members, Other Relations And Close Personal Friends: A group health plan may disclose PHI to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the

information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan may share your PHI with your spouse if he or she reasonably demonstrates to the plan and its representatives that your spouse is acting on your behalf and with your consent. Your spouse might do so by providing the plan with your claim number or social security number. Similarly, the plan may share PHI about a dependent child (whether or not emancipated) with the child's parents. The plan may also disclose your PHI to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

Each plan reserves the right to demand a written authorization or power of attorney before disclosing PHI to any person other than the patient at issue.

13. Appointment of a Personal Representative: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms: a power of attorney for health care purposes; a court order of appointment of the person as the conservator or guardian of the individual; or an individual who is the parent of an unemancipated minor child may general act as the child's person representative (subject to state law). The group health plan retains discretion to deny access to your PHI to a personal representative.

14. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your PHI to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Officer.

15. Individual Right to Request Alternative Communications: The group health plan will accommodate written requests to receive communications of PHI by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of PHI by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception. You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Officer.

16. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the group health plan maintains the PHI. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health plan to make decisions about individuals. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual. If access is denied, you or your personal representative will be provided with a written

denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

17. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your PHI for as long as the PHI is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

18. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your PHI by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) pursuant to an individual's authorization. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

19. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Officer (see section 22).

20. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Officer. You will be provided with notice of any material change in the plan's privacy practices.

21. Notification of Breach. A group health plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

22. Your Right to File a Complaint With the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may file a complaint with the group health plan in care of the HIPAA Privacy Officer (see section 23). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. No group health plan may retaliate against you for filing a complaint.

23. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact: Jami Lummus/HIPAA Privacy Officer at, P.O. Box 52608, Tulsa, OK 74152.

INITIAL NOTICE TO EMPLOYEES OF RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

All employees of Mesa Products, Inc. will be subject to the following rights, responsibilities and definitions. For any questions regarding information contained within this document please direct to the Human Resources Department of Mesa Products, Inc..

RIGHT TO DOCUMENTATION OF HEALTH COVERAGE:

Participants in the Mesa Products, Inc. Employee Health Plan are entitled to certain rights and protections under the Health Portability and Accountability Act of 1996 (HIPAA). HIPAA limits the circumstances under which coverage may be excluded for medical conditions present prior to enrollment in a health plan. By law, a pre-existing condition exclusion may not be imposed for more than 12 months. The 12 month exclusion period may be reduced by the participant's prior health coverage. Upon termination of coverage in the Mesa Products, Inc. Employee Health Plan, participants are entitled to a certificate providing evidence of coverage under this Plan, to be furnished by the Plan Administrator.

PRE-EXISTING CONDITIONS (DEFINED AS):

Any illness or injury which:

Commenced prior to;
Has been diagnosed; or
Expenses were incurred; or
Treatment was recommended; or
Treatment was received.

Within six (6) consecutive months prior to the participant's enrollment date, unless the treatment is received or expenses incurred after a period of twelve (12) consecutive months during which the participant has been continuously covered by the Plan. For purposes of this provision, Genetic information shall not be considered a condition.

The pre-existing condition shall not apply to:

Medical expense for the care and treatment of Pregnancy for a covered employee, or spouse;

Any Participant under the age of nineteen (19).

EXCEPTIONS:

The length of the pre-existing condition limitation may be reduced or eliminated if the participant has creditable coverage from another plan and a certificate of prior coverage is provided to the Plan Administrator. Prior coverage will not qualify under this provision if there was a break in coverage under a group or individual health plan of more than sixty-three (63) days. Waiting periods are not considered a break in coverage, nor will they extend the twelve (12) month pre-existing condition period.

If the Participant was continuously covered by a previous benefit plan, the 12 month pre-existing period will be reduced by the length of time the Participant was continuously covered immediately prior to the original effective date of the Plan.

REQUIREMENTS AND EFFECTIVE DATES:

TIMELY ENROLLMENT PERIOD:
An employee shall become eligible to participate in and shall be covered under the Plan for personal medical, dental and vision coverage on the first day of the month upon completion of the following:

Date of full-time employment (waiting period established by the Plan Administrator) and,

Completion of enrollment application, provided by the Plan Administrator.

An Employee Participant may also enroll his Dependents under the Plan for coverage at this time. Enrollment shall be considered "timely" provided the completed application is provided to the Plan Administrator no later than 31 days from the date of eligibility.

NOTE: If an eligible Employee does not apply for coverage for himself or his dependent(s) within the Timely Enrollment Period (31 days following his date of eligibility), enrollment and participation in the Plan is limited to the following provisions outlined in the Special Enrollment Period.

SPECIAL ENROLLMENT PERIOD:
Under certain circumstances; a Special Enrollment Period shall be available to Employees and their dependents who are eligible, but not enrolled in the Plan. Coverage shall be effective on the enrollment date, provided all of the following conditions are met:

1. The employee (or dependent) was covered under a group health plan or had health coverage at the time coverage under this Plan was initially offered or obtained other coverage while covered under this plan;

2. The employee stated in writing at the time coverage was initially offered, that the other health coverage was the reason for declining enrollment in the Plan or stated in writing at the time coverage was dropped that the other coverage being obtained was the reason for dropping coverage under this plan;

3. The other health coverage of the employee or dependent was provided under COBRA and the COBRA coverage was exhausted, or was not under COBRA as either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward the coverage were terminated; and

   the Employee requests enrollment in the Plan no later than 31 days after the exhaustion of COBRA coverage or the termination of coverage or employer contributions, as described in 3 above.

4. Effective April 1, 2009. The employee (or dependent) was covered under Medicaid or Children's Health Insurance Program (CHIP) and coverage was terminated due to either: 1) loss of eligibility; or 2) obtaining eligibility for a state premium assistance subsidy; and

   the employee requests enrollment in the Plan no later than 60 days after the date of termination of such coverage.

NOTE: Loss of other coverage due to the individual's failure to pay premiums or for cause (such as a fraudulent claim), shall not be considered a Special Enrollment right.

Dependents shall have special enrollment rights if:

1. The employee is a participant in the Plan (or is eligible to be enrolled but declined enrollment initially or dropped coverage as described in 2 above) and

2. A person becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption;

Then the dependent, (and if not otherwise enrolled, the employee) may be enrolled in the Plan as a covered dependent of the covered employee. In the case of birth or adoption of a child, the spouse of the Covered Employee may also be enrolled as a dependent of the Covered Employee if the spouse is otherwise eligible for coverage.

Dependents must be enrolled within 31 days of becoming eligible to enroll under a Special Enrollment Period for coverage to become effective on the date of the marriage, birth, adoption or placement for adoption.

IMPORTANT NOTICE FROM MESA PRODUCTS ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

IF YOU OR YOUR DEPENDENTS ARE CURRENTLY ENROLLED OR WILL BECOME ENROLLED IN MEDICARE IN THE NEXT 12 MONTHS, PLEASE READ THIS NOTICE. OTHERWISE, YOU CAN DISREGARD THIS NOTICE.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Mesa Products Employee Benefit Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Mesa Products has determined that the prescription drug coverage offered by the Mesa Products Employee Group Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Mesa Products coverage will not be affected. Because your existing coverage through Mesa Products is Creditable Coverage, you can retain your existing coverage and choose not to enroll in a Medicare drug plan. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current Mesa Products Employee Benefit Plan coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Mesa Products Employee Benefit Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the HR Department of Mesa Products Employee Benefit Plan for further information or call HealthCare Solutions Group at (800) 749-1422. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Mesa Products Employee Benefit Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	11-1-2010
Name of Entity/Sender:	Mesa Products
Contact--Position/Office:	Sherry McCoy/HealthCare Solutions Group, Inc.
Address:	P.O. Box 1309; Muskogee, OK 74402
Phone Number:	(800) 749-1422

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;

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

3. Prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your group health plan.

If you would like more information on WHCRA benefits, contact HealthCare Solutions Group at (800) 749-1422.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDRENS'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	FLORIDA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
ARIZONA – CHIP	GEORGIA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	MONTANA – Medicaid
Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084

INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MINNESOTA – Medicaid	
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	
MISSOURI – Medicaid	
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	

Phone: 573-751-2005	
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	VERMONT– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

ACKNOWLEDGMENT

I acknowledge that I read and understand the Health Insurance Handbook. I understand that this Handbook is available on SharePoint and that I am responsible for knowing its contents, including but not limited to, timely enrollment and life changing event procedures.

I acknowledge that the Plan Document is available to me on SharePoint and that a hard copy will be provided upon request. I understand that the information in the Plan Document is a complete description of the benefits provided by the Plan. I recognize that it is my responsibility to read and maintain this document, as it has been provided by the Plan Administrator to inform Participants of their rights and benefits provided therein.

I understand that the information in the Plan Document is intended to acquaint Participants with general benefits and procedures; however, the Plan Administrator remains free to act according to prudent business judgment and to change the benefits and procedures described therein at any time.

I understand that as a covered Participant, I must comply with all the provisions of the Plan in order to obtain maximum benefits.

I further understand that I will be responsible for complying with future changes in such benefits and procedures communicated to Participants from time to time.

I acknowledge that I received a copy of the notice entitled "Group Health Continuation Coverage Under COBRA." I acknowledge that I understand this document and that I will be responsible for complying with the Plan.

I acknowledge that I have received a copy of the notice entitled "Initial Notice to Employee of Rights Under the Health Insurance Portability and Accountability Act of 1996." I acknowledge that I understand this document and that it is my responsibility to comply with the Plan.

Signature Printed Name Date