Driving
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Summary Plan Descriptions

Benefit Plans

2015

Airgas

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INTRODUCTION

Airgas, Inc. sponsors the Airgas, Inc. Comprehensive Welfare Benefits Plan ("Plan"). The Plan provides benefits to eligible employees of Airgas, Inc. and its subsidiaries listed under the "Plan Information" section of this Summary Plan Description. If you are eligible to participate, the Plan provides a variety of benefits for you and your eligible dependents.

This Summary Plan Description ("SPD") provides you with important information about the Plan. Some of this information is also posted on the Airgas internal website under My Airgas.

Airgas urges you to review your SPD carefully. Please remember, however, that the information included in your SPD does not contain all Plan provisions. If there is a conflict between the SPD and the Plan, the terms of the Plan will apply. A copy of the Plan is available for inspection in the Human Resources Department, 259 N. Radnor-Chester Road, Radnor, PA 19087, during regular business hours. Alternatively, you may make a written request for a copy of the Plan.

GENERAL INFORMATION

SPD Contents

General Information

This section of the SPD provides you with important information about the matters listed below

- The kind of benefits the Plan provides.
- The amount of benefits the Plan provides.
- The conditions you and your dependents must satisfy to participate in the Plan.
- The conditions you and your dependents must satisfy to receive benefits.
- Your legal rights under the Employee Retirement Income Security Act ("ERISA").
- Procedures for making benefits claims and appealing from denied claims.
- General information about Plan administration.

Detailed Information about Each Benefit

Separate sections of the SPD provide you with detailed information about each benefit the Plan provides. Those sections also include important information about conditions for receipt of benefits, amount of benefits, exclusions and making claims for benefits and appealing from claim denials. A list of the benefits is provided below.

Benefits

The Plan provides a number of benefits. Airgas has purchased insurance to provide some of the benefits. Airgas provides other benefits out of its general assets.

Insured Benefits

The insurance company from which Airgas purchases the insurance policy or contract pays or provides the benefits listed below.

- Health benefits through certain health maintenance organizations (HMOs)
- Vision benefit insurance
- Life insurance
- Dependent life insurance
- Supplemental life insurance
- Accidental death and dismemberment insurance
- Long-term disability insurance
- Lifeworks Employee Assistance Program (EAP)
- STD Buy Up Plan

For benefits provided through insurance policies, Airgas enters into a contract with the insurance company that provides the benefits. Airgas determines the conditions that apply to eligibility to participate in the benefits program and the general schedule of benefits. The insurance company that provides the benefits administers its policy and makes all decisions about whether benefits are payable under a specific set of facts, and if so, the amount of benefits that its insurance policy provides.

These matters are explained for each benefit in the SPD section that describes the conditions applicable to eligibility to receive that benefit and the amount of benefit.

Airgas-provided Benefits

Airgas pays or provides for the benefits listed below out of its general assets.

- Health
- Prescription drugs
- Dental
- Short term disability
- Health care spending account
- Dependent care spending account

For these benefits, Airgas determines the conditions that apply to eligibility to participate in the benefits program and, with the assistance of consultants, designs the schedule of benefits that it will provide. Generally, Airgas hires independent third-party administrators to administer the benefits and make decisions about eligibility for benefits and the amount of benefits the program provides.

ELIGIBILITY

Eligible Employees

You are eligible to participate in all of the benefit programs described in this Summary Plan Description if you are an Airgas employee who (i) is employed on a regular and continuing basis, (ii) is regularly scheduled to work at least 30 hours per week on an annual basis and (iii) is not in an excluded classification as explained below. Your participation begins on the 31st day of your continuous employment measured from the date you began work for Airgas. For example, if you begin to work on April 15th, you become eligible for benefits on May 16th, assuming you remain an eligible Airgas employee. If you are transferred from an ineligible classification to an eligible classification, the 31 days is measured from your date of transfer.

Note: For purposes of determining length of service, Airgas frequently credits employment with a company or business that Airgas acquires for persons who become Airgas employees immediately after the acquisition. If you were an employee of an acquired business, you will be advised whether or not your past service is credited. In any event, you cannot become eligible for any period prior to the start of your Airgas employment.

To begin benefit coverage, you must enroll for those benefits that require employee contributions. If you do not enroll by the deadline, ordinarily you will not be eligible to enroll for benefits until the next January 1st, which is the effective date for the next annual open enrollment. [See the heading "*Enrollment*" for a more detailed discussion of these rules.]

Ineligible Employees and Classifications

Persons in any of the categories listed below are not eligible to participate in the Plan.

- Employees regularly scheduled to work less than 30 hours per week.
- Employees hired in a temporary status or not hired to work on a regular and continuing basis as determined under the rules and policies of the Airgas company that employs them.
- Employees in a collective bargaining unit, unless the collective bargaining agreement provides that they are eligible for some or all of the benefits the Plan provides.

Note: Employees who are members of collective bargain- ing units should review their bargaining agreement to de- termine whether they are eligible for some or all of the benefits described in this booklet and any special terms or conditions for eligibility. If you are employed by Airgas under the terms of a Collective Bargaining Agreement (CBA) that includes this benefit, this SPD neither changes nor amends the terms of your CBA.

- Persons who Airgas does not regard as its "employee" for purposes of federal income tax withholding against wages and/or social security taxes, such as independent contractors or persons who are employed by an independent third-party.

Eligible Dependents

Some of the benefit programs, such as the medical and dental benefits programs, allow certain of your family members to participate. The categories of eligible dependents are listed below.

No person may be covered both as an Employee and Dependent and no person may be covered as a Dependent of more than one Employee.

Your eligible Dependents may participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse/Domestic Partner provided he or she qualifies as a spouse/Domestic Partner under federal law. A legally separated spouse or a former spouse is not an eligible dependent.),
- Your Adult children of Airgas employees are eligible for coverage on Airgas Medical Dental and Vision Plans; coverage may continue up to age 26. An adult child includes your child who is married or unmarried, up to age 26, who is any of the following:
    - Your biological child;
    - Your legally-adopted child;
    - Your stepchild;
    - An eligible foster child, placed in your care by an appropriate court or placement agency;
    - A child for whom you are the current court-appointed legal guardian.

The following requirements are removed: unmarried, a full-time student, financial dependency on the employee and residency with the employee.

- Your disabled child, over age 26 who is unable to earn a living due to a physical or mental handicap and who was disabled prior to the age of 26 and continues to be disabled.
- Your natural or adopted children up to age 26 for whom you are required by a Qualified Medical Child Support Order ("QMCSO") or other court or administrative order.

Note: To obtain health plan coverage for a newborn child, you must enroll that child within 31 days of birth, even if you have other children covered in the health program.

Domestic Partner Coverage

For associates of Airgas the Plan treats a Domestic Partner as a dependent. A person is a Domestic Partner of an Airgas associate if they are a same-sex or opposite-sex couple who has registered with any state or local government domestic partnership registry. The children of a "domestic partner" who qualifies as an eligible dependent are treated as the children of the eligible employee and are eligible to participate on the same basis as any other child under the rules described above.

Note: To obtain health plan coverage for a newborn child, you must enroll that child within 31 days of birth, even if you have other children covered in the health program.

Exclusions

Any person not described as eligible as listed above is not a dependent for purposes of the Plan.Therefore, for example, grandchildren or other relatives or extended family members are not eligible.

Caution! Dependent Verification!

Each employee is responsible for making certain that the persons he or she enrolls as dependents are actually eligible to receive benefits under the eligibility rules described above. The Plan will not pay benefits to or for someone who is enrolled as a dependent but does not qualify as an eligible dependent. The claims administration process is designed to detect claims submitted for a person who does not meet the eligibility rules. If you elect to cover dependents, you will need to provide information confirming the dependent relationship within 31 days of enrolling a dependent. If the required information is not provided within that time period, your dependents will not be enrolled until the next annual enrollment period (assuming that you provided the required supporting documentation at that time). You are also responsible for keeping your covered dependent information up to date.

Determination of Eligibility

Airgas or its appointed third party administrator has the exclusive authority to determine whether an individual is an eligible employee or an eligible dependent

Dependent Eligibility Audit

Periodically Airgas conducts random audits of dependents covered under the Airgas health dental and/or vision care plans. If you are selected to participate in an audit, you must provide acceptable proof that the individuals you named as dependents for the health, dental and/or vision care benefits meet the definition of "dependent".

If you do not provide the required proof within the time-frame specified, the individual for whom the information is not provided/approved will be removed from coverage and you will not be permitted to add the individual back to coverage until the next annual enrollment.

Employee Payment on a Before Tax Basis

You may pay your share of the cost for medical, prescription drug, dental and vision benefits on a before tax basis using the Airgas Flexible Benefits Plan which is part of this Plan. If you choose to participate in either or both of the health care or dependent care spending account programs, you pay for them using the Flexible Benefits Plan. The advantage to you is that amounts you pay for these benefits are not subject to federal income tax or social security tax. Your contributions are deducted from your regular paycheck. They are not treated as wages for tax purposes; therefore, you pay lower taxes than if the amounts were subject to the usual income and social security taxes. For more information about the Flexible Benefits Plan, see the heading "Benefit Descriptions—Flexible Benefits Plan" later in this booklet.

Employee Payment on an After Tax Basis

You pay for optional additional life insurance coverage for yourself, life insurance coverage for your spouse or children, optional accidental death and dismemberment insurance, optional additional short-term disability insurance, and optional additional long-term disability insurance by payroll deduction. Your contributions are deducted from your regular paycheck on an after tax basis. That is, your contributions are treated as wages for purposes of income and social security taxes.

Spousal Surcharge

Your spouse or domestic partner are eligible to participate in the Airgas medical plans offered to eligible employees. If your covered spouse or domestic partner is eligible for health care coverage from his/her employer, but elects instead to participate in the Airgas medical plans you will be required to pay a surcharge of $100 per month in addition to the contribution required based on your election. If the surcharge applies in your situation, you must indicate 'yes' when enrolling in benefits. If at any time during the year circumstances change and the surcharge no longer applies, you may notify YBR by contacting them at 1-877-424-2363 and your employee contributions for health care will be reduced by the surcharge amount.

The surcharge applies only to medical plans (Aetna, UHC, PPO and HMOs). It does not apply to dental, vision or the flexible spending accounts.

ENROLLMENT

New Eligible Employees

Each person who becomes an eligible employee has the opportunity to enroll for optional benefits. New employees must enroll by the deadline.

Generally, you become eligible to participate on the 31st day of your continuous employment with Airgas, measured from the date that you began work as an eligible Airgas employee. Therefore, if the date you began work as an eligible employee is April 15th, you become eligible for benefits on May 16th, assuming you remain an Airgas employee. You have until June 16th to enroll since June 16th would be the 31st day after you became eligible to participate. In this example, if you enroll by June 16th, your eligibility will relate back to May 16th.

If a new eligible employee does not enroll, the employee will receive those benefits that Airgas provides without cost to the employee. However, the employee will not be eligible for any other benefits until the next January 1st unless the employee is eligible for a special mid-year election, as explained further in this section.

Continuing Eligible Employees

The Plan has an "open enrollment period" for each calendar year. Ordinarily, the open enrollment period is a three week period in October. Airgas will advise all eligible employees when the open enrollment period begins and ends. During the open enrollment period, each eligible employee will be given the opportunity to elect to participate in the various benefit programs that require employee contributions and to change benefit elections he or she previously made. If an eligible employee does not enroll during his or her first open enrollment period, he or she will not participate in any of the benefit programs that require employee contributions. If an eligible employee does not make a new enrollment after the first open enrollment, he or she will be deemed to have elected the benefits previously elected, except for the health and dependent care spending account benefits and group health coverage. For the two spending account programs, the employee will be treated as having elected to make no contributions. For the group health program, If the medical program, in which you participated is removed from the Plan, then at the open enrollment you will be treated as having elected the "core" program available under the Plan.

If you move your residence and that move results in your loss of eligibility to participate in the medical program you previously elected, you must make a mid-year election of a medical program from the options available in your new

location or you will be treated as having elected the "core" program available under the Plan.

The materials Airgas makes available before the start of each annual "open enrollment period" will explain your options, the cost to you of each available option and how to make your elections.

Generally, you enroll through "Your Benefits Resources™" or "YBR", which is an independent company that Airgas hired to handle benefits enrollment and certain other Plan administrative functions. YBR provides opportunities to enroll using its web site (www.ybr.com/airgas), and an automated resource line (toll free telephone: 1-877-424-2363) that is available seven days per week and 24 hours per day. A customer representative is generally available at the automated resource line from 8:00 a.m. to 9:00 p.m., Eastern Time, Monday through Friday.

Special Mid-Year Enrollments or Election Changes

The general rule is that if you do not enroll when you first become eligible and/or do not enroll during an open enrollment period, you will not be eligible for any benefits that require employee contributions for the remainder of the calendar year. In addition, if you do enroll, you may not change your elections or terminate your enrollment until the start of the next calendar year.

However, under certain specified circumstances, referred to as "life status changes", you may enroll for coverage (if you did not enroll when you first became eligible or during an open enrollment period), drop or terminate your coverage, add eligible dependents or drop eligible dependents or otherwise change your benefit elections. Any change that you desire to make must be consistent with the "life status change" that has occurred.

All changes will become effective as of the date of the life event.

As noted, the specified circumstances that permit you to change your elections are referred to as "life status changes". The "life status changes" are listed below. If you have a life status change, you must make your new election or election change within 31 days after the life status change event occurs. You do that through the YBR web site or through the automated resource line or by speaking with a customer service representative. If you add a dependent for the first time as a result of your life event, you will be required to provide proof of the dependent relationship within 31 days of electing coverage. Acceptable types of proof include such documents as marriage certificates, birth certificates, and tax filings. Other types of acceptable proof will be detailed in the request you receive following your election.

Note: It is critical that you make any life status change election within 31 days of the date the event occurs. If you do not, you will not be permitted to change your election until the next open enrollment.

The "life status changes" the Plan recognizes are as follows:

- Your marriage, the annulment of your marriage, your divorce or legal separation.
- Death of your spouse or an eligible dependent.
- Birth or adoption of your child or placement of a child with you for adoption.
- An event, such as attaining a stated age or change in full time student status, that causes a dependent to cease to qualify for coverage.
- A change in your eligibility status or the eligibility status of your spouse or other eligible dependent due to a change in employment.
- A change in your worksite or residence location, or that of your spouse or other eligible dependent.
- A change in your employment status or that of your spouse or dependent that results in gaining or losing eligibility for certain benefits.
- A significant change in the benefits the Plan provides or the cost of those benefits to you. *(Note: This does not apply to a change in health care spending account election.)*
- An election your spouse or dependent makes under a benefits plan offered by his or her employer that operates on other than a calendar year. *(Note: This does not apply to a change in health care spending account election.)*
- Receipt of a Qualified Medical Child Support Order covering your child.
- Changes in dependent care providers or costs *(Note: This only applies to dependent care spending accounts.)*
- Entitlement to Medicare or Medicaid.

In addition, the Health Insurance Portability and Accountability Act ("HIPAA") provides for certain midyear elections. If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for

adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, a midyear election is permitted if you or your eligible dependents become ineligible for Medicaid or the Children's Health Insurance Program and therefore lose coverage or become eligible for your State's health care premium assistance program. In either of those situations, you may request midyear enrollment in this Plan within 60 days from the date coverage was lost

Note: Airgas has the exclusive authority to determine whether a circumstance or "life status change" or other circumstance has occurred that permits a new election and the effective date of any such permitted change..

TERMINATION OF BENEFITS

General Rule for Employees

Your eligibility for benefits will end on the first to occur of any of the events listed below:

- Termination of your employment with Airgas for any reason.
- Your transfer to a job classification that is not eligible to participate.
- Your failure to pay your share of the cost for any benefit you elected.
- Your failure to re-enroll for benefits during any open enrollment period for benefits that require an affirmative annual election (except for a limited exception that applies to a health option, as previously noted.)
- Airgas amends the Plan in a manner that makes you ineligible.
- Airgas amends the Plan to eliminate benefits that you elected.
- Airgas terminates the Plan.

General Rule for Dependents

Your dependent's eligibility for benefits will end when your eligibility ends, or earlier if:

- The date the person no longer qualifies as an eligible dependent, for example, due to reaching the age limit for eligibility or change in status such as a divorce, except that health benefits for a dependent child terminate on the last day of the calendar month in which the child reaches the applicable age limit.
- The date the Plan is amended to change the rules for dependent coverage or eliminate dependent coverage.
- The date your dependent becomes covered as an employee.

Special Rules for Group Health Benefits: COBRA

Federal law requires that you have the opportunity to continue your coverage under employer-sponsored group health plans if coverage is lost for certain specified reasons, known as "qualifying events". This right to continuation coverage is frequently referred to as "COBRA coverage," after the Federal Law allowing such coverage. The Airgas programs that are subject to COBRA are the (i) medical program (which includes prescription drugs, (ii) dental program, (iii) vision program and (iv) health care spending account program.

As noted, if your coverage or the coverage of your eligible dependents terminates under these programs for any of several reasons, known as "qualifying events", you or your eligible dependents may elect to continue the coverage that was in effect on the date your "qualifying event" occurred for a fixed period of time by making a timely election to continue that coverage and by paying the full cost of that coverage. The rules that apply to this election are explained in detail in the section of the SPD that describes medical coverage. Some special rules apply to continuation coverage for the health care spending account. The description for these rules is found later in this booklet under the general description for that program.

You should read that material as well as other information that will be sent to you about the right to elect continuation coverage, and follow the procedures carefully. If you do not make a timely election to continue coverage, you will lose your right to do so.

If you have a "qualifying event" that entitles you to elect continuation coverage, you will receive election forms to choose whether you want the coverage and more information about the coverage.

However, for certain "qualifying events", such as your divorce or legal separation from your spouse or a dependent child's losing eligibility for coverage as a dependent child, you must notify the COBRA administrator within 60 days of the date that the "qualifying event occurs so that they can send you the election materials. You give this notice by contacting YBR at 1-877-424-2363 or on the web at www.ybr.com/airgas.

More information about the notification requirements, including notification requirements that apply to extended COBRA coverage due to disability, are explained in the section of this SPD that describes medical coverage.

When your COBRA continuation period expires for any reason, you are no longer eligible for group health coverage from Airgas.

Leave of Absence: Family and Medical Leave Act

If you are on an approved leave of absence under the Family and Medical Leave Act, your benefits will continue in the same manner that applies to active employees provided you continue to pay your share of the cost for your coverage that requires employee contributions. You will be billed directly for your coverage from YBR.

Leave of Absence: Military Leave

If you are a reservist or a member of a State National Guard unit and are called to active duty, many of your benefits will continue for up to one year on the same basis that applies to active employees provided you continue to pay your share of the cost for any coverage that requires employee contributions.

Unpaid Leaves of Absence for Medical Reasons

For employees on an unpaid leave of absence for medical reasons that extends beyond the period permitted by the Family and Medical Leave Act (FMLA), benefits may continue in the same manner that applies to active employees provided you continue to pay your share of the cost for your coverage that requires employee contributions. You will be billed directly for your coverage from YBR. You should contact your local HR representative to discuss when your benefits will terminate.

BENEFIT DESCRIPTIONS

Please refer to individual SPDs for more complete information.

Health Plan: Medical and Prescription Drug

The Plan provides medical benefit programs that Aetna Life Insurance Company ("Aetna") or United Healthcare, Inc. ("UHC") administer for Airgas. When you enroll for medical benefits, you receive prescription drug coverage under a prescription drug program that CVS/Caremark, Inc. administers. Your Summary Plan Description includes separate descriptions for the Aetna and UHC medical plans as well as a separate description for the prescription benefits.

The group medical plan, known as the Aetna Choice Point of Service (POS) II Plan that Aetna administers, or the Airgas, Inc. Medical Choice Plus Plan that UHC administers is available to all eligible participants. You may design your own plan by selecting among several options that the plan offers. Each option has a different level of cost-sharing that you must pay and a different level of coverage (deductibles, copay, coinsurance, etc.). The cost and coverage differences are explained in your enrollment election materials and/or the descriptions of coverage.

Airgas provides medical and prescription drug benefits out of its general assets. Aetna or UHC and CVS/Caremark administer the programs for the Plan; however, they do not insure the benefits. Aetna and UHC are the "claims fiduciaries" for medical benefits that they administer and CVS/Caremark is the claims fiduciary for the prescription drug benefit. That means that they have the sole and exclusive authority and responsibility to determine whether the Plan will accept a specific claim for benefits, and, if so, how much it will pay. The claim procedure and claim appeal procedure are explained in separate sections of this SPD.

In addition, if you live in a service area of a fully insured health maintenance organization ("HMO") that is part of the Plan, you will be eligible to elect participation in a program of benefits, including pharmacy, which the HMO offers. If an HMO is available to you, it will be identified on YBR when you enroll. Coverage and cost information will be provided in your enrollment materials. HMOs sponsored by Aetna are part of the self-insured arrangement. If you participate in an HMO sponsored by Aetna, you will receive your prescription benefit coverage through CVS/Caremark. HMOs sponsored by other parties generally provide benefits that are insured by the HMO. The HMO is responsible for ruling on all benefit claims. The procedures are included in the HMO booklet.

Your share of the cost to participate under any of the health program options available to you is explained in the annual enrollment materials. The cost may change from time to time. You pay your share with pre-tax contributions under the Airgas Flexible Benefits Plan. Currently, the employee share of the cost depends on the employee's annual benefit base, with higher paid employees paying a larger portion of the cost, and the number and type of dependents the employee covers. The term annual benefit base for purposes of an annual amount is defined as your annual base salary if you are paid on a salaried basis and your straight time hourly rate multiplied by 2080 if you are paid on an hourly basis. If you are paid in part by salary and part by commission, annual benefit base means your base pay plus your commissions for the previous 12 months. Your annual benefit base will be adjusted annually effective each September based on the change in your annual base salary, base salary and commissions or straight time hourly rate, as the case may be, for the 12-month period ending on the preceding June 30th. For example, any changes for the period July 1, 2013-June 30, 2014 become effective January 1, 2015 and apply for the 2015 plan year, which begins January 1, 2015 and ends December 31, 2015.

For new employees, base salary and hourly rate are determined as of date of hire. Commissions are based on expected commission payments for the year.

Dental Plan

The Plan provides dental benefit programs that Aetna administers. A description of the dental benefits is included as a separate section of your Summary Plan Description. This program is available to you even if you choose medical coverage through an HMO or decline medical coverage.

You may elect a "basic option" or a "premium option". You do not have to cover the same eligible dependents for dental coverage as you did for health coverage. The cost and coverage differences are explained in your enrollment election materials and/or the descriptions of coverage.

Airgas provides dental benefits out of its general assets. Aetna administers the program for the Plan; however, Aetna does not insure the benefits. Aetna is the "claims fiduciary" for these benefits. That means that Aetna has the sole and exclusive authority and responsibility to de- termine whether the Plan will accept a specific claim for benefits, and, if so, how much it will pay. The claim pro- cedure and claim appeal procedure are explained in the separate dental section of this SPD.

Your share of the cost to participate in a dental program option is explained in the annual enrollment materials. The cost may change from time to time. You pay your share with pretax contributions under the Airgas Flexible Benefits Plan. Currently, the employee share of the cost depends on the employee's annual benefit base, with higher paid employees paying a larger portion of the cost.

Vision Benefits

The Plan provides vision benefits through a fully-insured arrangement. The administrator is EyeMed Vision Care, LLC ("Eye- Med"). A description of the vision benefits is included as a separate section of this Summary Plan Description.

EyeMed has the sole and exclusive authority and responsibility to determine whether it will accept a specific claim for benefits, and, if so, how much it will pay. The claim procedure and claim appeal procedure are explained in the separate section.

You pay the entire cost of this benefit with pretax contributions under the Airgas Flexible Benefits Plan. The costs are explained in your annual enrollment materials.

Life Insurance

The Plan provides several life insurance/accidental death and dismemberment options. Hartford Life and Accident Insurance Company ("Hartford") provides all of the coverage through group policies that it has issued to Airgas. Descriptions of the various options that are available to you are included in your Summary Plan Description.

Hartford has the sole and exclusive authority and responsibility to determine whether it will accept a claim for benefits, and, if so, how much it will pay. The claim procedure and claim appeal procedure are explained in the separate section.

Basic Life and Accidental Death and Dismemberment

Airgas pays the full cost to provide each eligible employee with basic life insurance and basic accidental death and dismemberment insurance. The amount of insurance is the lesser of $50,000 or your annual benefit base.

See the full SPD for information on optional coverage offered under the Plan.

Short Term Disability

The Plan provides short-term disability benefits that Hartford Life and Accident Insurance Company ("Hartford") administers for Airgas. If you are an eligible employee, you participate in the benefit program automatically. Airgas pays all benefits out of its general assets. Hartford does not insure this benefit.

Hartford has the sole and exclusive authority and responsibility to determine whether your claim for short-term disability benefits qualifies under the program, and, if so, how long benefits are payable.

This program is described in detail in a separate section of this SPD. It explains, among other things, eligibility for the benefit, the formula for calculating benefits and information about submitting claims and appealing from a claim denial.

Because Airgas provides you this short-term disability benefit without cost to you by payment from its general assets, this benefit program is not an "employee welfare benefit plan" within the meaning of the Employee Retirement Income Security Act, generally known as "ERSIA". Therefore, ERISA information in this Summary Plan Description does not apply to the short-term disability program.

Long Term Disability

The Plan provides long-term disability benefits under a group insurance contract that Hartford Life and Accident Insurance Company ("Hartford") issued to Airgas. Hartford has the sole and exclusive authority and

responsibility to determine whether your claim for long term disability benefits qualifies under its contract, and, if so, how long benefits are payable.

The long term disability benefit program consists of two portions. There is basic coverage and a buy up plan. Please refer to the full SPD for details.

Benefit payments are reduced by any social security disability payment, worker's compensation benefit and certain other amounts that you receive. The offsets to your benefit payment are explained in the separate section of this SPD that describes the long-term disability benefit in detail. It explains, among other things, eligibility for benefits, the formula for calculating benefits, offsets to benefits and information about submitting a benefit claim and appealing from a claim denial.

Flexible Benefits /Spending Account Programs

General Information

The Plan includes a Flexible Benefits arrangement, which is a program that allows you to elect that your regular salary be reduced to pay your share of the cost for certain benefits with before tax dollars. The rules that control this type of arrangement are largely governed by Internal Revenue Code regulations since the arrangement permits you to convert otherwise taxable income into nontaxable benefits. For that reason, you may not make contributions on a before tax basis to provide coverage or benefits for any person who you do not claim as your dependent for federal income tax purposes. See the Flexible Spending account section of this SPD for the IRS description of eligible dependents for whom you can claim reimbursement under the spending account plans.

The Flexible Benefits arrangement allows you to pay your share of the premium for medical, prescription drug, dental and vision benefits with before tax dollars. This approach provides a tax savings for you by reducing your taxable income. The amount you make available from your salary or wages is not subject to Social Security tax, federal income tax and many state and local income or wage taxes. However, because your contributions may reduce your employer and employee contributions to Social Security, they may cause a reduction in your Social Security benefit at retirement.

The Flexible Benefits arrangement also allows you to elect to reduce the amount of taxable salary or wages payable to you to fund two "spending account" arrangements, one which permits reimbursement of certain qualifying medical care expenses and the other certain qualifying dependent care expenses. Some of the specifics of these arrangements are explained below.

Each of your spending accounts is a "bookkeeping account". That is, Airgas does not establish a trust fund or other separate or segregated asset pool to provide your reimbursements. Instead, the independent administrator that Airgas has selected sets up a bookkeeping account in the name of each eligible employee who elects to participate in either or both spending account arrangements. The amount deducted from the employee's pay is credited to his or her account. As benefits are paid out, the account is reduced to reflect the benefit payment..

"Your Spending Account" or "YSA" is the administrator for the spending account arrangements.

You elect to participate in a spending account arrangement during the annual open enrollment. Once you make your election for a year, you may not change that election unless a "life status event" occurs. [This is explained under the heading "Enrollment—Special Mid-Year Enrollments or Election Changes".] Since you cannot change your election at will, it is important that you consider your election carefully. Under Internal Revenue Code rules, you must forfeit any amount remaining in your account at the close of a calendar year. This "use it or lose it" requirement is imposed on Airgas by the Internal Revenue Code. Airgas has no choice but to honor it in order to preserve the tax benefits these arrangements offer to all eligible employees. This Plan has not been amended to allow for carryover.

The Health Care Spending Account arrangement is an "employee welfare benefit plan" that is subject to the requirements of the Employee Retirement Income Security Act ("ERISA"). However, neither the Flexible Spending program nor the Dependent Care Spending Account is covered by ERISA.

Health Care Spending Account

You may elect to contribute as little as $50 or as much as $2,500 per calendar year to your health care spending account. You may use your account to claim reimbursement of qualifying expenses for medical care for you or your eligible dependents that are actually incurred during the year.

As previously explained, due to Internal Revenue Code limitations, eligible dependents for purposes of this program are limited to those persons who qualify as your dependents under Internal Revenue Code rules that apply to this type of benefit.

An expense generally is incurred on the date the particular service is supplied or item purchased. However, for orthodontia services, the expense for a course of treatment will be deemed incurred at the time payment for it is made to the orthodontist even if the services are provided after the close of the calendar year. Remember that you are not reimbursed for any expense over the amount of annual benefit you elected or which is incurred before you become a participant in the spending account arrangement or after your participation terminates. However, if your employment or eligibility ends before you have incurred claims for your entire account, you may elect to continue participation for the remainder of the calendar year by making contributions on an after tax basis. The health care continuation coverage election package (COBRA) that you receive will include the necessary materials to make this election. You must complete and return them on a timely basis to continue participation.

Details about the kinds of expenses for which you may seek reimbursement, the schedule for making reimbursement and how to submit a claim for reimbursement and appeal from a denied claim are all included in the separate section of this Summary Plan Description that describes spending account arrangements.

Dependent Care Spending Account

You may elect to contribute as little as $50 or as much as $5,000 per year to your dependent care spending account, except as explained later in this section.

The program allows you to claim reimbursement for qualifying expenses you incur to allow you and your spouse (if you are married) to remain gainfully employed or look for work or for your spouse to be a full-time student.

Qualifying expenses must relate to care of a dependent that either is under age 13 or physically or mentally incapable of caring for him or herself. If the services are performed outside of your home, they must relate to a dependent who is under age 13 or who spends at least eight hours each day in your home. Due to Internal Revenue Code limitations, dependents for purposes of this program are limited to persons who qualify as such under Internal Revenue Code rules that apply to this type of benefit.

If your claim is for more than your current account balance, the excess portion will be carried over until such time as your contributions to your account for the calendar year are sufficient to cover the expenses. No claim will be paid that exceeds that the balance in your account. Also no claim will be carried over from one calendar year to the next.

You may not be reimbursed for any expenses for services rendered before you become a participant in this program or after your participation ends, except that if you have a balance in your account when your active participation ends you may continue to submit claims for the remainder of the calendar year if, but only if, you have taken other employment that would allow you to submit claims for dependent care under another employer's plan (if you were a participant in it.) It is not necessary for you to have actually paid an item prior to submitting a claim for it. However, you must have actually incurred the expense and had the service performed.

You may be required to provide reasonable documentation to establish that a claimed expense is one, which qualifies for reimbursement under this program.

There are some special limitations on the contribution amount. First, if you are married and your spouse resides with you but you file separate federal income tax returns, the maximum you may contribute is $2,500. Also, the amount you contribute can never exceed the lesser of you or your spouse's earned income as it appears on your respective Form(s) W-2 for the calendar year. For this purpose, a spouse who is either incapacitated or a student is considered to have earned income in the amount of $250 per month if there is one individual for whom you can claim work-related expenses and $500 per month if there are two or more such individuals. Finally, the maximum amount of benefit you and your spouse may exclude from taxable income in any year is a combined total of $5,000. Therefore, if your spouse has the opportunity to participate in a dependent care spending account program sponsored by your spouse's employer, the total that you and your spouse contribute to the plans should not exceed $5,000.

You may not claim any other federal income tax benefit, such as the household and dependent care credit, for the tax-free amounts you receive under this program. The actual determination of whether the benefits of this program or the credit are better for you depends on a number of factors, such as your filing status, number of dependents and the like. You should consult your tax adviser if you need assistance in deciding what is best for you. If you

use this program and your eligible dependent care expenses are greater than the reimbursement you receive and the amount of your reimbursement does not exceed the maximum amount of expenses eligible for the credit, you may be eligible for the credit for all or a portion of your unreimbursed eligible expenses.

ADMINISTRATIVE DISCRETION AND CLAIMS

Airgas, acting through its appropriate officers and employees, and each other fiduciary of the plan, such as the third-party administrators who rule on claims and appeals from denied claims, have complete discretionary authority to interpret the plan and to make all determinations that the plan requires, such as determinations with respect to eligibility to participate, eligibility for particular benefits and the amount of benefits. Each and every interpretation or determination that Airgas or any other plan fiduciary makes in exercising discretionary authority is binding on all parties, to include employees, participants and their beneficiaries, and shall be given full force and effect to the maximum extent permitted by applicable law.

Specific information about how to make a benefit claim and how to appeal from a denial of a specific claim is included in the booklet section for each benefit. You should review that information carefully when making a claim or appealing from a denied claim. You should be aware that failure to raise an issue or question during the claim procedure may prevent you from raising it later in any litigation. You should also be aware that the claim appeal procedures have certain time limitations for making an appeal and that failure to follow the appropriate limit can result in your loss of rights to litigate an adverse claim decision.

AMENDMENT AND TERMINATION

Airgas reserves the complete and unrestricted right to take any action it deems necessary or appropriate with respect to the Plan, including, but not limited to, the following;

- Amend the eligibility rules for employees and/or dependents for the entire Plan or for specific benefit programs.
- Establish different rules for different classes or groups of employees.
- Add, subtract or revise any benefit program.
- Retain or remove any third-party administrator or consultant.
- Retain or remove any insurance carrier.
- Increase or decrease the amount an employee is required to pay to participate in a benefit program.

In addition Airgas retains the right to terminate the Plan in its entirety.

Generally, Airgas has delegated the power to amend the Plan or terminate the Plan to its senior human resources officer or, if appointed, a committee named by the appropriate executive officers of Airgas.

ERISA RIGHTS

The following statement of your rights under the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") was prepared by the United States Department of Labor. Federal law and regulation require that we include it in this Summary Plan Description.

As a participant in the Airgas, Inc. Comprehensive Welfare Benefits Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan

as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

Prudent Action By Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance With Your Questions

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

SPECIAL FEDERAL RULES GOVERNING BIRTHS

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

PLAN INFORMATION

Name of Plan	Airgas, Inc. Comprehensive Welfare Benefits Plan
Plan Number	501
Name and address of Plan Sponsor	Airgas, Inc. 259 N. Radnor-Chester Rd. Radnor, PA 19087-5240
Telephone # of Plan Sponsor	610-687-5253
Employer Identification # of Plan Sponsor	56-0732648
Agent for Service of Legal Process	Robert H. Young, Jr. Vice Pres., General Counsel and Secretary Airgas, Inc. 259 N. Radnor-Chester Rd. Radnor, PA 19087-5240

Legal process may also be served on Airgas, Inc. in its capacity as Plan administrator.

Plan Year	January 1 – December 31
Type of Plan and Administration of Plan	The Plan provides welfare type benefits. Administration of the various benefit programs the Plan offers is provided by Airgas, Inc., as plan sponsor, insurance carriers and third-party administrators.

List of Airgas companies that participate in the Plan

Airgas USA, LLC
Airgas Carbonic, Inc.
Airgas, Inc.
Airgas Merchant Gases LLC
Nitrous Oxide Corp.
Airgas Safety, Inc.
Airgas On-Site Safety, Inc.
Airgas Specialty Gases, Inc.
Airgas Specialty Products, Inc.
Red-D-Arc US
Airgas Refrigerants, Inc.
Airgas Priority Nitrogen, LLC

Aetna
Summary Plan Description

Airgas

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WELCOME

Quick Reference Box

Aetna Member Services, claim inquiries, benefit information, precertification

1-888-342-3862

Aetna online access: Aetna Navigator™ at www.aetna.com
Group No. 720357

For contact information for all Airgas benefit plan providers, use the Airgas Benefits directory at www.airgasbenefitsdirectory.com.

Airgas, Inc. is pleased to provide you with this Summary Plan Description (SPD), which describes the medical, and prescription drug Benefits available to you and your covered family members under the Airgas, Inc. Welfare Benefit Plan. This SPD includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

Airgas, Inc. intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

The medical Benefits described in this section of the SPD are administered by Aetna Life Insurance Company. Aetna's goal is to give you the tools you need to make wise healthcare decisions. Aetna also helps your employer to administer claims. The prescription drug Benefits are administered by Caremark. Although Aetna and Caremark will assist you in many ways, they do not guarantee any Benefits. Airgas, Inc. is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Airgas, Inc. Welfare Benefit Plan works. If you have questions about medical coverage, contact Aetna at the number on the back of your ID card. If you have questions about prescription drug benefits, contact Caremark.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendment on the Airgas Intranet or on the YBR website at www.ybr.com/Airgas or request printed copies by contacting your local HR representative.
- Capitalized words in the SPD have special meanings and are defined in Section 16, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 16, *Glossary*.
- Airgas, Inc. is also referred to as Company.

INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time Employee who is scheduled to work at least 30 hours per week. If you are a member of a collective bargaining unit, you may not be eligible for benefits described in this SPD. Please contact your Human Resources representative for more information.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be

- Your spouse/Domestic Partner provided he or she qualifies as a spouse/ Domestic Partner under federal law. A legally separated spouse or a former spouse is not an eligible dependent. Effective April 1, 2009, the Airgas health and welfare plans do not cover Common-Law Spouses. (Dependents covered as a common-law spouse prior to April 1, 2009 may continue coverage.)
- Your children may continue up to age 26 (married or unmarried). For purposes of the Plan, the term "children" or "child" means:
- Your biological child;
- Your legally adopted child or child placed with you for adoption;
- Your stepchild;
- An eligible foster child, placed in your care by an appropriate court or placement agency;
- A child for whom you are the current court-appointed legal guardian.
- Your disabled child, over age 26 who is unable to earn a living due to a physical or mental handicap and who was disabled prior to the age of 26 and continues to be disabled.
- Your natural or adopted children up to age 26 for whom you are required by a Qualified Medical Child Support Order ("QMCSO") or other court or administrative order, to provide health insurance coverage.

Note: To obtain health plan coverage for a newborn child, you must enroll that child within 31 days of birth, even if you have other children covered in the health program

Domestic Partner Coverage

For employees of Airgas the Plan treats a Domestic Partner as a dependent. In addition, the children of a Domestic Partner are treated as the children of the eligible employee and are eligible to participate on the same basis as any other child under the rules described above. A person is a Domestic Partner of an Airgas employee if they are a same-sex or opposite-sex couples who has registered with any state or local government domestic partnership registry.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled.

Your child is considered to be disabled if he or she:

- is unable to earn a living because of a mental or physical disability that starts before he or she reaches the age limit for dependents, and
- depends mainly on you for support and maintenance.

You must provide proof of your child's disability no later than 31 days after your child reaches the dependent age limit. The child's coverage will end on the first to occur of the following:

- your child is no longer disabled if you fail to provide proof that the disability continues;
- you fail to have any required exam performed; or
- your child's coverage ends for a reason other than reaching the dependent age limit.

Proof of Dependent Relationship

You will be required to provide acceptable proof of your relationship to any dependent you elect to cover for medical, dental, vision, dependent life insurance and/or accidental death and dismemberment coverage whenever the dependent is added to coverage including when you are initially hired, annual enrollment or following a life event. Acceptable proof must be provided within the 31 days following the date you enter your dependent information into your benefits record either by using the YBR on line site or through the YBR Benefits Service Center.

If you do not provide the acceptable proof of dependent status within the stipulated time period, coverage for unverified dependents will be dropped at the end of the verification period and you will not be permitted to enroll your dependent(s) in the Airgas plans until the next annual enrollment, at which time you will again be required to provide the acceptable proof.

Dependent Eligibility Audit

Periodically Airgas conducts random audits of dependents covered under the Airgas health dental and/or vision care plans. If you are selected to participate in an audit, you must provide acceptable proof that the individuals you named as dependents for the health, dental and/or vision care benefits meet the definition of dependents. If you do not provide the required proof within the timeframe specified, the individual will be removed from coverage as of December 31 and you will not be permitted to add the individual back to coverage until the next annual enrollment without a qualifying event.

Cost of Coverage

You and Airgas, Inc. share in the cost of the Plan. Your payroll contribution amount depends on the Plan you select, your annual benefits salary and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you. Where benefits are taxable, for example coverage provided to domestic partners, the taxable portion of the cost is reported as imputed income.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of Airgas Inc.'s cost in covering a Domestic Partner will be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and Airgas, Inc. reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Your Benefit Resources (YBR) at 1-877-424-2363 or logging onto www.ybr.com/airgas.

How to Enroll

To enroll, call YBR at 1-877-424-2363 or log onto www.ybr.com/airgas within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, or the date specified on the personal report you receive from YBR if later, you will need to wait until the next Annual Enrollment to make your benefit elections.

Each year during Annual Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Annual Enrollment will become effective the following January 1.

Important

If you wish to change your benefit elections following your marriage, birth or adoption of a child, or other family status change, you must contact YBR at 1-877-424-2363 within 31 days of the event. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

When Coverage Begins

You may enroll in benefits either by contacting the YBR Service Center at 1-877-424-2363 or on the YBR web site: www.ybr.com/airgas. You must enroll by the deadline printed on the bottom of the personal report you will receive in the mail or work email. Following completion of your enrollment your elected coverage will begin on the 31st day of your continuous employment. There is no waiting period required if an employee moves from part-time to full-time status, provided the employee worked at least 120 hours for Airgas while a part-time employee. When you enroll for medical benefits, you automatically receive prescription drug coverage under the Caremark prescription drug program.

Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for newly eligible Dependents begins on the date they become eligible (through birth, adoption, etc.), provided you enroll them within 31 days of that event.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following a birth or an adoption, etc.). The following are considered family status changes for purposes of the Plan:

The "life status changes" the Plan recognizes are as follows:

- Your marriage, the annulment of your marriage, your divorce or legal separation.
- Death of your spouse or an eligible dependent.
- Birth or adoption of your child or placement of a child with you for adoption.
- An event, such as attaining a stated age that causes a dependent to cease to qualify for coverage.
- A change in your eligibility status or the eligibility status of your spouse or other eligible dependent due to a change in employment.
- A change in your worksite or residence location, or that of your spouse or other eligible dependent.
- A change in your employment status or that of your spouse or dependent that results in gaining or losing eligibility for certain benefits.
- A significant change in the benefits the Plan provides or the cost of those benefits to you. (Note: This does not apply to a change in health care spending account election.)
- An election your spouse or dependent makes under a benefits plan offered by his or her employer that operates on other than a calendar year. (Note: This does not apply to a change in health care spending account election.)
- Receipt of a Qualified Medical Child Support Order covering your child.
- Changes in dependent care providers or costs (Note: This only applies to dependent care spending accounts.)
- Entitlement to Medicare or Medicaid.

Note: Airgas has the exclusive authority to determine whether a circumstance or "life status change" or other circumstance has occurred that permits a new election.

If you wish to change your elections, you must contact YBR within 31 days of the change in family status. Other- wise, you will need to wait until the next Annual Enrollment.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Qualified Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Annual Enrollment, she elects not to participate in Airgas, Inc.'s medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Airgas, Inc.'s medical plan outside of Annual Enrollment provide she makes the change within 31 days of Tom's termination.

HOW THE PLAN WORKS

What this section includes:

- Network and non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Out-of-Pocket Maximum;
- Lifetime Maximum Benefit; and
- Coinsurance.

Network and Non-Network Benefits

As a participant in a this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with Aetna to provide those services at negotiated charges. Generally, when you receive Covered Health Services from a Network Provider, you pay less than you would if you receive the same care from a

non-Network Provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network Provider.

If you choose to seek care outside the network, the Plan generally pays Benefits at a lower level. Out-of-network services are also subject to the reasonable and customary (R&C) charge, as determined by Aetna. If you receive care from an out-of-network provider who charges you more than the R&C charge for a service or supply, you are required to pay the amount that exceeds the R&C charge. The excess amount could be significant and does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network Provider about their billed charges before you receive care. Emergency services as defined by the Plan that are received at a non- network Hospital are covered at the network level.

Looking for a Network Provider?

You may find in-network providers by using DocFind® at Aetna's website www.aetna.com.

Network Providers

Aetna contracts with health care Providers to participate in a network. At your request, Aetna will send you a directory of Network Providers free of charge. Keep in mind, a Provider's network status may change. To verify a Provider's status or request a Provider directory, you can call Aetna Member Services at the toll-free number on your ID card or log onto DocFind at www.aetna.com.

Network Providers are independent practitioners and are not employees of Airgas, Inc. or Aetna

Eligible Expenses

Eligible expenses are charges for Covered Health Services that are provided while the Plan is in effect. For certain Covered Health Services, the Plan will not pay for certain eligible expenses until you have met your Annual Deductible. Airgas, Inc. has delegated to Aetna the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the eligible expenses will be determined and otherwise covered under the Plan.

Don't Forget Your ID Card

Remember to show your Aetna ID card every time you receive health care services from a Provider. If you do not show your ID card, a Provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount you must pay each calendar year for Covered Health Services before the Plan begins paying for eligible expenses. There are separate network and non-network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward your Out-of-Pocket Maximum. Copays do not count toward the Annual Deductible.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate network and non-network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual

Out-of-Pocket Maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your network and non-network

Out-of-Pocket Maximums:

Plan Feature	Applies to the Network Out-of Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
Any penalty or reduced Benefits amount you incur by not obtaining prior authorization as required	No	No
Charges that exceed the Eligible Expenses	No	No

Coinsurance

Coinsurance is the percentage of covered expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance - Example

Let's assume that you receive Plan Benefits for outpatient surgery from a Network Provider. If the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

How the Plan Works - Example

The following example illustrates how Annual Deductibles, Copays, Out-of-Pocket Maximums, Lifetime Maximum Benefits and Coinsurance work in practice.

Let's say Gary has individual coverage under the Plan. He has met his network Annual Deductible, but not his non-network Annual Deductible and needs to see a Physician. The flow chart below shows what happens when he visits a network Physician versus a non-network Physician.

Network Benefits

1. Gary goes to see a network Physician, and presents his ID card.

▼

2. He receives treatment from the Physician. The Plan's eligible expense for the network office visit equals $125.

▼

3. On his way out, Gary pays a $20 Copay (based on the Plan option he elected). Since network Physician office sick visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.

▼

4. The Plan pays $105 ($125 eligible expense minus $20 Copay). Nothing is applied to his Annual Deductible, however, the $20 Copay is applied toward his Annual Out-of-Pocket Maximum.

Non-Network Benefits

1. Gary goes to see a non-network Physician, and presents his ID card.

▼

2. He receives treatment from the Physician. The eligible (R&C) expense for his visit is $175, however the Physician's fee is $225.

▼

3. The Physician's office requests no payment, informing Gary that it will bill Aetna directly.*

▼

4. Gary is responsible for paying the Eligible Expense of $175 directly to the Physician, because he has not yet met his Annual Deductible.

▼

5. Gary receives a bill from the Physician, and pays the Physician directly.

▼

6. Aetna applies the $175 toward Gary's Annual Deductible and Out-of-Pocket Maximum.

▼

7. The Physician's office, at its discretion, might bill Gary for the remaining $50:

$225	-	$175	=	$50
(Physician's fee)		(Eligible (R&C) Expense)		

Gary's $50 payment does not apply to his Annual Deductible or Out-of-Pocket Maximum.

* *Although non-Network Providers have the right to request payment in full at the time of service, they may also bill Aetna directly.*

PRECERTIFICATION

What this section includes:

- An overview of the Plan's Precertification rules; and
- Penalty amounts that apply for failure to precertify when required.

In order to receive full benefits from the Plan, you must follow certain precertification rules described in this section. Precertification is a process that helps you and your physician determine whether the services being recommended are covered services under the Plan. It also allows Aetna to coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning) and to register you for specialized programs or case management, when appropriate.

Your network provider contacts the Aetna precertification unit when the services you are to receive must be precertified. For services received out-of-network, you are required to ensure that the services are precertified by Aetna. If you don't precertify your non-network care as outlined, your benefits may be reduced as a penalty may apply for each failure.

Precertification is easy.

Simply call Aetna Member Services at the toll-free number on your ID card if you must precertify out-of-network care.

Type of Service	When to Precertify	Penalty for Failure to Precertify
Inpatient Hospital Confinement	Non-emergency admission: at least 14 days prior to admission Urgent admission (under urgent conditions as defined by the Plan) before you are scheduled to be admitted Emergency admission: within 48 hours or as soon as reasonably possible	$200
Alternatives to Hospital Inpatient Care • Skilled nursing facility • Home health care • Hospice care (inpatient or outpatient) • Private duty nursing care	Inpatient confinements: same as hospital inpatient (above) Outpatient care: Non-emergency: at least 14 days in advance or as soon as reasonably possible Emergency care: as soon as reasonably possible	$200
Outpatient Tests and Procedures • Allergy immunotherapy (treatment of allergies by injections) • Bunionectomy • Carpal Tunnel Surgery • Colonoscopy • Coronary Angiography • CT Scan – Spine • Dilation & Curettage (D&C) • Hemorrhoidectomy • Knee Arthroscopy • Laparoscopy • MRI – Knee • MRI – Spine • Septoplasty (nose surgery for functional improvement) • Tympanostomy (insertion of tubes into ears) • Upper Gastro-Intestinal Endoscopy	Inpatient confinements: same as hospital inpatient (above) Outpatient care: Non-emergency: at least 14 days in advance or as soon as reasonably possible Emergency care: as soon as reasonably possible	$200

PLAN HIGHLIGHTS

The table below provides an overview of the Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum. You may choose the Core plan or you may build your own plan to better meet your needs.

Core Plan Features	*Network*	*Non-Network*
Copays[1]		
• Emergency Health Services	$500	$500
• Hospital – Inpatient Stay	$100	$100
• Physician's Office Services – Primary Physician	$25	Not Applicable
• Physician's Office Services – Specialist	$35	Not Applicable
• Rehabilitation Services – Primary	$25	Not Applicable
• Rehabilitation Services – Specialist	$35	Not Applicable
• Urgent Care Center Services	$35	$35
Annual Deductible[2,3]		
• Individual	$1,000	$2,000
• Family (not to exceed $1,000 per covered person for Network Benefits and $2,000 per covered person for Non-Network Benefits)	$2,000	$4,000
Annual Out-of-Pocket Maximum[2,4]		
• Individual	$3,500	$7,000
• Family (not to exceed $3,500 per covered person for Network Benefits and $7,000 per covered person for Non-Network Benefits)	$7,000	$14,000
Lifetime Maximum Benefit[5] There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	Unlimited

[1]In addition to these Copays, you may be responsible for meeting the Annual Deductible for some Covered Health Services.

[2]Copays do not apply toward the Annual Deductible but do apply to the Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

[3]Family Deductible may be reached with any combination of eligible expenses incurred by two family members.

[4]Family Out-of-Pocket may be reached with any combination of eligible expenses incurred by two family members.

[4]Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan *Network*	*Non-Network*
Acupuncture Services *(Copay is per visit)*	100% after you pay a $25 PCP Copay or a $35 Specialist Physician Copay	60% after you meet the Annual Deductible
Ambulance Services – Emergency Only	80% after you meet the Network Annual Deductible	80% after you meet the Network Annual Deductible
Ambulance Services – Non-Emergency	80% after you meet the Network Annual Deductible If non-emergency and prior authorization is not obtained, then 60% after you meet the Network Annual Deductible	80% after you meet the Network Annual Deductible If non-emergency and prior authorization is not obtained, then 60% after you meet the Network Annual Deductible
Cancer Resource Services (CRS)[2] • Hospital - Inpatient Stay *(Limited to $300 per admission)*	80% after you pay a $100 Copay per day up to a maximum of $300 and meet the Annual Deductible	Not Covered
Clinial Trials	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries • Hospital - Inpatient Stay *(Copay is per admission)*	80% after you pay a $100 Copay per day up to a maximum of $300 and meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services – Accident Only *(Copay is per visit)*	100% after you pay a $25 Primary Physician or $35 Specialist Physician Copay	60% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	
Diabetes Self-Management Items • diabetes equipment	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
• diabetes supplies	Benefits for diabetic supplies and insulin are covered under your pharmacy plan administered by Caremark.	
Durable Medical Equipment (DME) *(Prior authorization required for DME over $1,000.)*	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	100% after you pay a $500 Copay and meet the Network Annual Deductible If admitted, $100 Copay per day to a maximum of $300.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan *Network*	*Non-Network*
Hearing Care (Routine) *(Copay is per visit)* Limited to one routine hearing (audiometric exam) every 24 months. Any combination of Network Benefits and Non-Network Benefits is limited to 2 hearing aids every 36 months up to a $3,000 per ear, per calendar year (combined Network and Non-Network). Repairs are limited to $250 per hearing aid every 36 months per calendar year (combined Network and Non-Network).	100% after you pay a $25 Primary Physician or $35 Specialist Physician Copay	60% after you meet the Annual Deductible
Home Health Care Any combination of Network Benefits and Non-Network Benefits is limited to 100 visits per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital – Inpatient Stay *(Copay is per admission)*	80% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible	60% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible
Infertility Services *(Diagnosis and treatment of underlying medical condition only)*	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Injections in a Physician's Office	Office Visit: 100% after you pay a $25 PCP Copay or a $35 Specialist Copay All Other Places of Service: 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient	Office Visit: 100% after you pay a $25 Copay All Other Places of Service: 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	Office Visit: 100% after you pay a $20 Copay All Other Places of Service: 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services • Hospital - Inpatient Stay *(Copay is per admission)*	80% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible	60% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible
• Physician's Office Services *(Copay is per visit)*	$100 after you pay a $25 Copay	$60 after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan *Network*	*Non-Network*
Neurobiological Disorders - Autism Spectrum Disorder Services • Hospital - Inpatient Stay Limited to $300 per admission.	80% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible	60% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible
• Physician's Office Services *(Copay is per visit)*	100% after you Pay a 25$ copay	60% after you meet the Annual Deductible
Nutritional Counseling *(Copay is per visit)*	100% after you pay a $25 PCP Copay or a $35 SpecialistPhysician Copay	60% after you meet the Annual Deductible
Obesity Surgery • Physician's Office Services *(Copay is per visit)*	100% after you pay a $20 Copay for a Primary Physician or $35 for a Specialist Physician	60% after you meet the Annual Deductible
• Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
• Hospital - Inpatient Stay *(Copay is per admission)*	80% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible	60% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible
Ostomy Supplies	Office Visit: 100% of eligible expenses Other Locations: 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury • Primary Physician *(Copay is per visit)*	100% after you pay a $25 Copay	60% after you meet the Annual Deductible
• Specialist Physician *(Copay is per visit)*	100% after you pay a $35 Copay	60% after you meet the Annual Deductible
Pregnancy – Maternity Services • Physician's Office Services *(Copay is per visit)*	100% after you pay a $25 PCP Copay or a $35 Specialist Copay	60% after you meet the Annual Deductible
• Hospital - Inpatient Stay *(Copay is per admission*	80% after you pay a $100 per day to a maximum of $300 Copay and meet the Annual Deductible	60% after you pay a $100 per day to a maximum of $300 Copay and meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan *Network*	*Non-Network*
Pregnancy – Maternity Services (*continued)*		
• Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Preventive Care Services • Physician Office Services	100%	60% after you meet the Annual Deductible
• Immunizations	100%	60% after you meet the Annual Deductible
• Breast Pumps	100%	60% after you meet the Annual Deductible
Private Duty Nursing - Outpatient *(Up to 70 shifts per calendar year)*	80% after you meet meet the Annual Deductible	`60% after you meet the Annual Deductible
Prosthetic Devices *Prior authorization required for Prosthetics over $1,000.*	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits for Reconstructive Procedures will be paid the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits for Reconstructive Procedures will be paid the same as those stated under each Covered Health Service category in this section.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment *(Copay is per visit)*	100% after you pay a $25 PCP Copay or a $35 Specialist Physician Copay	60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services *Any combination of Network Benefits and Non-Network Benefits is limited to 120 days per calendar year*	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Substance Use Disorder Services • Hospital - Inpatient Stay *(Copay is per admission)*	80% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible	60% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible
• Physician's Office Services	100% after you pay a $25 Copay	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan *Network*	*Non-Network*
Surgery - Outpatient *(Copay is per surgery)*	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint Dysfunction (TMJ)	Depending upon where the Covered Health Services is provided, Benefits for temporomandibular joint (TMJ) services will be the same as those stated under each Covered Health Services category in this section.	
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Transplantation Services	80% after you meet the Annual Deductible	Non-Network benefits are not Available
Travel and Lodging *(If services rendered by a Designated Facility)*	For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures	
Urgent Care Center Services *(Copay is per visit)*	100% after you pay a $35 Copay	100% after you pay a $35 Copay DME at an Urgent Care Facility: 60% after you meet the annual Deductible
Vision Examinations *One exam every 24 months*	100% after you pay a $25 PCP Copay or a $35 Specialist Physician Copay	60% after you meet the Annual Deductible
Wigs	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

1 You must obtain prior authorization from Personal Health Support, as described in Section 4, Personal Health Support to receive full Benefits before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for obtaining prior authorization from Personal Health Support before you receive certain Covered Health Services.

2 These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under Physician's Office Services, Physician Fees for Surgical and Medical Services, Hospital - Inpatient Stay, Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic Lab, X-Ray and Diagnostics – Outpatient, and Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.

ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Limitations and Exclusions that apply to Benefits.

This section supplements the benefit level information in Section 5, *Plan Highlights*.

This section includes descriptions of the covered Benefits. These descriptions include any limitations that may apply. Services that are not covered are described in Section 8, *Exclusions*.

For more information on the services covered please refer to Aetna's Clinical Policy Bulletins (CPBs) at **www.aetna.com/cpb**. You can accept the online terms, access the bulletins and then follow the instructions to search for the information you are seeking (e.g. obesity surgery, cochlear implants).

Acupuncture Services

The Plan pays for acupuncture therapy when it is performed by a physician as a form of anesthesia in connection with covered surgery and when it is performed by a physician as a means of assisting the patient to stop smoking.

Ambulance Services

The Plan covers Emergency ambulance services and transportation to the nearest Hospital where treatment is given in a medical emergency. See Section 16, *Glossary* for the definition of Emergency.

Ambulance service by air or water is covered in an Emergency if ground transportation is not available and your condition is unstable and requires medical supervision and rapid transport. In such circumstances, coverage also includes transportation from one hospital to another when the first hospital does not have the required services or facilities to treat your condition.

The Plan covers ground ambulance transportation as follows:

- To the first hospital where treatment is given in a medical Emergency.
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition.
- From hospital to home or another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to hospital (limited to 100 miles) for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition.
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Transport charges are not covered if not provided by a professional ambulance service or not required by your physical condition.

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as Aetna determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below;
- surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as Aetna determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below; and

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Dental Services (Oral Surgery)

The Plan covers treatment of the mouth, jaws and teeth that is medical and dental in nature. Charges by a physician, dentist or hospital for the following services are covered:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

- Surgery needed to:
  - treat a fracture, dislocation or wound
  - remove teeth that are partly or completely impacted in the jaw bone, will not erupt through the gum or cannot be removed without removing bone
  - remove cysts, tumors or other diseased tissues
  - alter the jaw, jaw joints or bite relationships when appliance therapy alone cannot result in functional improvement
- Dental work, surgery and orthodontic treatment to remove, repair, replace, restore or reposition natural teeth damaged or lost due to injury. Any such teeth must be stable, free from decay and firmly attached at the time of injury.

If crowns, dentures, bridgework or in-mouth appliances are installed due to an injury, the Plan includes charges for:

- the first denture or fixed bridgework to replace lost teeth
- the first crown to repair a damaged tooth
- an in-mouth appliance used in the first course of orthodontic treatment after the injury.

Except as noted above, this benefit does NOT cover charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations or related fittings or adjustments – whether or not the purpose is to relieve pain;
- for root canal therapy;
- for routine tooth removal that doesn't require cutting of bone;
- to remove, repair, replace or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace or restore fillings, crowns, dentures or bridgework;
- for non-surgical periodontal treatment;
- for dental cleaning, planning or scraping;
- for myofunctional therapy (muscle training therapy to correct or control harmful habits).

DIAGNOSTIC AND PREOPERATIVE TESTING

Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a physician, hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear medicine imaging including positron emission tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service where the recognized charge exceeds $500. Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an illness or injury. You must have definite symptoms that start,maintain or change a plan of treatment prescribed by a physician. The charges must be made by a physician,hospital or licensed radiological facility or lab.

Important Reminder

Refer to the Schedule of Benefits for details about any deductible, payment percentage and maximum that may apply to outpatient diagnostic testing, and lab and radiological services.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, covered expenses include charges made for tests performed by a hospital, surgery center, physician or licensed diagnostic laboratory provided the charges for the surgery are covered expenses and the tests are:

- Related to your surgery, and the surgery takes place in a hospital or surgery center;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a hospital;
- Not repeated in or by the hospital or surgery center where the surgery will be performed.
- Test results should appear in your medical record kept by the hospital or surgery center where the surgery is performed.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will not be covered.

Durable Medical Equipment (DME)

The Plan pays for the rental of Durable Medical Equipment (DME) or the initial purchase if long term care is planned and the equipment cannot be rented or is likely to cost less to purchase than rent.

Replacement of purchased equipment is covered if:

- the replacement is needed because of a change to your physical condition; and
- it is likely to cost less to replace the item than to repair the existing item or rent a similar item.

Maintenance and repairs needed due to misuse or abuse are not covered.

The Plan limits coverage to one item of equipment for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment that you purchase or rent for personal convenience or mobility.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- wheelchairs;
- Hospital beds;
- delivery pumps for tube feedings;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Emergency Health Services

The Plan covers charges made by a hospital or physician for services provided in an emergency room to evaluate and treat an emergency medical condition.

The emergency care benefit covers:

- use of emergency room facilities;
- emergency room physician services;
- hospital nursing staff services;
- radiologists and pathologist services.

Reminder

- Emergency Room visit – $500 copay, waived if admitted to the hospital; and
- The Plan does not pay benefits for non-emergency use of the emergency room.

Hearing Care

Benefits are available for the following Covered Health Services in a Provider's office:

- routine hearing (audiometric) exams once every 24 months by a physician certified as an otolaryngologist or otologist or a qualified audiologist; and
- hearing exams in case of Injury or Sickness.

The Plan does not cover:

- any hearing care service or supply that does not meet professionally accepted standards
- any hearing care service or supply covered under any workers' compensation or similar law
- any exam required by an employer as a condition of employment or which an employer is required to provide under a labor agreement or government law

Home Health Care

Covered Health Services are services that a Home Health Agency provides as part of a home health care plan if you are homebound due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by licensed nursing professionals in your home;
- home health aide services when provided in conjunction with skilled nursing care, that directly support the care;
- medical social services by a qualified social worker when provided in conjunction with skilled nursing care;
- not considered Custodial Care, as defined in Section 16, *Glossary*; and
- provided in part-time, intermittent visits of four hours or less with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure proper care which means

they are not on site for more than four hours at a time.

Any combination of network and non-network Benefits is limited to 100 visits per calendar year. Each visit of up to 4 hours is considered one visit.

The Plan does not cover charges for:

- services or supplies that are not part of a home health care plan;
- services of a person who usually lives with you or is a member of your family or your spouse's family;
- transportation relating to home health care.

Hospice Care

The Plan covers expenses for hospice care provided as part of a hospice care program. A hospice care program provides comfort and support services for the terminally ill and supportive care to the families. Hospice care can be provided on an inpatient or out- patient basis and includes medical supplies, prescription drugs, physical and occupational therapy, psychological and dietary counseling and social services that include assessment of your social and emotional needs and assistance to obtain resources to meet your assessed needs. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

The Plan does not cover charges made for:

- bereavement counseling;
- pastoral counseling;
- funeral arrangements;
- respite care;
- financial or legal counseling, which includes estate planning and the drafting of a will;
- homemaker or caretaker services which include companion services, transportation or housecleaning.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- services and supplies received during an Inpatient Stay; and
- room and board in a semi-private room (a room with two or more beds).

Private room charges that exceed the hospital's semi-private room rate are not covered unless a private room is required because of a contagious illness or immune system problem.

Room and board charges include:

- services of the hospital's nursing staff;
- admission and other fees;
- general and special diets;
- sundries and supplies.

Other covered hospital services and supplies include hospital charges such as:

- ambulance services;
- physicians and surgeons;
- operating and recovery rooms;
- intensive or special care facilities;
- administration of blood and blood products, but not the cost of the blood or blood products;
- oxygen and oxygen therapy;
- radiological services, laboratory testing and diagnostic services;
- speech therapy, physical therapy and occupational therapy;
- medications;
- Intravenous (IV) preparations;
- Discharge planning

A $100 copay per day applies to inpatient hospital stays up to a maximum of $300 per stay.

Please remember for non-network Benefits, you must precertify as follows:

- for elective admissions: 14 business days before your scheduled admission;
- for emergency admissions (also termed non-elective admissions): within two business days, or as soon as is reasonably possible.

If precertification is not obtained, Benefits will be subject to a $200 reduction.

Infertility Services

The Plan pays Benefits for infertility services and associated expenses for the diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician.

Injections in a Physician's Office

Benefits are paid by the Plan for injections administered in the Physician's office, for example allergy immunotherapy, when no other health service is received.

Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Please remember non-network hospital stays must be precertified in order to avoid a possible reduction in benefits.

Healthy Moms and Babies

The Plan offers a special maternity management program. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Mental Health and Substance Abuse Treatment

The Plan covers Mental Health and Substance Abuse (MH/SA) Treatment, which is part of a written treatment plan or program of therapy prescribed and supervised by a behavioral health provider.

A written treatment plan for the treatment of mental disorders includes follow-up treatment and is a plan for a condition that can be favorably changed.

A program of therapy for treatment of alcohol or substance abuse includes either:

- A follow-up program directed by a behavioral health care provider on a monthly basis; or
- Meetings at least twice a month with an organization devoted to the treatment of alcoholism or substance abuse.

Inpatient Treatment

Covered expenses include charges for room and board at the semi-private rate and other services and supplies provided during a stay in a hospital, psychiatric hospital or residential treatment facility.

For inpatient treatment of alcoholism or substance abuse, treatment of medical complications includes detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremors and hepatitis.

Inpatient MH/SA Treatment is subject to the following calendar year limits, which apply to network and non-network Benefits combined.

Please remember inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna for mental health and substance abuse treatment. Failure to precertify may result in a reduction in benefits.

The hospital copay also applies to inpatient stays for mental health and substance abuse treatment.

Outpatient Treatment and Partial Hospitalization

The plan covers partial hospitalization services (more than 4 hours but less than 24 hours per day) provided in a facility or program for intermediate, short-term or medically-directed intensive treatment. Partial hospitalization is only covered if you would need inpatient treatment if not admitted to this type of facility.

Nutritional Counseling

The Plan will pay for Covered Health Services provided by a registered dietician in an individual session if you have a medical condition that requires a special diet. Some examples of such medical conditions include:

- diabetes mellitus;
- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to three individual sessions in your lifetime for each medical condition.

Obesity Surgery

The Plan covers the medically necessary surgical treatment of morbid obesity received on an inpatient basis on the same basis as any other eligible surgery.

Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient surgery, diagnostic and therapeutic services received on an outpatient basis at a Hospital or Alternate Facility are paid by the Plan including

- outpatient surgery at a surgery center or outpatient department of a hospital and related services;
- lab and radiology/X-ray;
- mammography testing, other than as described under *Preventive Care* in this section;
- computerized tomography (CT) scans;
- position emission tomography (PET) scans;
- magnetic resonance imaging (MRIs);
- outpatient preoperative testing; and
- chemotherapy treatment and radiation therapy benefits.

Benefits include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees, including a surgeon's fee related to outpatient surgery, diagnostic and therapeutic services are described under *Professional Fees for Surgical and Medical Services* in this section. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* as follows.

Physician's Office Services

Benefits are paid by the Plan for Covered Health Services received in a Physician's office including:

- evaluation and treatment of a Sickness or Injury;
- vision screenings, which could be performed as part of an annual physical examination in a Provider's office (vision screenings do not include refractive examinations to detect vision impairment); and
- one routine vision exam, including refraction, to detect vision impairment in the Provider's office every 24 months.

Benefits for preventive services are described under *Preventive Care* in this section. Benefits for preventive hearing care are described under *Hearing Care* in this section.

Please Note

Your Physician does not have a copy of your SPD, you are responsible for knowing and communicating your Benefits.

Physician's Office Services - Specialist

The Plan pays for Covered Health Services given by a licensed Physician or other health care professional other than the Covered Person's primary Physician, known as a specialist. A specialist is a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. Examples of specialists are dermatologists, cardiologists, and neurologists. This Benefit applies to all Covered Health Services and supplies given in connection with each office visit.

Preventive Care

The Plan will pay Benefits for the Covered Preventive Care Health Services listed below, as well as preventive care services for which your Physician documents the need based on your family or medical history.

Alternatives to Physician Office Visits

WWalk-in clinics are health care facilities designed to offer an alternative to a physician's office visit for treatment of unscheduled and/or non-emergency illnesses or injuries. The clinics also offer administration of certain vaccines or immunizations.

For services to be covered by the Plan, clinics must be licensed and certified as required by any state or federal law or regulation, must be staffed by licensed practitioners and have a physician on call at all times who also sets protocol for clinical policies, guidelines and decisions.

Covered Preventive Care Services	
Children under age 7	▪ seven well baby exams for the first year of the child's life; ▪ three exams during the second year of the child's life; ▪ three exams during the third year of the child's life; ▪ one exam per calendar year thereafter; ▪ phenylketonuria (PKU) tests; ▪ testing for tuberculosis; ▪ immunizations* ▪ X-rays, lab and other tests in connection with an exam
Children age 7 and older	▪ one exam per year including related lab and other tests and administration of immunizations.
Women	▪ one mammogram per calendar year beginning at age 40; ▪ one routine gynecological exam per calendar year including breast and pelvic examination, treatment of minor infections, and PAP test.
Men	▪ PSA blood test and digital rectal exam annually, beginning at age 40.
Both Men and Women	▪ one routine physical exam per calendar year; ▪ age 50 and older - colonoscopy once every 10 years; ▪ age 50 and older - one double contrast barium enema every five years; ▪ age 50 and older - one sigmoidoscopy every five years; ▪ age 65 and older - one sigmoidoscopy every three - five years.

* Covered childhood immunizations generally include: Diptheria-tetanus-pertussis (DTP), Oral poliovirus (OPV), Measles-mumps-rubella (MMR), Conjugate haemophilus influenzae type B, Hepatitis B, and Varicella (Chicken Pox).

Private Duty Nursing - Outpatient

The Plan covers private duty nursing care given on an outpatient basis by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) if a person's condition requires skilled nursing services and visiting nurse care is not sufficient.

Any combination of network and non-network Benefits is limited to 70 shifts per calendar year. A shift is considered eight hours of skilled nursing care.

This benefit does not cover:

- any care that does not require the education, training and technical skills of an R.N. or L.P.N. This would include transportation, meal preparation, charting of vital signs and companionship activities;
- care provided to assist someone in the activities of daily life such as bathing, feeding, personal grooming, dressing or toileting; and getting in/out of bed or chair;
- service provided only to administer oral medicines, except where law requires administration by an R.N. or L.P.N..

Professional Fees for Surgical and Medical Services

The Plan pays professional fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, outpatient surgery facility, or birthing center.

When these services are performed in a Physician's office, Benefits are described under Physician's Office Services in this section.

Prosthetic Devices

Benefits are paid by the Plan for internal and external prosthetic devices and special appliances that improve or restore body part function that has been lost or damaged by illness, injury or congenital defect. Examples include, but are not limited to:

- artificial limbs;
- artificial eyes;
- speech generating device;
- cardiac pacemaker and pacemaker defibrillators; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm;
- breast implant after a mastectomy.

The Plan also covers replacement of a prosthetic device if:

- the replacement is needed because of a change in your physical condition or normal growth or wear and tear; or
- it is likely to cost less to buy a new one than to repair the existing one; or
- the existing one cannot be made serviceable.

The Plan does not cover charges for or expenses related to:

- orthopedic shoes, therapeutic shoes, foot orthotics or other devices to support the feet, unless required for the treatment of diabetes or to prevent complications of diabetes or if the shoe is an integral part of a covered leg brace;
- trusses, corsets and other support items.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services include:

- surgery needed to improve a significant functional impairment of a body part;
- surgery to correct the result of an accidental injury, in- cluding subsequent related or staged surgery, provided the surgery occurs no more than 24 months after the original injury. For a covered child, the time period may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure, provided that the reconstructive surgery occurs no more than 24 months after the original injury
- Surgery to correct a birth defect or a defect appearing after birth if it results in severe facial disfigurement or significant functional impairment requiring surgery to improve function.

Benefits for Reconstructive Procedures include breast re-construction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replace-ment of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy.

Note: Injuries that occur as a result of a non-surgical medical treatment are not considered accidental injuries, even if unplanned or unexpected. The Plan also does not provide Benefits for Cosmetic Procedures, as defined in Section 16, *Glossary*.

Please remember that you must precertify out-of-network inpatient confinements and certain outpatient procedures.

The precertification process can determine whether a service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy

The Plan provides short-term rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- speech therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

Rehabilitation services must be performed by a licensed or certified physical, occupational or speech therapist. Inpatient rehabilitation benefits are considered part of your inpatient hospital, hospice, home health care or skilled nursing facility benefits.

Cardiac and Pulmonary Rehabilitation

Inpatient cardiac rehabilitation benefits are considered as part of a hospital stay. A limited course of outpatient cardiac rehabilitation is covered following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction as recommended by your physician. For covered individuals at high risk, treatment is limited to 36 sessions in a 12 week period.

Inpatient pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease. Treatment is limited to a maximum of 36 hours for a six week period.

Autism Spectrum Disorder

Covered expenses include charges made by a physician or behavioral health provider for the services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits or therapy but excluding Applied Behavior Analysis) of Autism Spectrum Disorder when ordered by a physician, licensed psychologist, or licensed clinical social worker, as part of a Treatment Plan; and the covered child is diagnosed with Autism Spectrum Disorder.

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association

Physical, Occupational and Speech and Cognitive Therapy

The Plan will pay Benefits for :

- physical therapy for non-chronic conditions and acute illnesses and injuries if the therapy is expected to significantly improve, develop or restore resulting lost or impaired physical function;
- occupational therapy for non-chronic conditions and acute illnesses and injuries if therapy is expected to significantly improve, develop or restore resulting lost or impaired physical function or to relearn skills to significantly improve independence in activities of daily living.
- speech therapy or cognitive therapy only when a speech impediment or dysfunction results from injury, illness, stroke, trauma or a congenital anomaly.

Occupational therapy does not include vocational rehabilitation, employment counseling or educational training or services designed to develop physical function.

Benefits are limited to 60 visits per year for physical, occupational and speech therapy expenses combined. This visit limit applies to network and non-network Benefits combined. A “visit” consists of no more than one hour of therapy. Refer to the Plan Highlights for the visit maximums. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

The Plan does not cover therapies for treatment of delays in development unless resulting from acute illness or injury or congenital defects that can be surgically repaired.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- medical and nursing services, supplies, radiological services and lab work, physical, occupational and speech therapy received during the Inpatient Stay;
- oxygen and other gas therapy, and
- room and board in a semi-private room (a room with two or more beds).

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

The intent of skilled nursing is to provide Benefits if, as a result of an Injury or illness, you require:

- an intensity of care less than that provided at a general acute Hospital but greater than that available in a home setting; or
- a combination of skilled nursing, rehabilitation and facility services.

Note: This Benefit does not cover Custodial Care or Domiciliary Care, even if ordered by a Physician, charges for treatment of drug addiction, alcoholism, senility, mental retardation or any other mental illness.

Any combination of network and non-network Benefits is limited to 120 days per calendar year.

Please remember for non-network Benefits, you must precertify an inpatient stay or Benefits may be subject to a $200 reduction.

Spinal Treatment

The Plan pays Benefits for Spinal Treatment when provided by a network or non-network physician on an outpatient basis. Covered Health Services include manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

A "visit" consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

The Plan limits any combination of network and non-network Benefits for Spinal Treatment to one visit per day up to 60 visits per calendar year. This maximum does not apply to expenses incurred while a hospital inpatient, for treatment of scoliosis, for fracture care or for surgery.

Transplantation Services

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The network level of benefits is paid only for a treatment received at a facility designated by the plan as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services.

The plan covers:

- Charges made by a physician or transplant team.
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and sup-

plies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; or upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;

2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;

3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement; and

4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an **IOE** facility will be considered network care expenses.

Limitations

Unless specified above, not covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

Travel and Lodging

The Plan pays up to $10,000 per episode of care for travel and lodging expenses in connection with a transplant procedure or treatment at an IOC facility.

Travel expenses are expenses for transportation between a patient's home and the facility where services and treatment are received. These expenses must be approved in advance by Aetna.

Lodging expenses are covered for up to $50 per person per night for a patient and a companion.

Urgent Care

The Plan provides Benefits for services, including professional services, received at an Urgent Care Facility. Coverage includes use of the facility, physician's services, nursing staff services and radiologist and pathologist services.

The Plan does not pay benefits if you visit an urgent care provider for a non-urgent condition.

SPECIAL PROGRAMS AND RESOURCES

What this section includes:

Online tools and health and well-being resources available to you:

- Aetna Navigator™;
- Informed Health® Line;
- Aetna Natural Products and Services Program℠;
- Aetna Vision℠ Discounts.

Airgas, Inc. believes in the value of tools and resources to help you become an informed and educated health care consumer. Several convenient educational and support services, accessible by phone and the Internet, can help you to:

- access information on health care costs;
- get up-to-date health information; and
- navigate the complexities of the health care system.

Note: Health information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health.
Aetna and Airgas, Inc. are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment.

Aetna Navigator™

Aetna Navigator is a secure member website that allows you to:

- find information about your medical Plan benefits, family members covered under the Plan, wellness and health improvement programs included with the Plan;
- check the status of a claim, find out about claim payments and view Explanation of Benefits statements;
- request a replacement ID card, print a claim form, make changes to personal information such as your mailing address or e-mail Aetna Member Services.

Aetna Navigator also gives access to information with these tools:

- DocFind – the online provider directly that you can search for in-network doctors and hospitals;
- health care cost comparison tools to view estimate average costs in your area for surgery, office visits, tests and treatment for illnesses and conditions;
- links to Aetna health websites to find up-to-date information on hundreds of health topics or decision-support tools.

Informed Health® Line

At any time (available 24 hours a day, 7 days a week), you can call 1-800-556-1555 to speak to Informed Health Line nurses experienced in providing information on a variety of health topics. While the nurses don't diagnose problems, prescribe or give advice, they can:

- help you understand health issues and treatment choices;
- give you some good questions to ask your doctor; and
- tell you about the latest research on certain treatments and procedures and explain their risks and benefits.

The nurses can help you make sense of your health issues and communicate better with your doctor. They'll give you the facts you need to make decisions and choices you can feel good about.

Informed Health Line also includes an audio health library that gives you an easy way to access reliable health information from any touchtone phone, 24 hours a day, in English or Spanish.

Aetna Natural Products and Services Program℠

This program gives you access to professional services and health-related products at a reduced rate.
It provides:

- Access to professional services. You can receive reduced rates from natural therapy professionals including acupuncturists, massage therapists and nutritional counselors. You can find "Natural Therapy Professionals" in DocFind or by calling Aetna Member Services. After scheduling an appointment with the professional you've chosen, show your Aetna ID card and pay a reduced rate at the time of your visit.
- Access to products. You are eligible for discounts on online or phone purchases of over-the-counter vitamins, herbal and nutritional supplement and health-related products products through InterNatural. You can also purchase over-the-counter vitamins and herbal nutritional supplements online at a discounted rate through WebVitamins, Inc.

For online ordering, you can access InterNatural or WebVitamins, Inc. by choosing "Benefits/Health Programs/Natural Products and Services Discounts" from Aetna Navigator.

Aetna Vision Discounts

Aetna Vision Discounts help you and your family save on eye care products including eyeglasses, contact lenses and solutions, non-prescription sunglasses and other eye care accessories. You can also receive a discount on LASIK (laser correction) surgery through the program (although LASIK surgery is not covered under the plan). To take advantage of this program, visit DocFind and view eye care professionals and optical retailers. When you need products or supplies, you can choose from a wide selection of optical centers nationwide, such as Sears, JCPenney, Target and others. Just show your Aetna ID card and the discount will be applied on the spot. (Note: Airgas offers independent vision care benefits insured by Eyemed. The Eyemed and Aetna vision care programs operate independently.

EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:
Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*

The Plan does not pay Benefits for any of the following services, treatments or supplies even if they are recommended or prescribed by a Provider or are the only available treatment for your condition.

Alternative Treatments

- accupressure;
- acupuncture therapy;
- aromatherapy;
- hypnotism;
- massage therapy; and
- rolfing (holistic tissue massage)

Comfort and Convenience

Supplies, equipment and similar incidentals for personal comfort. Examples include:

- television;
- telephone;
- air conditioners;
- beauty/barber service;
- guest service;
- air purifiers and filters;
- batteries and battery chargers;
- dehumidifiers and humidifiers;
- ergonomically correct chairs;
- non-Hospital beds and electric, water or air beds;
- communication aids, wireless alert systems or home monitoring; and
- home remodeling to accommodate a health need (including, but not limited to, bathroom equipment, ramps, swimming pools, elevators, handrails, and stair glides).

Counseling

- marriage counseling;
- religious counseling
- family or financial counseling; and
- career counseling.

Drugs, Medications and Supplies

- prescription drugs for outpatient use that are filled by a prescription order or refill;
- over-the-counter drugs and supplies that may be obtained without a prescription, including vitamins;
- injectable drugs if an alternative oral drug is available;
- needles, syringes and injectable aids, except as covered for diabetic supplies;
- services related to the dispensing, injection or application of a drug;
- performance enhancing steroids;
- drugs to treat erectile dysfunction, impotence or sexual dysfunction or inadequacy; and
- immunizations for work or travel.

Experimental and Investigational Treatment

Experimental or investigational drugs, devices, treatments or procedures are excluded unless all of the following conditions are met:

- you have been diagnosed with cancer or a condition likely to cause death within one year;
- standard therapies have not been effective or are inappropriate;
- Aetna determines, based on medical and scientific evidence, that you would likely benefit for the treatment;
- You are enrolled in a clinical trial that meets these criteria;
- The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
- The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the FDA or Department of Defense) and conforms to NCI standards;
- The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
- You are treated in accordance with protocol.

Foot Care

Foot care is not covered. This includes services, any supplies or devices to improve comfort or the appearance of the feet, toes, or ankles including:

- treatment of calluses, bunions, toenails, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes;
- treatment of subluxation (joint or bone dislocation) of the foot;
- shoes (standard or custom), orthotics, arch supports, inserts, braces, guards or other supplies, even if required following the covered treatment of a injury or illness.

Medical Supplies and Appliances

- devices used specifically as safety items or to affect performance in sports-related activities;
- blood, blood plasma, synthetic blood, blood derivatives or substitutes and related services including processing, donor, storage or replacement costs.
- prescribed or non-prescribed medical supplies, except for ostomy bags and related supplies. Examples of supplies that are not covered include, but are not limited to:
  - elastic stockings, ace bandages, diabetic strips, and syringes; and
  - tubings, nasal cannulas, connectors and masks that are not used in connection with DME; and
- foot orthotic appliances (including some types of braces).

Mental Health/Substance Abuse

- treatment of a covered health care provider who specializes in the mental health care field and receives treatment as a part of their training in that field;
- treatment of impulse control disorders such as pathological gambling, kleptomania, caffeine or nicotine use;
- treatment of antisocial personality disorder;
- treatment in wilderness programs or other similar programs;
- treatment of mental retardation, defects and deficiencies unless otherwise specifically included.

Nutrition and Health Education

- megavitamin and nutrition based therapy;
- nutritional counseling for either individuals or groups, except as defined under Nutritional Counseling in Section 6, *Additional Coverage Details*;
- food of any kind, even if it is specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Foods that are not covered include:
  - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk;
  - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
  - oral vitamins and minerals;

  - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
  - other dietary and electrolyte supplements;
- health club memberships and programs, and spa treatments; and
- health education classes, including but not limited to asthma, smoking cessation, and weight control classes.

Physical Appearance

Cosmetic Procedures, as defined in Section 16, *Glossary*, are excluded from coverage. Examples include:

- face lifts, tummy tucks, liposuctions, removal of excess skin, blemishes or varicose veins;
- procedures to remove healthy cartilage or bone from the nose;
- chemical peels, dermabrasion, laser or light treatments or bleaching;
- tattoo or scar removal;
- repair of piercings or other voluntary body modifications, including removal of injected or implanted substances or devices;
- physical conditioning programs such as athletic training, bodybuilding, exercise programs or equipment and fitness club memberships;
- weight loss programs, diet supplements or appetite suppressants;
- wigs regardless of the reason for the hair loss except for when hair loss is due to a medical condition.; and
- otoplasty;
- treatments for hair loss;
- breast augmentation.

Pregnancy and Infertility

- health services and associated expenses for infertility treatments including, but not limited to:
  - in vitro fertilization (IVF);
  - gamete intrafallopian transfer (GIFT);
  - zygote intrafallopian transfer (ZIFT);
  - artificial insemination;
  - embryo transport; and
  - donor ovum and semen and related costs including collection, preparation and storage of;
- surrogate parenting;
- home ovulation prediction kits or home pregnancy tests;
- the reversal of voluntary sterilization;
- oral contraceptive supplies and services;
- services provided by a doula (labor aide); and
- parenting, pre-natal or birthing classes.

Providers

Services:

- performed by a Provider who is a family member, including your spouse, domestic partner, brother, sister, parent, in-law or child;
- performed by a Provider with your same legal residence;
- performed by an unlicensed Provider or a Provider who is operating outside of the scope of his/her license;
- provided at a diagnostic facility (Hospital or otherwise) without a written order from a Provider; and
- ordered by a Provider affiliated with a diagnostic facility (Hospital or otherwise), when that provider is not ac- tively involved in your medical care:
  - prior to ordering the service; or
  - after the service is received.

This exclusion does not apply to mammography testing.

Services Provided under Another Plan

Services for which coverage is available:

- under another plan, except as described in Section 10, *Coordination of Benefits (COB)*;
- under workers' compensation or similar legislation if you could elect it, or could have it elected for you;
- while on active military duty; and
- for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

- transplants:
  - except as identified under *Transplantation Services* in Section 6;
  - not consistent with the diagnosis of the condition.
- harvesting and/or storage of organs, bone marrow, tissues or stem cells without the expectation of transplantation within 12 months (or immediately for organ transplants); and

- services and supplies furnished to a donor when the recipient is not a covered individual.

Travel

- health services provided in a foreign country, unless in an Emergency; and
- travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in Section 6.

Vision and Hearing

- purchase cost of eyeglasses, contact lenses;
- fitting charges eyeglasses, and contact lenses;
- special vision procedures such as orthoptics, vision therapy or vision training; and
- surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

- autopsies and other coroner services and transportation services for a corpse;
- charges for:
  - missed appointments;
  - room or facility reservations;
  - completion of claim forms;
  - record processing; or
  - services, supplies or equipment that are advertised by the Provider as free;
- charges prohibited by federal anti-kickback or self-referral statutes;
- Custodial Care as defined in Section 16, *Glossary*, or services provided by a personal care assistant;
- growth hormone therapy; (see prescription drug coverage for information on coverage for Specialty Drugs)
- expenses for health services and supplies:
  - that do not meet the definition of necessary in Section 16, *Glossary*;
  - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country;
  - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
  - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
  - that exceed the Reasonable and Customary charge or any specified limitation in this SPD; or
- medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Appliances for snoring are always excluded;
- physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
  - required solely for purposes of career, education, sports or camp, employment, insurance, marriage or adoption; or as a result of incarceration;
  - conducted for purposes of medical research;
  - related to judicial or administrative proceedings or orders; or
  - required to obtain or maintain a license of any type;
- private duty nursing received on an inpatient basis;
- respite care;
- rest cures;
- sex transformation operations, hormone therapy or related medical or psychological counseling;
- speech therapy to treat stuttering, stammering, or other articulation disorders; and
- the following treatments for obesity:
  - non-surgical treatment, even if for morbid obesity; and
  - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6.

CLAIMS PROCEDURES

What this section includes:

- How network and non-network claims work; and
- What to do if your claim is denied, in whole or in part

Network Benefits

In general, if you receive Covered Services from a Network Provider, Aetna will pay the Physician or facility directly. If a Network Provider bills you for any Covered Health Service other than your Copay, please contact the Provider or call Aetna at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay owed to a Network Provider at the time of service, or when you receive a bill from the Provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network Provider, you (or the Provider if they prefer) must send the bill to Aetna for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to Aetna at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. You can obtain a medical or dental claim form by visiting the Airgas intranet, selections Departments, then HR Info for Employee and click on Forms. Or, you can receive one by calling Aetna at the toll-free number on your ID card .

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim. If, through no fault of your own, you are not able to meet the deadline for claim filing, your claim will still be accepted if filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received.

Benefits are payable to you, however, Aetna has the right to pay any health benefits to a service Provider. Benefits will be paid to providers unless you have told Aetna otherwise by the time you file the claim.

The Plan may pay up to $1,000 of any other benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Appeals of Adverse Benefit Determinations

You may submit an appeal if Aetna gives notice of an adverse benefit determination. This Plan provides for two levels of appeal. It will also provide an option to request an external review of the adverse benefit determination.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call Aetna at the number on your ID card before requesting a formal appeal. If Aetna cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you have 180 days following receipt of notice of a denial to request your level one appeal. If you submit your appeal in writing, your written communication should include:

- the patient's name and ID number as shown on the ID card;
- your Employer's name;
- A copy of Aetna's notice of an adverse benefit determination;
- the reason you are making the appeal; and
- any documentation or other written information to support your request.

You, your eligible Dependent or an authorized representative may send your written request for an appeal to:

Aetna
Attn: Appeals Resolution Team
P.O. Box 14463
Lexington, KY 40512

If you call in your appeal, contact Aetna at the toll-free number on your ID card to make your request.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, you should determine whether it is an:

- urgent care;
- pre-service; or
- post-service claim.

Review of an Appeal

Aetna will conduct a full and fair review of your appeal. The appeal may be reviewed by an appropriate individual(s) who did not make the initial benefit determination.

Once the review is complete, if Aetna upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from Aetna within 60 days following receipt of notice of the first level appeal. Aetna must notify you of the benefit determination within 15 days after receiving the completed appeal for a pre-service claim and 30 days after receiving the completed post-service appeal. A decision on an urgent care claim is made within 36 hours of receipt of appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments.

Voluntary External Review

If, after exhausting the two levels of appeal, you are not satisfied with the final determination, you may choose to participate in the voluntary external review program. This program only applies if the claim denial is based on:

- care is not considered appropriate; or
- the exclusions for Experimental and Investigational Services or Unproven Services.

The voluntary external review program is not available if the claim denial is based on explicit benefit exclusions or defined benefit limits. Contact Aetna at the toll-free number on your ID card for more information.

Timing of Claim Denials and Appeals

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care - a claim for Benefits provided in connection with Urgent Care services, as defined in Section 16, Glossary;
- Pre-Service - a claim for Benefits which the Plan must approve before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables on the following page describe the time frames which you and Aetna are required to follow.

Exhaustion of Process

You must exhaust the applicable Level one and Level two processes of the appeal procedure before you:

- establish any:
  - — litigation;
  - — arbitration; or
  - — administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the appeals procedure.

Urgent Care Claims*

Type of Claim or Appeal	*Timing*
If your claim is incomplete, Aetna must notify you within:	24 hours
You must then provide completed claim information to Aetna within:	48 hours after receiving notice
If Aetna denies your initial claim, they must notify you of the denial: ▪ if the initial claim is complete, within: ▪ after receiving the completed claim (if the initial claim is incomplete), within:	 72 hours 48 hours
You must appeal the claim denial no later than:	180 days after receiving the denial
Aetna must notify you of the appeal decision within:	72 hours after receiving the appeal

* You do not need to submit Urgent Care claim appeals in writing. You should call Aetna as soon as possible to appeal an Urgent Care claim.

Pre-Service Claims*

Type of Claim or Appeal	*Timing*
If your claim is incomplete, Aetna must notify you within:	15 days
You must then provide completed claim information to Aetna within:	45 days after receiving an extension notice*
If Aetna denies your initial claim, they must notify you of the denial: ▪ if the initial claim is complete, within: ▪ after receiving the completed claim (if the initial claim is incomplete), within:	 15 days 30 days**
You must appeal the claim denial no later than:	180 days after receiving the denial
Aetna must notify you of the appeal decision within:	15 days after receiving the appeal

* Aetna may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.
**This timeframe assumes that Aetna gives notice of the need for an extension during the initial 15-day period.

Post-Service Claims*

Type of Claim or Appeal	*Timing*
If your claim is incomplete, Aetna must notify you within:	30 days
You must then provide completed claim information to Aetna within: notice*	45 days after receiving an extension
If Aetna denies your initial claim, they must notify you of the denial: ▪ if the initial claim is complete, within: ▪ after receiving the completed claim (if the initial claim is incomplete), within:	 30 days 45 days**
You must appeal the claim denial no later than:	180 days after receiving the denial
Aetna must notify you of the appeal decision within:	30 days after receiving the appeal

* Aetna may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.
**This timeframe assumes that Aetna gives notice of the need for an extension during the initial 30-day period.

Claim Fiduciary

Claim decisions are made by the Claim Fiduciary in accordance with the provisions of the Plan. The Claim Fiduciary has complete authority to review denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its fiduciary responsibility, the Claim Fiduciary has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

The Claim Fiduciary has the right to adopt reasonable policies, procedures, rules, and interpretations of the Plan to promote orderly and efficient administration. The Claim Fiduciary may not act arbitrarily and capriciously, which would be an abuse of its discretionary authority.

Aetna is the Claim Fiduciary for the Plan, and has discretionary authority to review all denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its responsibilities, Aetna has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

Aetna has the right to adopt reasonable policies, procedures, rules, and interpretations of the Plan to promote orderly and efficient administration. Aetna may not abuse its discretionary authority by acting arbitrarily and capriciously.

Airgas is responsible for making reports and disclosures required by ERISA, including the creation, distribution, and final content of:

- Summary Plan Descriptions;
- Summary of material modifications; and
- Summary annual reports.

Recovery of Overpayment

If Aetna makes a benefit payment over the amount you are entitled to under this Plan, Aetna has the right to:

- Require that the overpayment be returned on request; or
- Reduce any future benefit payment by the amount of the overpayment.

This right does not affect any other right of overpayment recovery Aetna may have.

If you have named an individual as a dependent on the Airgas plan that does not qualify, or if you do not provide proof of dependent relationship as requested during an audit of covered dependents, the named individual will be removed from coverage all claims paid in the prior 2 year period will be considered by Aetna to be overpayments and will be reversed.

Type of Coverage

Coverage under this Plan is non-occupational. Only non-occupational accidental injuries and non-occupational diseases are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Physician Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. his will be done at no cost to the covered person.

Legal Action

No legal action can be brought to recover a benefit after three years from the claim filing deadline.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect as long as the loss occurs more than two years from the date coverage started. This will not apply to any condition that is not covered as of the date of the loss.

COORDINATION OF BENEFITS (COB)

What this section includes:

- how your Benefits under this Plan coordinate with other medical plans;
- how coverage is affected if you become eligible for Medicare; and
- procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an Employee pays bene- fits before a plan that covers the person as a Dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your Dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - — the parents are married and not legally separated; or
  - — a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - — the parent with custody of the child; then
  - — the Spouse of the parent with custody of the child; then
  - — the parent not having custody of the child; then
  - — the Spouse of the parent not having custody of the child;
- plans for active Employees pay before plans covering laid-off or retired Employees;
- finally, if none of the above rules determines which plan is primary or secondary, the plan that has covered the individual claimant the longest will pay first. Only expenses normally paid by the Plan will be paid under COB.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the primary plan's allowable expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense When This Plan is Secondary

When this Plan is secondary, the allowable expense is the primary plan's network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plan's reasonable and customary charges..

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that Aetna should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Com- pany-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care Provider, Aetna reserves the right to recover the excess amount.

SUBROGATION AND REIMBURSEMENT

As used throughout this provision, the term Responsible Party means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term Responsible Party includes the liability insurer of such party, or any insurance coverage.

For purposes of this provision, the term Insurance Coverage refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

For purposes of this provision, a Covered Person includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation

Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition for which Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person; the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative agent; and/or any other source possessing funds representing the amount of benefits paid by the plan or Airgas.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that this plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recov-ery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such set- tlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those desig- nated as pain and suffering, non-economic damages and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the plan within 30 days of the date when any notice is given to a party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and his/her agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Responsible Party. The plan reserves the right to notify Responsible Party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end;
- Extended coverage; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, Airgas, Inc. will still pay claims for Covered Health Services that you receive before your coverage ended. However, once your coverage ends, Benefits are not provided for medical services that you receive before your coverage ended, even if the underlying condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the date your employment with the Company ends;
- the date the Plan ends;
- the date you stop making the required contributions;
- the date you are no longer eligible;
- the date Aetna receives notice from Airgas, Inc. through it's adminstrator to end your coverage, or the date requested in the notice, if later; or
- the date you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date you stop making the required contributions;
- the date Aetna receives written notice from Airgas, Inc. to end your coverage, or the date requested in the notice, if later; or
- the date your Dependents no longer qualify as Dependents under this Plan.
- the deadline for providing proof of your relationship to the individual named as a dependent on the plan.

In addition, a domestic partner* will no longer be considered to be a defined dependent on the earlier to occur of:

- the date the Plan no longer allows coverage for a domestic partner;
- the date of termination of the domestic partnership.

Note: Airgas, Inc. has the right to demand that you pay back all Benefits Airgas, Inc. paid to you, or paid in your name, during any time you were incorrectly covered under the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 16, *Glossary.*

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Airgas, Inc. is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call YBR, the recordkeeper for the Plan if you have questions about your right to continue coverage

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- an Employee;
- an Employee's enrolled Dependent, including with re- spect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
- an Employee's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

COBRA

If Coverage Ends Because of the Following Qualifying Events:	*You May Elect COBRA for:* Yourself	Your Spouse	Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
Airgas, Inc. files for bankruptcy under Title 11, United States Code.[2]	N/A	36 months[3]	36 months[3]

[1] Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2] This is a qualifying event for any retired Employee and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3] From the date of the Employee's death if the Employee dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	*You May Elect COBRA Dependent Coverage for Up To:*
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, you Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a Provider, inform that Provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Annual Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide YBR with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that un- employment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second elec- tion period is not retroactive to the date that Plan cover- age was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes eligible for Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified pursuant to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

OTHER IMPORTANT INFORMATION

What this section includes:

- court-ordered Benefits for Dependent children;
- the future of the Plan; and
- how to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. Copies of these documents, as well as the latest summary annual reports of Plan operations and Plan descriptions as filed with the Internal Revenue Service and the U.S. Department of Labor, are available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of these documents by written request to the Plan Administrator, for a nominal charge.

GLOSSARY

What this section includes:
- definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or amendments to the SPD, the Addendum shall be controlling.

Alternate Facility – a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services;
- Emergency health services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Abuse Treatment on an inpatient basis (for example a Residential Treatment Facility) or an outpatient basis.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year.

Annual Enrollment – the period of time, determined by Airgas, Inc., during which eligible Employees may enroll themselves and their Dependents under the Plan.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan.

Claims Administrator – Aetna (also known as Aetna Life Insurance Company) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services.

Company – Airgas, Inc.

Congenital Anomaly – a physical developmental defect that is present at birth.

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services.

Cosmetic Procedures – procedures or services that change or improve or enhance appearance.

Covered Expenses/Health Services – those health services and supplies that are shown as covered.

Covered Person – either the Employee or an eligible Dependent only while enrolled for Benefits under the Plan.

Creditable Coverage – a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes:

- health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).

Custodial Care – services and supplies primarily to meet personal needs. Examples of custodial care include:

- routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- watching or protecting a person;
- respite care, adult (or child) day care, or convalescent care;
- institutional care, including room and board for rest cures, adult day care and convalescent care;
- help with daily living activities such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- any services that a person without medical or paramedical training could be trained to perform; and
- any service that can be performed by a person without any medical or paramedical training.

Deductible – see Annual Deductible

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under Eligibility in Section 2, *Introduction*.

DME – see Durable Medical Equipment (DME).

Durable Medical Equipment (DME) – medical equipment (and accessories needed to operate it) that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of an illness or injury;
- suited for use in the home;
- not normally of use to people who do not have an illness or injury;
- not for use in altering air quality or temperature; and
- not for exercise or training.

Eligible Expenses – charges for Covered Health Services that are considered for benefits while the Plan is in effect, determined as follows:

- Network Benefits
  Eligible Expenses are Based On:
  Negotiated charges (contracted rates) with a Provider who has contracted to furnish services or supplies for such charges.
- Non-Network Benefits
  Eligible Expenses are Based On:
  Health care services or supplies furnished by an out-of-network provider who has not contracted with Aetna to furnish those services or supplies at negotiated charges.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

Emergency Care – Treatment given in a hospital's emergency room to evaluate and treat an emergency medical condition.

Emergency Medical Condition – a recent and severe medical condition, including but not limited to severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of a such a nature that failure to get immediate medical care could result in:

- placing your health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employee – a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – Airgas, Inc.

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

Experimental and Investigational – a drug, a device, a procedure or treatment will be determined to be experimental or investigational if:

- there are insufficient outcomes data available from con-

trolled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved;

- approval required by the FDA has not been granted for marketing; or
- a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational or for research purposes; or
- it is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trail, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or investigational or for research purposes.

EOB – see Explanation of Benefits (EOB).

Explanation of Benefits (EOB) – a statement provided by Aetna to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why any service or supply was not covered by the Plan.

Family Lifetime Maximum Benefit Amount is the maximum amount the Plan will pay for Covered medical and prescription drug benefits for you and all of your covered dependents during the entire period you are enrolled in this Plan and any other medical plans offered by Airgas, Inc. The family lifetime maximum amount of $2,000,000 applies to the combined network and non-networks benefits paid by this Plan.

Full-time Student – a person who is enrolled in and attending, full-time, a recognized course of study or training at:

- an accredited high school;
- an accredited college or university; or
- a licensed vocational, technical, automotive, or beautician school, or similar training school.

The educational institution determines what constitutes Full-time Student status. You continue to be a Full-time Student during periods of regular vacation established by the institution. You are no longer a Full-time Student as of the last day of the calendar month you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

Home Health Agency – an agency that meets all of the following requirements:

- mainly provides skilled nursing and other therapeutic services;
- is associated with a professional group (of at least one physician and one R.N.) which makes policy;
- has full-time supervision by a physician or an R.N.;
- keeps complete medical records on each person;
- has an administrator;
- meets licensing standards.

Hospice Care – care given to a terminally ill (prognosis of 6 months or less to live) person by or under arrangements with a hospice care agency as part of a hospice care program.

Hospice Care Agency – an agency or organization that meets all of the following requirements:

- has hospice care available 24 hours a day;
- meets licensing or certification standards established by the jurisdiction where it is located;
- provides skilled nursing services, medical social services and psychological and dietary counseling;
- provides physician services, physical and occupational therapy, part-time home health aide services for terminally ill or inpatient care when needed for pain control and acute and chronic symptom management;
- has at least one physician, one R.N. and one licensed or certified social worker employed by the agency;
- assesses patient medical and social needs;
- develops a hospice care program to meet those needs;
- provides on-going quality assurance;
- permits area medical personnel to utilize its services;
- keeps medical records on patients;
- has a full-time administrator.

Hospital – an institution that:

- is primarily engaged in providing on premises inpatient medical, surgical and diagnostic services;
- is supervised by a staff of physicians;
- provides 24-hour R.N. service;
- charges patients for its services;
- operates in accordance with the laws of the jurisdiction in which it is located; and
- if not meeting all other requirements, operates lawfully and is accredited as a hospital by the Joint Commission on the Accreditation or Healthcare Organizations.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Illness – a pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury – an accidental bodily injury that is the sole and direct result of:

- an unexpected or reasonably unforeseen occurrence or event;
- the reasonable unforeseeable consequences of a voluntary act by the person;
- an act or event definite as to time and place.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Residential Treatment Facility.

Late Enrollee – an Employee or Dependent who enrolls for coverage under the Plan at a time other than:

- within 31 days of the date you first become eligible for coverage under the Plan;
- during an Annual Enrollment; and
- within 31 days of the date you experience a qualified change in family status as described under *Changing Your Coverage* in Section 2, *Introduction*.

Lifetime Maximum Benefit – the most the Plan will pay for covered expenses incurred by any one covered person during their lifetime.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare – Parts A, B, and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Medically Necessary or Medical Necessity – Health care or dental services, and supplies or prescription drugs that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

- in accordance with generally accepted standards of medical or dental practice;
- clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician, other health care or dental provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with physician or dental specialty society recommendations and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

Mental Health and Substance Abuse (MH/SA) Treatment – treatment for the conditions including but not limited to:

- alcoholism and substance abuse;
- bipolar disorder;
- major depressive disorder;
- obsessive compulsive disorder;
- panic disorder;
- Pervasive Mental Developmental Disorder (Autism);
- psychotic depression;
- schizophrenia;
- physical or psychological dependency on a controlled substance or alcohol agent.

Network Provider – a health care Provider who has:

- entered into an agreement with Aetna; and
- agreed to accept specified reimbursement rates for Covered Health Services.

Non-Occupational Injury or Non-Occupational Illness – an illness or injury that does not arise out of (or in the course) of any work for pay or profit or result in any way from an illness or injury that does.

An illness will be considered to be non-occupational regardless of cause if proof is furnished that the person is covered under any type of workers' compensation law and is not covered for that illness under such law.

Out-of-Pocket Maximum – the maximum amount you pay out-of-pocket every calendar year including the amount you pay toward the Annual Deductible as shown in the Plan Highlights.

Two separate Out-of-Pocket Maximums apply for network Benefits and non-network Benefits. Once you reach the network Out-of-Pocket Maximum, the Plan pays network Benefits at 100% of Eligible Expenses during the rest of that calendar year. Once you reach the non-network Out-of-Pocket Maximum, the Plan pays non-network Benefits at 100% of Eligible Expenses during the rest of that calendar year.

Physician – a duly licensed member of a medical profession who:

- has an M.D. or a D.O degree;
- is properly licensed or certified to provide medical care by law; and
- provides medical services within the scope of his or her license.

This also includes a health professional who:

- is properly licensed or certified to legally provide medical care where he or she practices;
- provides medical services within the scope of his or her license or certificate;
- has the medical training and clinical expertise suitable to treat the condition;
- specializes in psychiatry if an illness or injury is caused by mental health or substance abuse;
- is not you or related to you.

Plan – The Airgas, Inc. Medical Plan.

Plan Administrator – Airgas, Inc. or its designee.

Plan Sponsor – Airgas, Inc.

Preexisting Condition – a Preexisting Condition occurs when you or your eligible Dependent receives medical care, advice, took medications or has been diagnosed or treated for any Sickness or Injury within 90 days before coverage under this Plan begins. A Preexisting Condition does not include Pregnancy.

If you have Creditable Coverage, you or your Dependent will be eligible to receive Plan Benefits for a Preexisting Condition. Continuous Creditable Coverage is defined in this section.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

Provider – a health care professional or facility operating as required by law and considered a physician for the purposes of Plan administration.

Reasonable and Customary Charge – only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing it; and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:

- Unusual; or
- Not often provided in the area; or
- Provided by only a small number of providers in the area

Aetna will take into account factors such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the reasonable charge is the rate established in such agreement.

Rehabilitation Facility – a facility or distinct part of a facility that provides rehabilitative services, meets licensing and certification standards established by the jurisdiction where it is located and charges for services.

Residential Treatment Facility – an institution that meets the following requirements:

- has an on-site licensed behavioral health provider 24 hours per day, 7 days per week;
- provides comprehensive patient assessment;
- has the availability of on-site medical treatment 24 hours a day, 7 days a week that is actively supervised by an attending physician;
- offers group therapy with at least an R.N. or masters-level health professional'
- has services managed by a licensed behavioral health provider who meets Aetna's credentialing criteria and functions under the direction/supervision of a licensed psychiatrist;
- meets applicable licensing standards;
- is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

Room and Board – charges made by an institution for room and board and other medically necessary services and supplies.

Skilled Nursing Facility – an institution that meets requirements including but not limited to:

- is licensed to and provides inpatient professional nursing care or physical restoration services for individuals convalescing from an illness or injury;
- provides 24 hour a day nursing care directed by a full-time R.N.;
- is supervised by a full-time physician or R.N.;
- keeps medical records for each patient and has a utilization review plan;
- is not mainly a place for rest, for the aged, for drug addicts, alcoholics, mental retardates or for custodial or educational care; and
- is licensed and approved under state or local law.

Spouse – an individual to whom you are legally married provided he or she qualifies as a spouse under federal law.

Total Disability – an Employee's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's inability to perform the normal activities of a person of like age and gender.

Urgent Condition – a sudden illness, injury or condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

Urgent Care Provider – Is:

A freestanding facility that:

- Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available;
- Routinely provides on-going unscheduled medical services for more than 8 consecutive hours;
- Makes charges;
- Is licensed and certified as required by law;
- Keeps medical records on patients and provides an on-going quality assurance program;
- Is run by a staff of physicians with at least one physician on call at all times.

A physician's office that:

- Has contracted with Aetna to provide urgent care.

Is not the emergency room or outpatient department of a hospital.

IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:

- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the medical Plan, as well as information required of all *Summary Plan Descriptions* by ERISA as defined in Section 15, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

Airgas, Inc. is the Plan Sponsor and Plan Administrator of the Airgas, Inc. Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Medical Plan
Airgas, Inc.
259 North Radnor-Chester Road
Radnor, PA 19087-5283
(610) 902-5283

Claims Administrator

Aetna is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

The Plan Sponsor also has selected a provider network established by Aetna.

Plan Name:	Airgas, Inc. Welfare Benefit Plan
Plan Number:	501
Employer ID:	56-0732648
Plan Type:	Welfare Benefits Plan
Plan Year:	January 1 – December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, trust agreements, collective bargaining agreements, summary annual reports, and other documents filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements, and copies of the latest summary annual reports, and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies; and
- receive a summary annual report of the Plan's financial activities. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or

your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

You will be provided a certificate of creditable coverage in writing, free of charge, from UnitedHealthcare:

- when you lose coverage under the Plan;
- when you become entitled to elect COBRA;
- when your COBRA coverage ends;
- if you request a certificate of credible coverage before losing coverage; or
- if you request a certificate of credible coverage up to 24 months after losing coverage.

You may request a certificate of creditable coverage by calling the toll-free number on your ID card.

If you have creditable coverage from another group health plan, you may receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. Without evidence of creditable coverage, Plan Benefits for the treatment of a preexisting condition may be excluded for 12 months (18 months for late enrollees) after your enrollment date in your coverage. In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, Claims Procedures, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest summary annual report from the Plan, and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ig- nored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you dis- agree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discrimi- nated against for asserting your rights, you may seek as- sistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (800) 998-7542.

The Plan's Benefits are administered by Airgas, Inc., the Plan Administrator. Aetna Life Insurance Company is the Claims Administrator and processes claims for the Plan and provides appeal services; however, neither Aetna nor Airgas, Inc. is responsible for any decision you or your Dependents make to receive or not receive treatment, services or supplies, whether provided by a Network or non-Network Provider. Aetna and Airgas, Inc. are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network Providers.

United Healthcare
Summary Plan Description

Airgas

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WELCOME

Quick Reference Box

Group Number: 710288

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (888) 400-9454;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800; and
- Online assistance: www.myuhc.com.

Airgas, Inc. is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the Airgas, Inc. Welfare Benefit Plan. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, Glossary.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Airgas, Inc. intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Airgas, Inc. is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Airgas, Inc. Welfare Benefit Plan works. If you have questions contact Your Benefit Resources (YBR) on the web: www.ybr.com/airgas or contact the YBR Customer Care Center at 877-4AG-Benefits (877-424-2363 or contact UnitedHealthcare directly by calling the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at www.ybr.com/airgas or on the Airgas intranet site (Airnet). For hardcopy of the SPD contact your local HR representative.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Airgas, Inc. is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time Employee who is scheduled to work at least 30 hours per week. If you are a member of a collective bargaining unit, you may not be eligible for Benefits described in this SPD. Please contact your Human Resources representative for more information.

No person may be covered both as an Employee and Dependent and no person may be covered as a Dependent of more than one Employee.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse/Domestic Partner provided he or she qualifies as a spouse/Domestic Partner under federal law. A legally separated spouse or a former spouse is not an eligible dependent.), as defined in Section 14, *Glossary*.
- Adult children of Airgas employees are eligible for coverage on Airgas Medical Dental and Vision Plans; coverage may continue up to age 26. An adult child includes your child who is married or unmarried, up to age 26, who is any of the following:
    - Your biological child;
    - Your legally-adopted child;
    - Your stepchild
    - An eligible foster child, placed in your care by an appropriate court or placement agency;
    - A child for whom you are the current court-appointed legal guardian.

The following requirements are removed: unmarried, a full-time student, financial dependency on the employee and residency with the employee.

- Your disabled child, over age 26 who is unable to earn a living due to a physical or mental handicap and who was disabled prior to the age of 26 and continues to be disabled.
- Your natural or adopted children up to age 26 for whom you are required by a Qualified Medical Child Support Order ("QMCSO") or other court or administrative order, as described in Section 13, Other Important Information. to provide health insurance coverage.

Note: To obtain health plan coverage for a newborn child, you must enroll that child within 31 days of birth, even if you have other children covered under the Plan.

Domestic Partner Coverage

For employees of Airgas the Plan treats a Domestic Partner as a dependent. In addition, the children of a Domestic Partner are treated as the children of the eligible employee and are eligible to participate on the same basis as any other child under the rules described above. A person is a Domestic Partner of an Airgas employee if they are a same-sex or opposite-sex couple who has registered with any state or local government domestic partnership registry.

Note: To obtain health plan coverage for a newborn child, you must enroll that child within 31 days of birth, even if you have other children covered under the Plan.

Your child is considered to be disabled if he or she:

- is unable to earn a living because of a mental or physical disability that starts before he or she reaches the age limit for dependents, and
- depends mainly on you for support and maintenance.

You must provide proof of your child's disability no later than 31 days after your child reaches the dependent age limit. The child's coverage will end on the first to occur of the following:

- your child is no longer disabled if you fail to provide proof that the disability continues;
- you fail to have any required exam performed; or
- your child's coverage ends for a reason other than reaching the dependent age limit.

Proof of Dependent Relationship

You will be required to provide acceptable proof of your relationship to any Dependent you elect to cover for health care coverage whenever the Dependent is added to coverage including when you are initially hired, annual enrollment or following a life event. Acceptable proof must be provided within the 30 day period following the date you enter your Dependent information into your benefits record either by using the YBR on line site or through the customer care center. Your Dependent will not be enrolled in your selected plans until the proof of Dependent relationship is provided. Once provided, coverage will be made effective as of your original date of eligibility. If you do not provide the acceptable proof of Dependent status within the stipulated time period, you will not be permitted to enroll your Dependent(s) in the Airgas plan until the next annual enrollment, at which time you will again be required to provide the acceptable proof.

Dependent Eligibility Audit

Periodically Airgas conducts random audits of dependents covered under the Airgas health care plans. If you are selected to participate in an audit, you must provide acceptable proof that the individuals you named as Dependents for the health Benefits meet the definition of Dependents. If you do not provide the required proof within the timeframe specified, the individual will be removed from coverage at the end of the year in which the audit takes place and you will not be permitted to add the individual back to coverage until the next annual enrollment without a qualifying event.

Cost of Coverage

You and Airgas, Inc. share in the cost of the Plan. Your payroll contributions for medical, dental and vision coverage will be based on the number of dependents you decide to cover. "Unitized pricing" is in effect for all dependent children: a per child contribution is calculated upon your enrollment, capped at three children.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of Airgas Inc.'s cost in covering a Domestic Partner may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and Airgas, Inc. reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by contacting YBR on the web: *www.ybr.com/airgas* or contact the YBR Customer Care Center at 877-4AG-Benefits (877-424-2363.)

How to Enroll

To enroll, call the YBR Customer Care Center at 1-877-424-2363 or log onto *www.ybr.com/airgas* within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, or the date specified on the personal report you receive from YBR if later, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact YBR at 1-877-424-2363 within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

You may enroll in benefits either by contacting the YBR Service Center at 1-877-424-2363 or on the YBR web site: www.ybr.com/airgas. You must enroll by the deadline printed on the bottom of the personal report you will receive in the mail. Following completion of your enrollment your elected coverage will begin on the 31st day of your employment. There is no waiting period required if an Employee moves from part-time to full-time status, provided the Employee worked at least 120 hours for Airgas while a part-time employee. When you enroll for medical benefits, you automatically receive prescription drug coverage under the Caremark prescription drug program.

Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for newly eligible Dependents begins on the date they become eligible (through birth, adoption, etc.) provided you enroll them within 31 days of that event.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse/Domestic Partner following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, the annulment of your marriage, your divorce or legal separation;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse/Domestic Partner's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of your Spouse/Domestic Partner or an eligible Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse/Domestic Partner's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse/Domestic Partner; or
- a court or administrative order.

Note: Airgas has the exclusive authority to determine whether a circumstance or “life status change” or other circumstance has occurred that permits a new election

If you wish to change your elections, you must contact YBR within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

If you are Rehired by the Company

Employees who separate from employment and are rehired within thirty (30) days are reinstated to the coverage in place at the time of separation of employment; the 31-day waiting period is waived. Cover age employee contributions are effective the date of rehire.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Airgas, Inc.'s medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Airgas, Inc.'s medical plan outside of annual Open Enrollment provided she makes the change within 31 days of Tom's termination.

HOW THE PLAN WORKS

What this section includes:

- Accessing Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify the Claims Administrator and if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through a non-Network provider. This provision works best during the precertification process and is based on standard criteria of adequate access.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Looking for a Network Provider?

In addition to other helpful information, www.myuhc.com, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of Airgas, Inc. or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the non-Network level.

Eligible Expenses

Airgas, Inc. has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Claims Administrator will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are the Claims Administrator's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by the Claims Administrator, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates or subcontractors, at the Claims Administrator's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
    - For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
    - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

      When a rate is not published by CMS for the service, the Claims Administrator uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, the Claims Administrator will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

When Covered Health Services are received from a Network provider, Eligible Expenses are the Claims Administrator's contracted fee(s) with that provider.

IMPORTANT: As a participant in the Plan, you are reminded that you are responsible for confirming that your selected provider is in-network at the time of service.

Don't Forget Your ID Card

Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits.. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance - Example

Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

How the Plan Works - Example

The following example illustrates how Annual Deductibles, Copays, Out-of-Pocket Maximums, Lifetime Maximum Benefits and Coinsurance work in practice.

Let's say Gary has individual coverage under the Plan. He has met his network Annual Deductible, but not his non-network Annual Deductible and needs to see a Physician. The flow chart below shows what happens when he visits a network Physician versus a non-network Physician.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Feature	Applies to the Network Out-of Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses	No	No

PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact Personal Health Support.

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice.:

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. There are some Network Benefits, however, for which you are responsible for obtaining authorization before you receive the services. Services for which prior authorization is required are identified below and in Section 6, Additional Coverage Details within each Covered Health Service category.

It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the toll-free telephone number on the back of your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

To obtain prior authorization, call the toll-free telephone number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

fNetwork providers are generally responsible for obtaining prior authorization from the Claims Administrator or contacting Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from the Claims Administrator or contacting Personal Health Support.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator or contacting Personal Health Support before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

The services that require prior authorization are:

- ambulance - non-emergent air;
- breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature;
- clinical Trials;
- congenital Heart Disease services;
- durable Medical Equipment for items that will cost more than $1,000 to purchase or rent;
- genetic Testing – BRCA;
- home health care;
- hospice care - inpatient;
- maternity care that exceeds the delivery timeframes as described in Section 6, *Additional Coverage Details;*
- lab, X-Ray and Diagnostics – Outpatient - sleep studies;
- lab, X-ray and Major Diagnostics – Outpatient - CT, PET Scans, MRI, MRA and Nuclear Medicine including diagnostic catheterization and electrophysiology implants;
- mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- neurobiological Disorders - Autism Spectrum Disorder Services -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility);
- obesity surgery;
- prosthetic Devices for items that will cost more than $1,000 to purchase or rent;
- reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- surgery – Outpatient - cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators and sleep apnea surgeries and orthognathic surgeries;
- therapeutics - outpatient dialysis treatments, intensity modulated radiation therapy and MR-guided focused ultrasound as described under Therapeutic Treatments - Outpatient in Section 6, Additional Coverage Details; and
- transplantation services.

Notification is required within 48 hours of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency. If the confinement begins on a Friday or Saturday, the 48-hour requirement will be extended to 72 hours.

When you choose to receive services from non-Network providers, UnitedHealthcare urges you to confirm that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services.

For prior authorization timeframes, and reductions in Benefits that apply if you do not obtain prior authorization from the Claims Administrator, see Section 6, *Additional Coverage Details*.

Contacting the Claims Administrator or Personal Health Support is easy.
Simply call the toll-free number on your ID card.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, the Claims Administrator's final coverage determination will be modified to account for those differences, and the Plan will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from the Claims Administrator before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, Coordination of Benefits (COB).

CORE PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	*Network*	*Non-Network*
Copays[1]		
Emergency Health Services	$500	$500
Hospital - Inpatient Stay	$100	$100
Physician's Office Services - Primary Physician	$25	Not Applicable
Physician's Office Services - Specialist	$35	Not Applicable
Rehabilitation Services - Primary	$25	Not Applicable
Rehabilitation Services - Specialist	$35	Not Applicable
Urgent Care Center Services	$35	$35
Annual Deductible[2,3]		
Individual	$1,000	$2,000
Family *(not to exceed $1,000 per Covered Person for Network Benefits and $2,000 per Covered Person for Non-Network Benefits)*	$2,000	$4,000
Annual Out-of-Pocket Maximum[2,4]		
Individual	$3,500	$7,000
Family *(not to exceed $3,500 per Covered Person for Network Benefits and $7,000 per Covered Person for Non-Network Benefits)*	$7,000	$14,000
Lifetime Maximum Benefit[5] *There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.*	Unlimited	

[1] In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages. With the exception of Emergency Health Services, a Copay does not apply when you visit a non-Network Provider.

[2] Copays do not apply toward the Annual Deductible but do apply to the Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

[3] Family Deductible may be reached with any combination of eligible expenses incurred by two family members.

[4] Family Out-of-Pocket may be reached with any combination of eligible expenses incurred by two family members.

[5] Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*

Covered Health Services[1]	**Percentage of Eligible Expenses Payable by the Plan** ***Network***	***Non-Network***
Acupuncture Services *(Copay is per visit)*	100% after you pay a $25 PCP Copay or a $35 Specialist Physician Copay	60% after you meet the Annual Deductible
Ambulance Services – Emergency Only	80% after you meet the Network Annual Deductible	80% after you meet the Network Annual Deductible
Ambulance Services – Non-Emergency	80% after you meet the Network Annual Deductible If non-emergency and prior authorization is not obtained, then 60% after you meet the Network Annual Deductible	80% after you meet the Network Annual Deductible If non-emergency and prior authorization is not obtained, then 60% after you meet the Network Annual Deductible
Cancer Resource Services (CRS)[2] • Hospital - Inpatient Stay *(Limited to $300 per admission)*	80% after you pay a $100 Copay per day up to a maximum of $300 and meet the Annual Deductible	Not Covered
Clinial Trials	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries • Hospital - Inpatient Stay *(Copay is per admission)*	80% after you pay a $100 Copay per day up to a maximum of $300 and meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services – Accident Only *(Copay is per visit)*	100% after you pay a $25 Primary Physician or $35 Specialist Physician Copay	60% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	
Diabetes Self-Management Items • diabetes equipment	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
• diabetes supplies	Benefits for diabetic supplies and insulin are covered under your pharmacy plan administered by Caremark.	
Durable Medical Equipment (DME) *(Prior authorization required for DME over $1,000.)*	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	100% after you pay a $500 Copay and meet the Network Annual Deductible If admitted, $100 Copay per day to a maximum of $300.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan *Network*	*Non-Network*
Hearing Care (Routine) *(Copay is per visit)* Limited to one routine hearing (audiometric exam) every 24 months. Any combination of Network Benefits and Non-Network Benefits is limited to 2 hearing aids every 36 months up to a $3,000 per ear, per calendar year (combined Network and Non-Network). Repairs are limited to $250 per hearing aid every 36 months per calendar year (combined Network and Non-Network).	100% after you pay a $25 Primary Physician or $35 Specialist Physician Copay	60% after you meet the Annual Deductible
Home Health Care Any combination of Network Benefits and Non-Network Benefits is limited to 100 visits per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital – Inpatient Stay *(Copay is per admission)*	80% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible	60% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible
Infertility Services *(Diagnosis and treatment of underlying medical condition only)*	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Injections in a Physician's Office	Office Visit: 100% after you pay a $25 PCP Copay or a $35 Specialist Copay All Other Places of Service: 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient	Office Visit: 100% after you pay a $25 Copay All Other Places of Service: 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	Office Visit: 100% after you pay a $20 Copay All Other Places of Service: 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services • Hospital - Inpatient Stay *(Copay is per admission)*	80% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible	60% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible
• Physician's Office Services *(Copay is per visit)*	$100 after you pay a $25 Copay	$60 after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan *Network*	*Non-Network*
Neurobiological Disorders - Autism Spectrum Disorder Services • Hospital - Inpatient Stay Limited to $300 per admission.	80% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible	60% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible
• Physician's Office Services *(Copay is per visit)*	100% after you Pay a 25$ copay	60% after you meet the Annual Deductible
Nutritional Counseling *(Copay is per visit)*	100% after you pay a $25 PCP Copay or a $35 SpecialistPhysician Copay	60% after you meet the Annual Deductible
Obesity Surgery • Physician's Office Services *(Copay is per visit)*	100% after you pay a $20 Copay for a Primary Physician or $35 for a Specialist Physician	60% after you meet the Annual Deductible
• Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
• Hospital - Inpatient Stay *(Copay is per admission)* *See Section 6, Additional Coverage Details for limits*	80% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible	60% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible
Ostomy Supplies	Office Visit: 100% of eligible expenses Other Locations: 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury • Primary Physician *(Copay is per visit)*	100% after you pay a $25 Copay	60% after you meet the Annual Deductible
• Specialist Physician *(Copay is per visit)*	100% after you pay a $35 Copay	60% after you meet the Annual Deductible
Pregnancy – Maternity Services • Physician's Office Services *(Copay is per visit)*	100% after you pay a $25 PCP Copay or a $35 Specialist Copay	60% after you meet the Annual Deductible
• Hospital - Inpatient Stay *(Copay is per admission*	80% after you pay a $100 per day to a maximum of $300 Copay and meet the Annual Deductible	60% after you pay a $100 per day to a maximum of $300 Copay and meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan *Network*	*Non-Network*
Pregnancy – Maternity Services (*continued)*		
• Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Preventive Care Services • Physician Office Services	100%	60% after you meet the Annual Deductible
• Immunizations	100%	60% after you meet the Annual Deductible
• Breast Pumps	100%	60% after you meet the Annual Deductible
Private Duty Nursing - Outpatient *(Up to 70 shifts per calendar year)*	80% after you meet meet the Annual Deductible	`60% after you meet the Annual Deductible
Prosthetic Devices *Prior authorization required for Prosthetics over $1,000.*	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits for Reconstructive Procedures will be paid the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits for Reconstructive Procedures will be paid the same as those stated under each Covered Health Service category in this section.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment *(Copay is per visit)* *See Section 6, Additional Coverage Details, for visit limits*	100% after you pay a $25 PCP Copay or a $35 Specialist Physician Copay	60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services *Any combination of Network Benefits and Non-Network Benefits is limited to 120 days per calendar year*	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Substance Use Disorder Services • Hospital - Inpatient Stay *(Copay is per admission)*	80% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible	60% after you pay a $100 Copay per day to a maximum of $300 and meet the Annual Deductible
• Physician's Office Services	100% after you pay a $25 Copay	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan *Network*	*Non-Network*
Surgery - Outpatient *(Copay is per surgery)*	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint Dysfunction (TMJ)	Depending upon where the Covered Health Services is provided, Benefits for temporomandibular joint (TMJ) services will be the same as those stated under each Covered Health Services category in this section.	
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Transplantation Services	80% after you meet the Annual Deductible	Non-Network benefits are not Available
Travel and Lodging *(If services rendered by a Designated Facility)*	For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures	
Urgent Care Center Services *(Copay is per visit)*	100% after you pay a $35 Copay	100% after you pay a $35 Copay DME at an Urgent Care Facility: 60% after you meet the annual Deductible
Vision Examinations *One exam every 24 months*	100% after you pay a $25 PCP Copay or a $35 Specialist Physician Copay	60% after you meet the Annual Deductible
Wigs *See Section 6, Additional Coverage Details, for limits*	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

1 You must obtain prior authorization from Personal Health Support, as described in Section 4, Personal Health Support to receive full Benefits before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for obtaining prior authorization from Personal Health Support before you receive certain Covered Health Services. See Section 6, Additional Coverage Details for further information.

2 These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under Physician's Office Services, Physician Fees for Surgical and Medical Services, Hospital - Inpatient Stay, Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic Lab, X-Ray and Diagnostics – Outpatient, and Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.

ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain prior authorization before you receive them, and any reduction in Benefits that may apply if you do not call Personal Health Support to obtain prior authorization.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine; or
- Acupuncturist.

Acupuncture services are limited to needle therapy for the following;

- as a form of anesthesia in connection with a covered surgery; and
- to aid in smoking cessation.

Did you know…

You generally pay less out-of-pocket when you use a Network provider?

Ambulance Services - Emergency Only

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, Glossary for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

Ambulance Services - Non-Emergency

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

In most cases, UnitedHealthcare will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must obtain prior authorization from Personal Health Support as soon as possible prior to the transport. If authorization from Personal Health Support is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or
- visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated

Facility, the Plan pays Benefits as described under:

- Physician's Office Services;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper authorization to the Designated Facility provider performing the services (even if you self-refer to a provider in that Network).

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below;
- surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below; and

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial;
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- the Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - certain *Category B* devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*);

- *Centers for Disease Control and Prevention (CDC)*;
- Agency for *Healthcare Research and Quality (AHRQ)*;
- Centers for *Medicare and Medicaid Services (CMS)*;
- a cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*;
- a qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
  - ♦ comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
  - ♦ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- the study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration;*
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement

You must obtain prior authorization as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be subject to a $200 reduction.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about these guidelines.

Prior Authorization Requirements

For Designated Network Benefits you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization and if, as a result, the CHD services are not performed at a Designated Facility, Designated Network Benefits will not be paid. Non-Network Benefits will apply.

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Per-

sonal Health Support at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the CHD program, you must contact United Resource Networks at (888) 936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Dental Services - Accident

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage to a sound, natural tooth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Before the Plan will cover treatment of an injured tooth, the dentist must certify that the tooth is virgin or unrestored, and that it:

- has no decay;
- has no filling on more than two surfaces;
- has no gum disease associated with bone loss;
- has no root canal therapy;
- is not a dental implant; and
- functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within three months of the accident and completed within 12 months of the accident.

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
Diabetic Self-Management Items	Insulin pumps and blood glucose monitors for the management and treatment of diabetes, based upon the medical needs of the Covered Person. Insulin pumps and blood glucose monitors are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section. Diabetic supplies are covered under your pharmacy plan administered by Caremark.

Prior Authorization Requirement

For Non-Network Benefits, you must obtain prior authorization from Personal Health Support before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be subject to a $200 reduction.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and blood glucose monitors as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy and Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Coverage is provided for cranial orthotics (helmets) prescribed by a Physician. Orthotics are excluded for orthopedic shoes, therapeutic shoes, foot orthotics or other devices to support the feet, unless required for the treatment of diabetes or to prevent complications of diabetes or if the shoe is an integral part of a covered leg brace. Dental braces are also excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Disposable Medical Supplies

Benefits for disposable medical supplies include:

- Durable Medical Equipment and supplies that are necessary for the effective use of the item/device (e.g., oxygen tubing or mask, or tubing for a delivery pump); and
- medical supplies such as gauze, dressings, casts and splints.

Prior Authorization Requirements

Please remember for Non-Network Benefits, you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either from Personal Health Support if the retail purchase cost or cumulative rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be subject to a $200 reduction.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If the confinement begins on a Friday or Saturday, the 48-hour requirement will be extended to 72 hours. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Notification Requirements

Please remember for Non-Network Benefits, notify the Claims Administrator within 48 hours of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency. If the confinement begins on a Friday or Saturday, the 48-hour requirement will be extended to 72 hours. If notification is not provided, Benefits for the Inpatient Hospital Stay will be subject to a $200 reduction.

Hearing Care

Benefits are available for the following Covered Health Services when received from a Network Provider in the Provider's office:

- routine hearing exams once every 24 months; and
- hearing exams in case of Injury or Sickness.

Surgery to place a cochlear implant is also covered by the Plan when requests are consistent with professionally accepted standards. Cochlear implantation can either be an inpatient or outpatient procedure.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network Benefits and Non-Network Benefits is limited to 100 visits per calendar year. One visit equals four hours of Skilled Care services.

The Plan does not cover any of the following services:

- services or supplies that are not part of a home health care plan;
- services of a person who usually lives with you or is a member of your family or your Spouse/Domestic Partner's family; and
- transportation relating to home health care.

Prior Authorization Requirements

For Non-Network Benefits, please remember that you must obtain prior authorization from Personal Health Support five business days before receiving services or as soon as reasonably possible. If authorization is not obtained as required, Benefits will be subject to a $200 reduction.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

The Plan does not cover charges made for:

- bereavement counseling;
- pastoral counseling;
- funeral arrangements;
- respite care;
- financial or legal counseling, which includes estate planning and the drafting of a will; and
- homemaker or caretaker services which include companion services, transportation or housecleaning.

Prior Authorization Requirement

For Non-Network Benefits, please remember that you must obtain prior authorization from Personal Health Support five business days before admission for an Inpatient Stay in a hospice facility or as soon as reasonably possible. If you fail to obtain prior as required, Benefits will be subject to a $200 reduction.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Professional Fees for Surgical and Medical Services.*

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic, and Therapeutic Treatments - Outpatient, respectively.*

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- a scheduled admission, you must obtain prior authorization 14 business days before admission;
- a non-elective admissions (or admissions resulting from an Emergency) you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $200 reduction.

Infertility Services

The Plan pays Benefits for infertility services and associated expenses for the diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician.

What is Coinsurance?

Coinsurance is the amount you pay for a Covered Health Service, not including the Copay and/or the Deductible.

For example, if the Plan pays 80% of Eligible Expenses for care received from a Network provider, your Coinsurance is 20%.

Injections in a Physician's Office

Benefits are paid by the Plan for injections administered in the Physician's office, for example allergy immunotherapy, when no other health service is received.

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- lab and radiology/x-ray; and
- mammography.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Prior Authorization Requirements
For Non-Network Benefits for sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be subject to a $200 reduction.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services*.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received including diagnostic catheterization and electrophysiology implants. If authorization is not obtained as required, Benefits will be subject to a $200 reduction.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;

- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must obtain prior authorization from the MH/SUD Administrator before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If you fail to obtain prior authorization as required, Benefits will be subject to a $200 reduction.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders) that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following services provided on either an outpatient or inpatient basis:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must obtain prior authorization from the MH/SUD Administrator before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If you fail to obtain prior authorization as required Benefits will be subject to a $200 reduction.

Nutritional Counseling

Nutritional counseling is covered if medically necessary for a chronic disease when a dietary adjustment is therapeutic in nature. The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or health-care professional when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include:

- diabetes mellitus;
- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Obesity Surgery

The Plan covers surgical treatment of morbid obesity received on an inpatient basis provided all of the following are true:

- you have a minimum Body Mass Index (BMI) of 40;
- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years; and
- you are over the age of 21.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Prior Authorization Requirements

For Non-Network Benefits, please remember that you must obtain prior authorization 14 business days before receiving services or as soon as reasonably possible. If authorization is not obtained as required, Benefits will be subject to a $200 reduction.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

Physician's Office Services

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

The Plan pays for Covered Health Services given by a licensed Physician or other health care professional other than the Covered Person's Primary Physician, known as a Specialist Physician. A Specialist Physician has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Benefits for preventive services are described under Preventive Care Services in this section.

Prior Authorization Required

Please remember for Non-Network Benefits, you must obtain prior authorization for Genetic Testing – BRCA. If authorization from is not obtained as required, Benefits will be subject to a $200 reduction.

Please Note

Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

PREGNANCY - MATERNITY SERVICES

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement

You must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be subject to a $200 reduction.

Healthy moms and babies

The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, Resources to Help you Stay Healthy, for details.

PREVENTIVE CARE SERVICES

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- preventive bone density tests only.

These services are not covered under Preventive care services: Screening using CT Colonography, PSA and Screening Mammography under age 40. Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights* under *Covered Health Services*.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- which pump is the most cost effective;
- whether the pump should be purchased or rented;

- duration of a rental; and
- timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

PRIVATE DUTY NURSING - OUTPATIENT

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.) if a Covered Person's condition requires skilled nursing services and visiting care is not sufficient.

Any combination of Network and Non-Network Benefits is limited to 70 shifts of Private Duty Nursing care per Covered Person per calendar year. A shift is considered up to 8 hours of skilled nursing care.

The Plan does not cover inpatient private duty nursing care.

PROSTHETIC DEVICES

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every five calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Prior Authorization Requirements

For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be subject to a $200 reduction.

Note: Prosthetic devices are different from DME - see Durable Medical Equipment (DME) in this section.

RECONSTRUCTIVE PROCEDURES

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic proce-

dures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Prior Authorization Requirement

Please remember for Non-Network Benefits for:

- a scheduled admission, you must obtain prior authorization 14 business days before a scheduled reconstructive procedure is performed;
- a non-scheduled procedures (or inpatient admissions resulting from an Emergency) you must provide notification within 48 hours or as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $200 reduction.

REHABILITATION SERVICES - OUTPATIENT THERAPY AND MANIPULATIVE TREATMENT

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Benefits are limited to:

- 60 visits per calendar year for physical, occupational and speech therapy combined;
- 36 visits per calendar year for cardiac rehabilitation therapy; and
- 60 visits per calendar year for Manipulative Treatment.

These visit limits apply to Network Benefits and Non-Network Benefits combined.

SCOPIC PROCEDURES - OUTPATIENT DIAGNOSTIC AND THERAPEUTIC

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under Surgery - Outpatient. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

SKILLED NURSING FACILITY/INPATIENT REHABILITATION FACILITY SERVICES

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;
- it is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, Glossary.

Any combination of Network Benefits and Non-Network Benefits is limited to 120 days per calendar year.

Please remember for Non-Network Benefits, you must: as follows:

- obtain prior authorization from Personal Health Support for elective admissions: 14 business days before your scheduled admission;
- notify Personal Health Support for non-elective admissions (or admissions resulting from an Emergency: as soon as is reasonably possible.

If authorization Personal Health Support is not notified, Benefits for the extended stay will be subject to a $200 reduction.

SUBSTANCE USE DISORDER SERVICES

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

SPECIAL SUBSTANCE USE DISORDER PROGRAMS AND SERVICES

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must obtain prior authorization from the MH/SUD Administrator before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If you fail to obtain prior authorization as required, Benefits will be subject to a $200 reduction.

SURGERY - OUTPATIENT

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

When these services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services* earlier in this section.

Prior Authorization Requirements
For Non-Network Benefits, you must obtain prior authorization from Personal Health Support for diagnostic catheterization, electrophysiology implant and sleep apnea surgeries 14 business days before scheduled services are received or, provide notification for non-scheduled services, within 48 hours or as soon as is reasonably possible. If you fail to obtain prior authorization, Benefits will be subject to a $200 reduction.

Temporomandibular Joint Dysfunction (TMJ)

The Plan covers diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Medical Provider, Specialty Dentist or oral Surgeon. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology. Appliances are covered, subject to deductible and coinsurance

The Plan does not pay Benefits for services that are dental in nature.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Prior Authorization Requirement
For Non-Network Benefits for all outpatient therapeutics you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within 48 hours or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $200 reduction.

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network provider and received at a Designated Facility. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart:
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the telephone number on your ID card for information about these guidelines.

Please remember for Network Benefits, you must obtain prior authorization from United Resource Networks or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization, Network Benefits will not be paid.

Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD);
- transplantation services; and
- cancer-related treatments.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows::

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility (for CRS and transplantation) or the CHD facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel

expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

A combined overall maximum Benefit of $10,000 per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all cancer treatments, transplant procedures and CHD treatments during the entire period that person is covered under this Plan.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, Glossary. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services* earlier in this section.

Vision Examinations

The Plan pays Benefits for:

- vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment); and
- one routine vision exam, including refraction, to detect vision impairment by a legally qualified ophthalmologist or optometrist every 24 months.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from medical treatment such as chemotherapy.

The Plan does not cover wigs for male pattern baldness or alopecia.

RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

Airgas, Inc. believes in giving you the tools you need to be an educated health care consumer. To that end, Airgas, Inc. has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Airgas, Inc. are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Assessment

You and your Spouse/Domestic Partner are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.
Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – Airgas, Inc.'s way of helping you meet your health and wellness goals.

NurseLine℠

NurseLine℠ is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Airgas, Inc. has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine℠ toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

With NurseLine℠, you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

TREATMENT DECISION SUPPORT

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium℠ Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth PremiumSM Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium℠ Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth PremiumSM Program including how to locate a UnitedHealth PremiumSM Physician or facility, log onto www.myuhc.com or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs

With www.myuhc.com you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

If you have not already registered as a www.myuhc.com subscriber, simply go to www.myuhc.com and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy

With www.myuhc.com you can:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to www.myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, Glossary under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, Additional Coverage Details, those limits are stated in the corresponding Covered Health Service category in Section 5, Plan Highlights. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, Plan Highlights. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. acupressure;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage); and

6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, Additional Coverage Details.

Comfort and Convenience

Supplies, equipment and similar incidentals for personal comfort. Examples include:

1. television
2. telephone;
3. air conditioners;
4. beauty/barber service;
5. guest service;
6. air purifiers and filters;
7. batteries and battery chargers;
8. dehumidifiers and humidifiers;
9. ergonomically correct chairs;
10. non-Hospital beds and comfort beds;
11. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 6, *Additional Coverage Details*; and
12. home remodeling to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Dental

1. dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details*.

2. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, including oral appliances;
3. preventive dental care;
4. Preventive care, diagnosis or treatment of the teeth or gums. Examples include:
   - extractions (not including wisdom teeth that are partly or completely impacted in the jaw bone, will not erupt through the gum or cannot be removed without removing bone);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes;

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.
5. dental implants and braces;
   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.
6. dental braces (orthodontics);
7. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and
8. treatment of malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Drugs

1. prescription drugs for outpatient use that are filled by a prescription order or refill;
2. self-injectable medications. (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);
3. non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office; and
4. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 6, Additional Coverage Details. Routine foot care services that are not covered include:
   - cutting or removal of corns and calluses;
   - nail trimming or cutting; and
   - debriding (removal of dead skin or underlying tissue);
2. hygienic and preventive maintenance foot care. Examples include:
   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and
   - other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
3. treatment of flat feet;
4. treatment of subluxation (joint or bone dislocation) of the foot; and
5. foot orthotics (even if prescribed by a Physician) for orthopedic shoes, therapeutic shoes or other devices to support the feet, unless they are required for the treatment of diabetes or to prevent complications of diabetes. Shoes are excluded unless they are an integral part of a covered leg brace.:

Medical Supplies and Appliances

1. devices used specifically as safety items or to affect performance in sports-related activities;
2. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:
   - elastic stockings, diabetic strips, and syringes; and
   - urinary catheters;

   This exclusion does not apply to:
   - ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in Section 6, *Additional Coverage Details*;
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*; or
3. tubings, nasal cannulas, connectors and masks that are not used in connection with DME;
4. orthotic appliances that straighten or re-shape a body part (including some types of braces). Examples of excluded orthotic appliances and devices include, but are not limited to, any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease;
5. trusses, corsets and other support items; and
6. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

Mental Health/Substance Use Disorder

In addition to all other exclusions listed in this Section 8, Exclusions, the exclusions listed directly below apply to services described under Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services and/or Substance Use Disorder Services in Section 6, Additional Coverage Details.

1. services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

2. health services or supplies that do not meet the definition of a Covered Health Service – see the definition in Section 14, *Glossary*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
   - Medically Necessary;
   - described as a Covered Health Service in this Plan under Section 5, *Plan Highlights* and Section 6, *Additional Coverage Details*; and
   - Not otherwise excluded in this Plan under this Section 8, *Exclusions*;
3. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis;
5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder;
6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;
8. learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
9. intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
11. all unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
12. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;
13. intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder; and
14. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition and Health Education

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods);
2. food of any kind. Foods that are not covered include:
   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU), unless they are the only source of nutrition. Infant formula available over the counter is always excluded;
   - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - oral vitamins and minerals;
   - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - other dietary and electrolyte supplements;
3. health club memberships and programs, and spa treatments; and
4. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:
   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;

Physical Appearance (continued)

- tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); and
- replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;
- nutritional procedures or treatments;

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation;
3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;
4. wigs regardless of the reason for the hair loss except for when hair loss results from medical treatment such as chemotherapy;
5. treatments for hair loss;
6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;
7. varicose vein treatment of the lower extremities, when it is considered cosmetic; and
8. treatment of benign gynecomastia (abnormal breast enlargement in males).

Pregnancy and Infertility

1. health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment:

   This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. surrogate parenting, donor eggs, donor sperm and host uterus;
3. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);
4. in vitro fertilization regardless of the reason for treatment;
5. the reversal of voluntary sterilization;
6. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;
7. oral contraceptives. Oral contraceptives are covered under your prescription drug plan administered by Caremark;
8. services provided by a doula (labor aide); and
9. parenting, pre-natal or birthing classes.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse/Domestic Partner, brother, sister, parent or child;
2. a provider may perform on himself or herself;
3. performed by a provider with your same legal residence;
4. ordered or delivered by a Christian Science practitioner;
5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;
6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;
7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and
8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:
   - prior to ordering the service; or
   - after the service is received.

   This exclusion does not apply to mammography testing.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;
2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
3. while on active military duty; and
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants,
   - except as identified under *Transplantation Services* in Section 6, *Additional Coverage Details*;
   - determined by Personal Health Support not to be proven procedures for the involved diagnoses; and
   - not consistent with the diagnosis of the condition;
2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and
3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. travel or transportation expenses, even if ordered by a Physician, except as identified under T*ravel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Vision and Hearing

1. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);
2. purchase cost and associated fitting charges for eyeglasses or contact lenses;
3. exams to diagnose or treat a disease or Injury, drugs or medicines;
4. any vision care services covered under another part of this plan or any other employer plan;
5. any vision or hearing care services covered under any worker's compensation or similar law;
6. any vision care supplies;
7. any vision or hearing exam required by an employer as a condition of employment, or that an employer is required to provide under a labor agreement or government law;
8. any vision or hearing services or supplies that do not meet professionally accepted standards;
9. purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices;
10. orthoptics, vision training, eye exercise or vision therapy other than as a treatment for strabismus (misalignment of the eyes); and
11. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;
2. charges for:
   - missed appointments;
   - room or facility reservations;
   - completion of claim forms;
   - record processing; or
   - services, supplies or equipment that are advertised by the Provider as free;
3. charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency;
4. charges prohibited by federal anti-kickback or self-referral statutes;
5. chelation therapy, except to treat heavy metal poisoning;
6. Custodial Care as defined in Section 14, *Glossary*, or services provided by a personal care assistant;
7. diagnostic tests that are:
   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;
8. Domiciliary Care, as defined in Section 14, *Glossary*;
9. growth hormone therapy;
10. expenses for health services and supplies:
    - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;

- that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
- for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
- that exceed Eligible Expenses or any specified limitation in this SPD;
- for which a non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;

11. foreign language and sign language services;
12. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;
13. health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 14, *Glossary*. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following:
    - Medically Necessary;
    - described as a Covered Health Service in this Summary Plan Description; and
    - not otherwise excluded in this Summary Plan Description under this Section 8, *Exclusions*.
14. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
15. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer). Appliances for snoring are always excluded;
16. private duty nursing received on an inpatient basis;
17. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in Section 6, *Additional Coverage Details*;
18. rest cures;
19. sex transformation operations and related services;
20. speech therapy to treat stuttering, stammering, or other articulation disorders;
21. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, Sickness, stroke, cancer, autism spectrum disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;
22. Manipulative Treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies;
23. storage of blood, umbilical cord or other material for use in a Covered Health Service, except if needed for an imminent surgery;
24. the following treatments for obesity:
    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*; and
25. treatment of hyperhidrosis (excessive sweating);
26. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain; and
27. physical , psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
    - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
    - conducted for purposes of medical research;
    - related to judicial or administrative proceedings or orders; or
    - required to obtain or maintain a license of any type.
28. Biofeedback

CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting www.myuhc.com, calling the number on your ID card or contacting the Benefits Department. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letters:

- Your name and address.
- The patient's name, age and relationship to the Participant.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes: excludes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare, at the address on your ID card. When filing a claim for outpatient Prescription Drug Product Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

You may not assign your Benefits under the Plan to a non-Network provider without UnitedHealthcare's consent. When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Employee) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is

made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims

All claim forms for non-Network services must be submitted within 90 days after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 90-day requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. If, through no fault of your own, you are unable to meet the deadline, your claim will be accepted if you file it as soon as possible. However, if a claim is filed more than 2 years after the deadline, it will not be covered unless you are legally incapacitated. All foreign claims will be considered as Non-Network Benefits.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;.
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals

P.O. Box 30432

Salt Lake City, UT 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by;

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.
- the reason you disagree with the denial; and
- any documentation or other written information to support your request

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination. UnitedHealthcare must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service claim and 30 days after receiving the completed post-service appeal.Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. This process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;

Standard External Review (continued)

- a preliminary review by UnitedHealthcare of the request;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- urgent care request for Benefits - a request for Benefits provided in connection with urgent care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must obtain prior authorization from UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*

Type of Request for Benefits or Appeal	*Timing*
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	24 hours
You must then provide completed request for Benefits to UnitedHealthcare within:	48 hours after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	72 hours
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits..

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	***Timing***
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	5 days
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	15 days
You must then provide completed request for Benefits information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
▪ if the initial request for Benefits is complete, within:	15 days
▪ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the first level appeal
UnitedHealthcare must notify you of the first level appeal decision within:	15 days after receiving the adverse benefit determination
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

Post-Service Claims	
Type of Claim or Appeal	***Timing***
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within	45 days
UnitedHealthcare must notify you of the benefit determination:	
▪ if the initial claim is complete, within:	30 days
▪ after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against Airgas, Inc. or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Airgas, Inc. or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Airgas, Inc. or the Claims Administrator.

You cannot bring any legal action against Airgas, Inc. or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Airgas, Inc. or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Airgas, Inc. or the Claims Administrator.

COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number. This Plan will use a Pursue and Pay approach which means that for claims $10,000 or greater, a letter will be sent to request other insurance information before a claim is paid when the other insurance information in not up to date.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;

- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - — the parents are married and not legally separated or living together whether or not they have ever been married; or
  - — a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - — the parent with custody of the child; then
  - — the Spouse/Domestic Partner of the parent with custody of the child; then
  - — the parent not having custody of the child; then
  - — the Spouse/Domestic Partner of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples
1) Let's say you and your Spouse/Domestic Partner both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse/Domestic Partner's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse/Domestic Partner both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse/Domestic Partner's birthday to determine which plan pays first. If you were born on June 11 and your Spouse/Domestic Partner was born on May 30, your Spouse/Domestic Partner's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the primary plan's allowable expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense When This Plan is Secondary

When this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When

the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older; (however, Domestic Partners are excluded as provided by Medicare);
- individuals with end-stage renal disease, for a limited period of time; and
- disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider. When calculating the Plan's secondary Benefits in these circumstances, for administrative convenience UnitedHealthcare in its sole discretion may treat the provider's billed charges as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to the Claims Administrator. Your Spouse also can enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with the Claims Administrator.

This cross-over process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming

benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

OVERPAYMENT AND UNDERPAYMENT OF BENEFITS

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Claims Administrator should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment the Plan made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which the Claims Administrator makes payments, with the understanding that the Claims Administrator will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is alleged to be responsible.

Subrogation - Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Reimbursement - Example

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor (for example workers' compensation cases);
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - providing any relevant information requested by the Plan;
  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
  - responding to requests for information about any accident or injuries;
  - making court appearances;
  - obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
  - complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan;

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end;
- Extended coverage; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, Airgas, Inc. will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Your coverage under the Plan will end on the earliest of:

- the date your employment with the Company ends;
- the date the Plan ends;
- the date you stop making the required contributions;
- the date you are no longer eligible; or
- the date UnitedHealthcare receives written notice from Airgas, Inc. to end your coverage, or the date requested in the notice, if later.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date you stop making the required contributions;
- the date UnitedHealthcare receives written notice from Airgas, Inc. to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

OTHER EVENTS ENDING YOUR COVERAGE

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you permit an unauthorized person to use your ID card or you use another person's ID card;
- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent;
- you commit an act of physical or verbal abuse that imposes a threat to Airgas, Inc.'s staff, UnitedHealthcare's staff, a provider or another Covered Person; or
- you violate any terms of the Plan.

Note: Airgas, Inc. has the right to demand that you pay back Benefits Airgas, Inc. paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

COVERAGE FOR A DISABLED CHILD

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to Airgas, Inc. proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon Airgas, Inc.'s request, that the child continues to meet these conditions.

The proof might include medical examinations at Airgas, Inc.'s expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

EXTENDED COVERAGE FOR TOTAL DISABILITY

If a Covered Person has a Total Disability on the date their coverage under the Plan ends, their Benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of:

- the Total Disability ends; or
- twelve months from the date coverage would have ended.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 **(COBRA)**, as defined in Section 14, *Glossary*.

Continuation coverage under **COBRA** is available only to Plans that are subject to the terms of **COBRA**. You can contact your Plan Administrator to determine if Airgas, Inc. is subject to the provisions of **COBRA**.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- an Employee;
- an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
- an Employee's former Spouse/Domestic Partner.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events	**You May Elect COBRA** *For Yourself*	*For Your Spouse/ Domestic Partner*	*For Your Child(ren)*
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
Airgas, Inc. files for bankruptcy under Title 11, United States Code.[2]	36 months[3]	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any retired Employee and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Employee's death if the Employee dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When	*You May Elect COBRA Dependent*
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice. procedures for You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide AON Hewitt/YBR with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 15, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: *If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.*

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and Airgas, Inc.;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Airgas, Inc.

In order to make choices about your health care coverage and treatment, Airgas, Inc. believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Airgas, Inc. and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Airgas, Inc. and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Airgas, Inc. and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Airgas, Inc., UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not Airgas, Inc.'s agents or employees, nor are they agents or employees of UnitedHealthcare. Airgas, Inc. and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

Airgas, Inc. and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Airgas, Inc. and UnitedHealthcare arranges for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Airgas, Inc.'s employees nor are they employees of UnitedHealthcare. Airgas, Inc. and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Airgas, Inc. and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Airgas, Inc. is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

Airgas, Inc. and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

Airgas, Inc. and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Airgas, Inc. may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Airgas, Inc. does so in any particular case shall not in any way be deemed to require Airgas, Inc. to do so in other similar cases.

Information and Records

Airgas, Inc. and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Airgas, Inc. and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Airgas, Inc. and UnitedHealthcare will keep this information confidential. Airgas, Inc. and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Airgas, Inc. and UnitedHealthcare with all information or copies of records relating to the services provided to you. Airgas, Inc. and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Employee's enrollment form. Airgas, Inc. and UnitedHealthcare agree that such information and records will be considered confidential.

Airgas, Inc. and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Airgas, Inc. is required to do by law or regulation. During and after the term of the Plan, Airgas, Inc. and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Airgas, Inc. recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Airgas, Inc. and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Airgas, Inc. recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

Airgas, Inc. and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Airgas, Inc. and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Genetic Information Nondiscrimination Act ("GINA")

The Genetic Information Nondiscrimination Act ("GINA") prohibits using genetic information to discriminate with respect to health benefits. Employer-sponsored group health plans and insurers are prohibited from restricting enrollment or adjusting premiums based on genetic information and requiring or requesting genetic information or genetic testing prior to, or in connection with, enrollment.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

GLOSSARY

What this section includes:

- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility – a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Autism Spectrum Disorders – a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

BMI – see Body Mass Index (BMI).

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by Airgas, Inc. The CRS program provides:

- specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Certificate of Creditable Coverage – A document furnished by a group health plan or a health insurance company that shows the amount of time the individual has had coverage. This document is used to reduce or eliminate the length of time a preexisting condition exclusion applies.

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company – Airgas, Inc.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as

described in Section 3, *How the Plan Works.*

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary;
- included in Sections 5 and 6, *Plan Highlights and Additional Coverage Details* described as a Covered Health Service;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

Covered Person – either the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, Introduction. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated United Resource Networks Facility – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

DME – see Durable Medical Equipment (DME).

Domestic Partner – same-sex and opposite-sex couples who have registered with any state or local government domestic partnership registry.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- ordered or provided by a Physician for outpatient use;
- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- as reported by generally recognized professionals or publications;
- as used for Medicare; or

- as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or substance use disorders which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Employee – a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under Eligibility in Section 2, Introduction. An Employee must live and/or work in the United States.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – Airgas, Inc.

EOB – see Explanation of Benefits (EOB).

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

Experimental and Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to *FDA* oversight

Exceptions:

EOB – see Explanation of Benefits (EOB).

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator and Airgas Inc. may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator Airgas, Inc. must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Full-time Student – a person who is enrolled in and attending, full-time, a recognized course of study or training at:

- an accredited high school;
- an accredited college or university; or
- a licensed vocational, technical, automotive, or beautician school, or similar training school.

The educational institution determines what constitutes Full-time Student status. You continue to be a Full-time Student during periods of regular vacation established by the institution. You are no longer a Full-time Student as of the last day of the calendar month you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

Genetic Testing – examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Injury – bodily damage from trauma other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment – a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Manipulative Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion.

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on

www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on **www.unitedhealthcareonline.com**.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by Airgas, Inc. who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits – description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits – description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Open Enrollment – the period of time, determined by Airgas, Inc., during which eligible Employees may enroll themselves and their Dependents under the Plan. Airgas, Inc. determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The Airgas, Inc. Medical Plan.

Plan Administrator – Airgas, Inc. or its designee.

Plan Sponsor – Airgas, Inc.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- no skilled services are identified;

- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Provider – a health care professional or facility operating as required by law.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment Facility – a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
  - — room and board;
  - — evaluation and diagnosis;
  - — counseling; and
  - — referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Semi-private Room – a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness, or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness, or substance-related and addictive disorder.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician – a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse – an individual to whom you are legally married.

Substance Use Disorder Services – Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Total Disability – an Employee's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's inability to perform the normal activities of a person of like age and gender.

Transitional Care – Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program℠ – a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium Program℠ Physician or facility for certain medical conditions.

To be designated as a UnitedHealth PremiumSM provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium ProgramSM Physician or facility.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note: ▪ If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:

- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in Section 14, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

Airgas, Inc. is the Plan Sponsor and Plan Administrator of the Airgas, Inc. Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Medical Plan

Airgas, Inc.
259 North Radnor-Chester Road
Radnor, PA 19087-5283
(610) 902-6012

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United HealthCare Services, Inc.

9900 Bren Road East

Minnetonka, MN 55343

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan.

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	Airgas, Inc. Comprehensive Welfare Benefits Plan
Plan Number:	501
Employer ID:	56-0732648
Plan Type:	Welfare Benefits Plan
Plan Year:	January 1, – December 31,
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration; and
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue health care coverage for yourself, Spouse/Domestic Partner or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

You will be provided a Certificate of Creditable Coverage in writing, free of charge, from AON Hewitt/YBR:

- when you lose coverage under the Plan;
- when you become entitled to elect COBRA;
- when your COBRA coverage ends;
- if you request a Certificate of Creditable Coverage before losing coverage; or
- if you request a Certificate of Creditable Coverage up to 24 months after losing coverage.

You may request a Certificate of Creditable Coverage by contacting the Plan Administrator.

If you have creditable coverage from another group health plan, you may receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. Without evidence of creditable coverage, Plan Benefits for the treatment of a preexisting condition may be excluded for 12 months (18 months for late enrollees) after your enrollment date in your coverage. In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, Claims Procedures, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

The Plan's Benefits are administered by Airgas, Inc., the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and Airgas, Inc. are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network provider. UnitedHealthcare and Airgas, Inc. are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers.

Prescription Drug Plan
Summary Plan Description

Airgas

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PROGRAM DESIGN

CVS Caremark administers the prescription drug program. When you enroll in a plan offered by Aetna or United Health Care your prescription drug coverage is provided by CVS Caremark. For questions about the plan you may contact CVS Caremark Customer Care at 866-273-8573. The program is a 3-tier benefit design. Two of the three optional designs available to you apply a co-payment approach for generic drugs and a coinsurance approach for preferred and non-preferred brand drugs. A third alternative provides a three tier copayment structure. Under the co-payment structure the amount you pay will vary based on whether your prescription drug is a Generic or on CVS Caremark's listing of Preferred Brand drugs. Under the coinsurance structure you will pay a percentage of the drug cost up to a maximum dollar amount which is dependent on the plan you choose.

The level of coverage provided by the prescription drug plan is dependent on the optional level you choose. If you participate in the Aetna Choice POS II or in the United Health Choice Plus Plan (including the Harvard Pilgrim network) you may choose your prescription drug coverage from the three available levels. If you participate in the Aetna HMO, you automatically receive the option providing the copayment structure.

For all plan options, only drugs that are necessary for the medical treatment of disease or illness and are widely accepted as effective, appropriate and essential—based on the recognized standards of the medical community are covered under the plan. Further, the drug therapy must be consistent in type, frequency and duration of treatment with the guidelines of national medical, research and governmental agencies.

Shortly after you enroll, you will receive a booklet that includes additional information about the prescription drug program, your program identification cards, answers to frequently asked questions, claim forms, order forms and the like. You should review that booklet carefully and include it with your Summary Plan Description

SUMMARY OF PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefit Choices

Generic drugs are the most affordable way for you to obtain quality medications at your lowest copayment level. The U.S. Food and Drug Administration (FDA) requires that generic drugs have the same active chemical composition and potency and be offered in the same form as their brand name equivalents.

Preferred Brand drugs are brand name drugs that have no generic equivalent and have been determined to be clinically effective, in addition to being cost effective when compared to similar acting drugs. These medications are subject to higher copay or coinsurance than generics.

Non-Preferred Brand drugs are brand name drugs that have either equally effective or less costly generic equivalents or have one or more preferred brand options.

Generic drugs are dispensed whenever there is a generic equivalent unless you or your physician specifies a brand name only drug.

Prescription Drug Benefit Choices	Option 1	Option 2	Option 3
RETAIL *(up to 30 day supply)*			
Generic	$9 copay	70% covered $150 per Rx maximum	50% covered $200 per Rx maximum
Brand Formulary	$35 copay	70% covered $150 per Rx maximum	50% covered $200 per Rx maximum
Brand Non-Formulary	$70 copay	70% covered $300 per Rx maximum	50% covered $400 per Rx maximum
MAIL ORDER *(up to 90 day supply)*			
Generic	$18 copay	70% covered $300 per Rx maximum	50% covered $400 per Rx maximum
Brand Formulary	$70 copay	70% covered $300 per Rx maximum	50% covered $400 per Rx maximum
Brand Non-Formulary	$140 copay	70% covered $600 per Rx maximum	50% covered $800 per Rx maximum
TOTAL OUT-OF-POCKET MAXIMUM			
Single Family	$2,100 $4,200	$2,100 $4,200	$2,100 $4,200

Using the Prescription Drug Plan

Shortly after electing to participate in an Aetna or United HealthCare medical plan, you will receive a booklet directly from CVS Caremark with information on the CVS Caremark program as well as ID cards, claim forms and other information about the retail and mail order benefits.

Retail Pharmacy

You may purchase up to a 30-day supply of prescription drugs at retail pharmacies. To receive the highest benefits available for retail prescriptions, you must go to a participating pharmacy. Although CVS pharmacy is a participating pharmacy in the CVS Caremark pharmacy network, you are not required to use a CVS pharmacy. A complete listing of CVS Caremark participating network retail pharmacies can be found by clicking on "Register Now" at www.caremark.com and following the instructions on registering as a CVS Caremark member.

There are no claim forms to file when using CVS Caremark's extensive network of participating pharmacies as long as you are able to present your ID card confirming your eligibility to participate. Simply present your ID card at the time you fill your prescription. If you forget your card, your claim must be submitted in paper form even if you are using a participating pharmacy.

You may elect to get your prescription at any pharmacy, however, when using a non-participating pharmacy you must pay the full cost of the drug and submit a claim for reimbursement. You may submit your claim form to:

CVS Caremark, Inc.
Attn: Claims Department
P.O. Box 686005
San Antonio, TX 78268-6005

Mail Order Prescriptions

The most cost efficient means of purchasing maintenance drugs is by using CVS Caremark's mail order program. Maintenance drugs are those that you are expected to take over an extended period of time. You may purchase up to a 90-day supply of medication when using the mail order service, and you will pay only a two-month copay or coinsurance amount. The drugs will be delivered to your home within 14 days of CVS Caremark receiving the prescription. You can find out if a drug you are taking is a maintenance drug by contacting the CVS Caremark Service Center at 866-273-8573 or by accessing www.caremark.com and registering as a CVS Caremark member. There are many benefits of registering on Caremark.com.

CVS Caremark's Mail Service Program is convenient to use. Here are some helpful tips:

- If you need your medication immediately, ask your physician for two prescriptions—one for a short-term supply and one for the mail order service.
- Fill your short-term prescription at a participating pharmacy and pay your co-payment.
- Sign up for mail service by calling Customer Care (866-273-8573) and ask for a representative or by logging onto Caremark.com. You can also complete a mail service order form and mail the form, the original mail order prescription and your co-payment in a pre-addressed CVS CAREMARK envelope.
- You will receive a new Mail Service Order Form and pre-addressed envelope with each shipment.

Mail Service Refills

Once you have processed a prescription through CVS Caremark, you may obtain refills online, by phone or by mail. Order your prescriptions three weeks in advance of your current prescription running out. Suggested refill dates will be included on the prescription label you receive from CVS Caremark. Members can receive their 90 day supply by mail service or at their local CVS retail pharmacy for the copay.

Penalty

A penalty will apply if you continue to have your prescription for a maintenance drug filled at retail after having filled it twice at retail. The third time the prescription is filled, you will be required to pay the mail order copay amount which is two times the amount for one month's supply of your prescription. The penalty will continue to apply for each one-month refill.

Generic Programs

Generic Step Therapy is a program such that if your prescription drug has a Generic available, the plan will only pay for the Generic drug first. You will be required to try the Generic drug for 30 days. This applies even if it's not a Direct Generic, but is a Generic drug within the same class of drugs as the prescribed medication. If the Generic drug isn't effective in treating your condition, the next 'step' will be the brand-name drug. If you choose to use a Non-Preferred Brand drug without trying a Generic first, or without obtaining prior approval, you will pay the full cost of the Brand drug.

Dispense as Written is a program also described as Mandatory Generic. If your doctor prescribed a Brand drug and a Direct Generic is available, the cost of the Generic will be the maxim benefit allowed under the plan. You will pay the difference in cost if you choose the Non-Generic.

To determine what Generics are available for a drug you've been prescribed, you can login to caremark.com.

Specialty Pharmacy Services

CVS Caremark Specialty Services dispenses very high cost medications that are used for chronic diseases. These drugs are also referred to as Biotech medications. Most are temperature sensitive and injectable. If you have any question about a drug or the Specialty Drug Program you may contact Specialty Services at 800-237-2767.

Biotech products to treat the following must be dispensed through the Specialty Pharmacy

- Allergic Asthma;
- Crohn's disease;
- Cystic Fibrosis;
- Growth Hormone Disorders;
- Hemophilia, von Willebrand Disease and related bleeding disorders;
- Hematopoetics ;
- Hepatitis C;
- HIV;
- Hormone Therapies;
- Immune Deficiencies;
- Infertility;
- Lysosomal storage disorder;
- Macular degeneration;
- Multiple Sclerosis;
- Cancer (oral and injectables)
- Osteo/Rheumatoid Arthritis;
- Osteoporosis;
- Psoriasis;
- Pulmonary Arterial Hypertention and Pulmonary Diseases;
- Renal Disease;
- Respiratory Syncytial Virus (RSV);

If your provider prescribes a Specialty Drug you must submit your prescription to CVS Caremark for evaluation and subsequent fulfillment. For certain specialty drugs, CVS Caremark will evaluate your medical records to determine if an alternative therapy is appropriate in your case. In making that determination, CVS Caremark will work closely with your personal physician; however, the final decision as to whether or not the prescription will be covered under the Airgas plan will be made by CVS Caremark. If the use of the specialty drug is approved by CVS Caremark, all refills of the prescription must be purchased through the CVS Caremark Specialty pharmacy.

If your physician has any questions regarding coverage of Specialty drugs or the step program, he/she may contact CVS Caremark at 800-237-2767. Having your physician call is the quickest way to have your prescription filled since CVS Caremark will need to have information on your diagnosis as the expected duration of the treatment if the drug is approved. Following approval for use of the drug, a home patient representative will then contact you to arrange delivery. You may have it delivered to where it is most convenient for you, either to your home or to your physician's office. When using CVS Caremark's Specialty pharmacy, you have access to additional benefits, including:

- Assigned Care Team consisting of a designated patient representative, clinical coordinator and reimbursement specialist;
- Coordinated nursing services;
- Access to a CVS Caremark nurse or pharmacist 24 hours/day, 365 days/year;
- Education and training;
- Customized delivery options;
- Access to medically necessary ancillary supplies and supporting drug therapies.

Managed Care Strategies

Custom Care Mail and Custom Care Retail

As a way to manage the cost and effectiveness of the prescription drug program, CVS Caremark provides managed care programs that focus on generic substitution, drug utilization and, clinical appropriateness of the drug prescribed.

Upon receipt, prescriptions are evaluated to determine if a generic drug is available for the brand name prescribed. If a generic is available, CVS Caremark will contact the physician's office and ask if the generic drug may be substituted for the brand. If the physician agrees to the substitution, the participant will receive the generic form of the drug along with a letter explaining the basis for the change. If the physician does not agree to have the brand name drug substituted by a generic, the prescription will be filled with the brand name drug. The final decision on what drug to dispense will always be made by the physician.

CVS Caremark will also evaluate the prescription to ensure that the dose of the drug prescribed is consistent with industry standards and guidelines. If the dosage prescribed is outside of the recommended guidelines, CVS Caremark will contact the physician's office directly to confirm the required dose. If there is a change to the dose and/or a change in the instructions for taking the drug, CVS Caremark will make the change as instructed by the physician and will notify the participant. As with the generic substitution, final decisions are made by the physician.

Finally, the drug prescribed is considered in conjunction with other drugs you may be taking. If there is a possible negative interaction, CVS Caremark will notify your physician. If upon notification your physician makes any changes, CVS Caremark will notify you and fill the prescription in accordance with the most recent physician instructions.

Drug Coverage Limits

In the ongoing effort to effectively manage your prescription drug benefits, clinical guidelines are included under the plans. For certain medications, a prior authorization will be required to ensure the appropriate use of the medication based on medical necessity / medical diagnosis.

The following products are subject to specific quantity limits:

Erectile Dysfunction Medications: 6 pills/30-day retail supply; 18 pills/90-day mail order supply.

Influenza Treatments: Tamiflu 75 mg - 40 tablets/year; Tamiflu Susp - 12 bottles/year; Relenza inhaler - 80 units/year; Flumadine 100 mg - 80 tablets/year.

Smoking Cessation Prescription: 68 pills/30-day retail supply; 204 pills/90-day mail order supply.

Fertility: $10,000 Lifetime

Deductible, Annual Out-of-Pocket Maximum and Lifetime Maximum

You are not required to meet a separate deductible under the prescription drug benefit plan before you may receive benefits under the plan. No costs that you incur for a co-payment and/or a co-insurance for your prescription drugs will be counted toward any deductible you must meet under the medical plan.

Annual Out-of-Pocket maximum applies to the prescription drug plan administered by Caremark. Costs that you incur related to payment of a co-payment and/or a co-insurance for your prescription drugs will be counted toward your Annual Out-of Pocket maximum you must meet under the prescription plan.

Aside from the specific limits for certain drugs, e.g. fertility drugs, there is no specific lifetime maximum applicable to the prescription drug plan.

What The Prescription Drug Benefit Does Not Cover

The following is a list of examples of some items that are not covered under the prescription drug program. This list is not intended to be exhaustive.

- Any non-Prescription smoking cessation aids or drugs.
- Any appetite suppressants.
- A device of any type unless specifically included as a Prescription Drug.
- Any drug entirely consumed at the time and place it is prescribed.
- More than a 30-day supply or 100 unit doses per Prescription or refill. However, this limit does not apply to a supply of up to 90 days per Prescription or refill for drugs that are provided by a Mail-Order Pharmacy.
- The administration or injection of any drug.
- The following injectable drugs: allergy sera or extracts;
- Any refill of a drug if it is more than the number of refills specified by the Prescriber.
- Any refill of a drug dispensed more than one year after the latest Prescription for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any health care facility; or any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or Prescription Drug expense benefit plan carried or sponsored by your employer.
- Any Prescription Drug also obtainable without a Prescription on an “over the counter” basis.
- Immunization agents.
- Biological sera and blood products.
- Nutritional supplements.
- Retinoids filled by participants over the age of 26 years

Claim Appeals Procedure for Denied Claims

If you submit a claim to CVS Caremark that CVS Caremark denies, CVS Caremark will send you an “explanation of benefits” and a letter outlining how to appeal the claim denial.

Generally, you will be instructed to send your written appeal to an "appeals coordinator". You may send any information you have to the appeals coordinator in support of your claim and request confirmation of the plan provisions on which the denial was based.

If the claim relates to clinical matters, a pharmacist will review and research the clinical data base, your claims history and any additional information you provided and will speak with your physician or you, if appropriate.

You will be advised of the decision on your appeal. If the appeal is denied, you will receive instructions about how to make a second level appeal to Caremark.

CVS Caremark has established a "Second Level Appeals Team" to consider appeals. That Team will review the matter, as well as any additional information you submit.

The time frame for you to make appeals and for CVS Caremark to respond will be included in the information CVS Caremark sends to you with any claim denial. They cannot be more stringent than those that apply to group health plan claims. These are described in the group health plan section of your summary plan description.

You will be advised of the decision of your Second Level appeal. If the appeal is denied, under the Patient Protection and Affordable Care Ace(ACA), you may further appeal your claim using the external review process. The external review process is performed by an Independent Review Organization (IRO) and is required to comply with the federal external review process. The IRO will conduct its external review without giving any consideration to any earlier determinations made on behalf of the Plan and the Plan Sponsor. The IRO will provide the member and CVS Caremark (on behalf of the Plan) with written notice of its final External Review decision within 45 days after the IRO receives the request.

Dental
Summary Plan Description

Airgas

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DENTAL COVERAGE

Airgas, Inc. offers two dental plans – the Basic and Premium options. You may enroll in either plan and cover yourself and any eligible dependents. Dependents must be covered by the same option you elect for yourself. Dental coverage is available regardless of whether you enroll in or decline medical coverage.

After you enroll, you will receive a Dental Plan ID card.

The PPO Dental Plan

The plan covers diagnostic and preventive services such as periodic exams, X-rays and cleanings, not subject to a plan deductible. For other covered services, the Plan begins paying benefits after the calendar year deductible is satisfied. Benefit payments are based on reasonable charges as defined by Aetna.

Choosing Dental Providers

You can go to any dentist you choose.

If you use a dentist who participates in the Aetna provider network, you may lower your out-of-pocket costs. The cost for services from an in-network provider is based on negotiated charges (which are usually lower) and you will not be billed for costs above the reasonable charges. Another advantage is that network dentists will submit claims for you.

If you go to an out-of-network dentist, you (or your dentist) must file a claim for reimbursement. Benefit payment percentages are based on reasonable charges.

Finding Network Providers

You can see if your dentist is currently participating in the network or determine if there is a network dentist in your area by calling Aetna at 1-877-238-6200 or by using DocFind at Aetna's website *www.aetna.com*.

Calendar Year Deductible

There is no deductible for Diagnostic and Preventive services. You and each of your covered dependents must pay a separate $50 deductible each calendar year before the Basic or Premium Plans begin paying benefits for any Basic Restorative or Major Restorative services.

Dental Plan Choices

Benefit Maximums

The Plan pays up to a $1,500 maximum per calendar year per covered person for any combination of the following services:

- Diagnostic and Preventive
- Basic Restorative
- Major Restorative

An orthodontic lifetime maximum applies to all covered orthodontic services under the Premium option.

	Basic	*Premium*
Annual Deductible		
•Individual	$50	$50
•Family	$150	$150
Coinsurance		
•Diagnostic and Preventive	100% no deductible	100% no deductible
•Basic Restorative	50% after deductible	80% after deductible
•Major Restorative	50% after deductible	50% after deductible
•Orthodontia	Not covered	50% no deductible
Annual Maximum	$1,500	$1,500
Orthodontia Lifetime Maximum	Not Applicable	$1,500

Pretreatment Estimate of Benefits

A pretreatment estimate determines how much the Plan will pay for care after Aetna evaluates whether the suggested treatment is appropriate. To determine how much the Plan will pay for the dental treatment you are going to receive or if your treatment is expected to cost $350 or more, you should ask your dentist for a pretreatment estimate of benefits from Aetna before the work begins. Because claims for additional treatment may be filed after you obtain the pretreatment estimate, the estimate may not reflect the exact total cost of your treatment, but you will have a good idea of what your costs will be.

If you do not obtain a pretreatment estimate of benefits, the benefit amount payable may be less than would have been paid if the request for a pretreatment estimate were submitted. If any necessary information is missing, benefits will be reduced by the amount of covered expenses that Aetna cannot verify.

To obtain a pretreatment estimate of benefits obtain an Aetna claim form or an ADA approved claim form from the Aetna Website. Give the form to your dentist to notify Aetna of the treatment plan. Aetna will review the treatment plan, may request supporing x-rays and other diagnostic records, and inform you and your dentist how much the Plan will pay.

If your treatment is delayed for a significant amount of time (e.g., 12 months or more) or there is a major change in your treatment, be sure your dentist submits a new form to Aetna.

COVERED EXPENSES

Diagnostic and Preventive Services

Both the Basic and Premium options pay 100% (not subject to the deductible) of the reasonable charges for the following services and supplies:

- Oral exams twice per year, including prophylaxis, scaling and cleaning of teeth
- Sealants, per tooth (limited to one application every 3 years for permanent molars only for children under age 16)
- X-rays for diagnosis not to exceed one full-mouth series in a 3 year period and two sets of bitewings per year
- Topical application of fluoride (limited to one course of treatment per year to children under age 18)

Basic Restorative Services

The Basic option pays 50% and the Premium option pays 80% of Basic Restorative services which include:

- Fillings (amalgam and composite only)
- Non-surgical treatment of diseased periodontal structures
- Non-surgical endodontic treatment (includes root canal therapy)
- Non-surgical extractions
- General anesthetics given in connection with covered surgical services
- Periapical X-rays
- Relining or rebasing after six months from the date of placement of a denture
- Repair or recementing of crowns, inlays, dentures or bridgework
- Oral surgical procedures including those to remove impacted teeth, remove or drain odontogenic cysts, transplant a tooth or tooth bud or suture a soft tissue injury
- Consulting with a dentist or physician when required, except due to pre-orthodontic treatment
- First installation of a space maintainer to replace any baby tooth that is lost prematurely
- Emergency palliative treatment
- Localized delivery of chemotherapeutic agent
- Periodontal maintenance procedures following active therapy (limited to 2 per year)

Major Restorative Services

Both options pay 50% of reasonable charges after the deductible for services and supplies including:

- Inlays, gold fillings or crowns. This includes precision attachments for denture. (The "Prosthesis Replacement Rule" below must be met.)
- Onlays and crown build-ups
- Dental implants
- First installation of removable dentures. This includes adjustments for the 6-month period after they were installed
- First installation of fixed bridgework. This includes inlays and crowns as abutments.
- Replacement of an existing removable denture or fixed bridgework by a new denture or the adding of teeth to a partial removable denture. (The "Prosthesis Replacement Rule" below must be met.)
- Replacement of an existing removable denture or fixed bridgework by a new fixed bridgework or the adding of teeth to existing fixed bridgework. (The "Prosthesis Replacement Rule" below must be met.)
- Core buildup, including any pins

Prosthesis Replacement Rule

Certain replacements or additions to existing dentures, bridgework or crown will be covered under this Plan. However, the existing prosthetic must be at least 5 years old. But satisfactory proof must be given to Aetna that:

- The replacement or addition of teeth is required to replace teeth extracted after the present denture or bridgework was installed
- The present denture or bridgework cannot be made serviceable.
- The present denture is a temporary one and cannot be made permanent. Replacement by a permanent denture is needed. It takes place within 12 months from the date the temporary one was first installed.

Tooth Missing But Not Replaced Rule

Coverage for the first installation of removable dentures; removable bridges; and fixed bridgework is subject to the requirements that such dentures; removable bridges; and fixed bridgework are

- needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and
- are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 5 years.

Orthodontic Services (Premium Option Only)

The Premium option pays 50% for orthodontia treatment, not subject to the deductible. The $1,500 orthodontic lifetime maximum benefit applies for all expenses incurred by a covered family member in his or her lifetime. This applies even if there is a break in coverage. To determine how much the plan will pay for orthodontia treatment, your dentist should request a pretreatment estimate of benefits from Aetna before the treatment begins.

Orthodontic benefits cover procedures and appliances furnished to prevent or diagnose or correct a misalignment of the teeth, bite or jaw or jaw joint relationship.

Payment Sequence

Benefit payments for an orthodontic treatment will be made in installments. Normally, 25% of the pretreatment estimate is considered to be the initial fee. The plan will pay 50% of the initial fee. Monthly fees are then determined by dividing the balance of the pretreatment estimate by the number of months the treatment is expected to take. The plan pays 50% of each monthly fee once the service has been incurred until treatment is completed or the $1,500 orthodontic lifetime maximum benefit is reached, whichever comes first.

Alternative Treatment

There is often more than one satisfactory way to treat certain dental conditions. Covered dental expenses will be limited to alternate services and supplies that:

- Are customarily used nationwide for treatment
- Meet broadly accepted national practice standards

Limitations and Exclusions

Expenses for items not specifically included are not covered. Examples of excluded items or services are listed below. This list is not intended to be exhaustive.

- Any dental services and supplies covered in whole or in part under a medical plan or any other plan of group benefits provided by Airgas, Inc.
- Treatment by someone other than a dentist, except scaling and cleaning of teeth and topical application of fluoride by a licensed dental hygienist under a dentist's supervision
- Services or supplies for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies that improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, including charges for personalization or characterization of dentures
- The replacement of a prosthetic device that is lost, missing or stolen
- Any services or supplies for orthodontic treatment, except as specifically provided
- Services or supplies to increase vertical dimension. These are dentures, crowns, inlays and onlays, bridgework or any other appliance or service
- Facings on molar crowns and pontics
- Those for services and supplies not necessary, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the patient's attending dentist.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the patient's attending dentist
- Those for, or in connection with, services or supplies that are, as determined by Aetna, to be experimental or investigational
- Those for services of a resident physician or intern in that capacity
- Those that are made only because there is dental coverage
- Those that a covered person is not legally obliged to pay
- Those for services and supplies furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government
- Those service and supplies furnished, paid for, or for which benefits are provided or required under any law of a government. This exclusion will not apply to "no fault" auto insurance if it meets certain Plan criteria. This exclusion will also not apply to a plan established by a government for its own associates or dependents or to Medicaid.
- Those for acupuncture therapy. Acupuncture is not excluded when it is performed by a physician as a form of anesthesia in connection with surgery that is covered under this Plan.
- Those to the extent they are not reasonable charges, as determined by Aetna
- Those for a service or supply furnished by a network provider in excess of that provider's negotiated charge for that service or supply

Dental Services After Coverage Ends

The individual receiving treatment must be covered by this Plan on the day treatment is received. Typically, charges are considered to be incurred on the date services are provided. However, for dentures, fixed bridgework and crowns, charges are considered as incurred when ordered. This applies only if the item is finally installed or delivered no more than 31 days after coverage ends. "Ordered" means that:

- Impressions have been made from which the dentures, crowns, or fixed bridgework will be produced
- The teeth must have been fully prepared if fixed bridgework and crowns will serve as retainers or support, or if they are being restored

Filing Dental Claims

If you use an Aetna network dentist, you should not have to file a claim; you need only pay your share of the cost at the time you receive treatment. Show your ID card to the dentist, tell your Dentist that you participate in the Plan and confirm that your dentist is a current Aetna network provider.

If you do not use an Aetna network dentist, your dentist may ask you to pay the full cost for services, and you may need to submit a claim to Aetna directly. If you take your claim form with you to your appointments, your dentist's office may submit it for you. If your dentist will not submit your completed claim forms, send them to:

Aetna
P.O. Box 14094
Lexington, KY 40512-4094

Coordination with Other Plans

If you have coverage under other medical and/or dental group plans or receive payments for an illness or injury caused by another person, the benefits you receive from this Plan may be adjusted. This may mean a reduction in benefits under the Plan.

Coordination Of Benefits

The Plan coordinates with benefits available through other group plans and/or no-fault automobile coverage. "Other group plans" include any other plan of dental or medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, whether or not the plan is insured
- "No-fault" and traditional "fault" auto insurance, including medical payments coverage provided on other than a group basis, to the extent allowed by law

To find out if benefits under this Plan will be reduced, Aetna must first determine which plan pays benefits first.

The information below outlines the order in which plans pay for each circumstance described:

Only one plan has a coordination of benefits (COB) provision.

- Plan without a COB provision.
- Plan with a COB provision.

One plan covers the person as a dependent, the other covers the person as an employee.

- Plan that covers a person as an employee.
- Plan that covers a person as a dependent.

The person is eligible for Medicare and not actively working. (Medicare Secondary Payer Rules apply.)

- Plan that covers the person as a dependent of a working spouse.
- Medicare
- Plan that covers the person as a retired employee.

A child's parents are not divorced or separated.

- Plan of the parent whose birthday occurs earlier in the calendar year.
- Plan of the parent whose birthday occurs later in the calendar year.

If both parents have the same birthday, the plan that covered the parent longest pays first.

If the other plan doesn't have the parent birthday rule, the other plan's COB rule applies.

A child's parents are separated or divorced, and there is a joint custody court decree that does not state health care responsibility.

- Plan of the parent whose birthday occurs earlier in the calendar year.
- Plan of the parent whose birthday occurs later in the calendar year.

If both parents have the same birthday, the plan that covered the parent longest pays first.

If the other plan doesn't have the parent birthday rule, the other plan's COB rule applies.

A child's parents are separated or divorced, and a court decree does state health care responsibility.

- Plan of the parent with financial responsibility for medical, dental or other health care expenses.
- Any other plan that covers the child as a dependent.

A child's parents are separated or divorced, and there is no court decree.

- Plan of the natural parent with whom the child resides.
- Plan of the stepparent with whom the child resides.
- Plan of the natural parent with whom the child does not reside.
- Plan of the stepparent with whom the child does not reside.

A person has coverage as an active employee or as the dependent of an active employee and coverage as a retired or laid-off employee.

- Plan that covers the person as an active employee or dependent of an active employee.
- Plan that covers the person as a retired or laid-off employee.

A person is covered under a federal or state right of continuation law (e.g., COBRA).

- Plan that is not a mandated continuation plan.
- Plan that covers a person under a right of continuation under federal or state laws.

The above rules do not establish an order of payment.

- The plan that has covered the person longest pays before any others.

If the other plan pays first, the benefits paid under this Plan will be reduced. Aetna will calculate the reduced amount as follows:

- 100% of allowable expenses, minus
- Benefits payable from your other plan(s)

Allowable expenses are the necessary and reasonable health expenses covered (in whole or in part) under any of your plan(s) (or those of the person for whom you make a claim).

If other plan(s) provide benefits in the form of services rather than cash payments, the cash value of the services will be used in the calculation.

Claims and Benefit Payment

It is important to keep records of medical expenses, including the names of physicians, dates that expenses are incurred and copies of bills and receipts.

Filing Claims

You must file a claim for reimbursement if using an out-of-network provider. To file a claim, you complete a claim form, available from your Human Resources Department or online at Aetna Navigator. The form contains instructions for filing. Your ID card shows the address to send your claim.

All claims must be filed promptly. The deadline for filing a claim is 90 days after you incur a covered expense. If, through no fault of your own, you are unable to meet the deadline, your claim will still be accepted if you file as soon as possible.

However, if a claim is filed more than two years after the deadline, it will not be covered unless you are legally incapacitated.

You can file claims for benefits and appeal adverse claim decisions yourself or through an authorized representative. An "authorized representative" is someone you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Physical Exams

Aetna has the right to require an exam of any person for whom certification or benefits have been requested. The exam will be done at any reasonable time while certification or a claim for benefits is pending or under review. This exam may be performed by a doctor or dentist Aetna has chosen and will be at Aetna's expense.

Claim Processing Timeframes

Aetna will make a decision on your claim. For concurrent care claims, Aetna will send you written notification of an affirmative benefit determination. For other types of claims, you may receive only a written notice if Aetna makes an adverse benefit determination.

Aetna will provide you with written notices of adverse benefit determinations within the timeframes shown below. Timeframes may be extended under certain limited circumstances. The notice you receive from Aetna will provide information that will assist you in appealing an adverse benefit determination.

Extensions of Time Frames

The time periods described in the chart may be extended, as follows:

Type of Claim	*Response Time*
Urgent care claim: a claim for medical care or treatment where delay could: • Seriously jeopardize your life or health or your ability to regain maximum function • Subject you to severe pain that cannot be adequately managed without the requested care or treatment	As soon as possible, but not later than 72 hours
Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care (precertification).	15 calendar days
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Urgent care claim - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment. Other claims - 15 calendar days
Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.	With enough advance notice to allow you to appeal.
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days

For urgent care claims: If Aetna does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after the additional information is provided.

For non-urgent pre-service and post-service claims: The time frames may be extended for up to 15 additional days for reasons beyond the plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied.

If an extension is necessary because Aetna needs more informationto process your post-service claim, Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier). If you fail to provide the information, your claim will be denied.

Payment of Benefits

Benefits will be paid as soon as Aetna receives the necessary proof to support the claim. All benefits are payable to you. However, Aetna has the right to pay any benefits directly to your dentist or other care provider. This will be done unless you tell Aetna otherwise by the time you file the claim.

If your claim is defined in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial and the review procedures.

Recovery of Overpayment

If Aetna makes a benefit payment over the amount that you are entitled to under this plan, Aetna has the right to:

- Require that the overpayment be returned on request; or
- Reduce any future benefit payment by the amount of the overpayment.

This right does not affect any other right of overpayment recovery Aetna may have.

Legal Action

No legal action can be brought to recover a benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, as long as the loss occurs more than 2 years from the date coverage started. This will not apply to any condition that is not covered as of the date of the loss.

The Appeal Process – Dental

Aetna will send you written notice of an adverse benefit determination. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal. Requests for appeal must be made in writing within 180 days from the receipt of the notice. However, appeals of adverse benefit determinations involving urgent care may be made orally.

The Plan provides for two levels of appeal plus an option to seek external review of the adverse benefit determination. If you are dissatisfied with the outcome of your level one appeal and wish to file a level two appeal, your appeal must be filed no later than 60 days following receipt of the level one notice of adverse benefit determination. The following chart summarizes some information about how appeals are handled for different types of claims.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. In the case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

If the level one and level two appeals uphold the original adverse benefit determination for a medical claim, you may have the right to pursue an external review of your claim. See External Review for more information.

External Review

You may file a voluntary appeal for external review of any final appeal determination that qualifies. An external review is a review by an independent physician, with appropriate expertise in the area at issue, of claim denials and denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment.

You must complete the two levels of appeal before you can appeal for external review. Subject to verification procedures that the plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal.

You must request this voluntary level of review within 60 days after you receive the final denial notice.

If you file a voluntary appeal, any applicable statute of limitations will be tolled (suspended) while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Type of Claim	*Level One Appeal*	*Level Two Appeal*
Urgent care claim: a claim for medical care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	36 hours Review provided by Aetna personnel not involved in making the adverse benefit determination.	36 hours Review provided by Aetna personnel not involved in making the adverse benefit determination.
Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care.	15 calendar days Reviewed by Aetna personnel not involved in making the adverse benefit determination.	15 calendar days Reviewed by Aetna personnel not involved in making the adverse benefit determination.
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim; depending on the circumstances.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days Reviewed by Aetna personnel not involved in making the adverse benefit determination.	30 calendar days Reviewed by Aetna personnel not involved in making the adverse benefit determination.

You may request a review by an external review organization (ERO) if:

- You have received notice of the denial of a claim
- Your claim was denied because the care was not medically necessary or was experimental or investigational
- The cost of the service or treatment in question for which you are responsible exceeds $500
- You have exhausted the applicable Plan appeal process

The final claim denial letter you receive will describe the process to follow if you wish to pursue an external review, and will include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter. The form must be accompanied by a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the external review organization that will conduct the review of your claim. The external review organization will select an independent physician with appropriate expertise to perform the review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the Request for External Review Form, and will follow the applicable plan's contractual documents and plan criteria governing the benefits.

You will generally be notified of the decision of the External Review Organization within 30 days of Aetna's receipt of your request form and all necessary information. An expedited review is available if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would jeopardize your health. Expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the external review organization to Aetna. Aetna is responsible for the cost of sending this information to the external review organization.

Claim Fiduciary

Aetna has complete discretionary authority to review all denied claims for benefits under the medical and dental plans. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its responsibilities, Aetna has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the plan.

Aetna has the right to adopt reasonable policies, procedures, rules and interpretations of the plan to promote orderly and efficient administration. Aetna may not abuse its discretionary authority by acting arbitrarily and capriciously. Airgas is responsible for making reports and disclosures required by applicable laws and regulations.

Termination of Coverage

When Employment Ends

Employee coverage under the plan ends on the first to occur of the following:

- The plan is discontinued
- You voluntarily stop your coverage
- The coverage is terminated under the group contract
- You are no longer in an eligible class for all or part of your coverage
- You fail to make any required contribution
- You become covered under another medical plan offered by your employer
- Your employment stops

If you cease active work, ask your employer if you can continue any of your coverage.

Dependent coverage will end if:

- You are no longer eligible for dependents' coverage
- You do not make the required contributions for dependents' coverage
- Your own coverage ends
- You die
- Your dependent is no longer eligible for coverage
- Your dependent becomes eligible for comparable benefits under this or another group plan offered by your employer

Family and Medical Leave

If Airgas grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act (FMLA) of 1993, you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

If you are granted an approved FMLA leave for longer than the period required by FMLA, Airgas will determine how your coverage will be continued, subject to the prior written approval of Aetna.

Uniformed Services Employment and Re-employment Rights

The Uniformed Services Employment and Re-employment Rights Act (USERRA) entitles employees who are absent because of active uniformed service (including National Guard duty) to continue health care coverage for themselves, their dependents or both until the earlier of:

- The date the group plan is terminated
- The end of the period for which contributions are paid if you fail to make timely payment of a required contribution
- 24 months from the start of the absence
- The day after the date on which the employee fails to report or apply for re-employment as required

The cost of coverage may be 102% of the full cost of plan coverage.

COBRA Continuation

If your health plan is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, you and your dependents have the right to continue health coverage if it ends for the reasons ("qualifying events") described below. You may continue only the plan coverage in effect at the time and must pay required premiums.

Qualifying Events and Continuation Periods

The chart below outlines:

- The qualifying events that trigger the right to continue coverage
- Those eligible to elect continued coverage
- The maximum continuation period

Qualifying Event Causing Loss of Coverage	*Covered Persons Eligible for Continued Coverage*	*Maximum Continuation Period*
Termination of active employment (*except for gross misconduct*)	You, Your spouse, Your dependent children	18 months
Reduction in work hours	You, Your spouse, Your dependent children	18 months
Divorce or legal separation	Your spouse, Your dependent children	36 months
Children no longer qualify as eligible for dependent coverage	Your dependent children	36 months
Your death	Your spouse, Your dependent children	36 months
You are a retiree with health coverage and your former employer files for bankruptcy	You, Your spouse Your dependent children	18 months

THE REQUIRED PREMIUM FOR THE 18- OR 36-MONTH CONTINUATION PERIOD MAY BE UP TO 102% OF THE PLAN COST.

Disability Extension

The 18-month continuation period may be extended for an additional 11 months if you or your covered dependents qualify for disability status under Title II or XVI of the Social Security Act during the 18- month continuation period. The additional 11 months of continued coverage is available for the disabled individual and any family member of the disabled person.

Your employer must be notified of a determination of disability within 60 days of the date of the determination and before the end of the 18-month continuation period.

The required premiums for the 18th through 29th month of continued coverage may be up to 150% of the plan cost.

Multiple Qualifying Events

If your spouse or dependent children experience a second qualifying event during the 18- or 29-month continuation period, their maximum continuation period can be extended to 36 months.

Electing Continued Coverage

You will be notified by mail about how to continue coverage under COBRA at the time you or your dependents become eligible. You or your dependents will need to elect continued coverage within 60 days of the qualifying event or the date of your employer's COBRA notice, if later. The election must include an agreement to pay required premiums.

For certain "qualifying events", such as divorce or legal separation from your spouse or a dependent child's losing eligibility for coverage as a dependent child, you or your dependents will need to notify the COBRA administrator within 60 days of a divorce or legal separation or loss of dependent child eligibility or the date coverage ends due to them, if later, so that the COBRA administrator can send the appropriate election material. You or your dependents give this notice by contacting YBR at 1-877-847-2436 or on the web at www.ybr.com/benefits.

Acquiring New Dependents during Continuation

If you acquire any new dependents during a period of continuation (through birth, adoption or marriage), they can be added for the remainder of the continuation period if:

- They meet the definition of an eligible dependent
- You notify your employer within 31 days of their eligibility
- You pay the additional required premiums

When COBRA Continuation Ends

Continued coverage ends on the first of the following events:

- The end of the maximum COBRA continuation period
- Failure to pay required premiums
- Coverage under another group plan that does not restrict coverage for preexisting conditions
- Your employer no longer offers a group health plan
- You or a family member becomes enrolled in Medicare benefits
- You or your dependents die

Other Continuation Provisions

If this plan contains any other continuation provisions, contact your employer for information on how they may affect COBRA continuation provisions.

Vision
Summary Plan Description

Airgas

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VISION PROGRAM BENEFITS

The following is a description of the vision program included in the Airgas Comprehensive Welfare Benefits Plan. This section of your Summary Plan Description is intended to be your source for information about the vision benefit. Information related to eligibility, when coverage begins and ends, enrollment, costs of the program and your rights under ERISA are covered in the *Introduction Section.*

The benefit descriptions in this section are for summary purposes only. Every effort has been made to ensure that the information correctly reflects the terms of the plan documents and contracts. In all cases, however, the official plan documents and contracts will control administration and operation of this program.

Participation in this benefit program is entirely voluntary. Employees who elect to participate pay the entire cost of the benefit by pretax payroll deduction.

The vision plan is designed and managed by EyeMed Vision Care, LLC ("Eyemed"). The benefits are underwritten by Fidelity Security Life.

In this section of the Summary Plan Description, the term "Member" means an Airgas employee who is eligible for and has elected to purchase vision benefits. The term "Participating Provider" or "in-network" means a vision care provider that is part of the Eyemed system.

Examination Benefit

In Network Benefit

A Member is entitled to paid in full comprehensive spectacle eye examination, including dilation performed by a Participating Provider.

Out of Network Benefit

A Member is entitled to a comprehensive spectacle eye examination with dilation, up to a $35.00 retail value. The Member must pay at the point of service and will be reimbursed up to $35.00 toward an eye examination after submitting a complete claim.

Member Pays

There is a $10.00 copayment for the in network benefit only.

Fitting and Follow up

Contact lens fit and two follow-ups are available once a comprehensive eye exam has been completed.

- Standard Contact lens - spherical clear contact lenses in conventional wear and planned replacement. Examples include but not limited to disposable, frequent replacement, etc. Standard benefit: member pays up to $55 of the usual and customary charge.
- Premium Contact Lens - all lens designs, materials and specialty fittings other than Standard Contact Lenses. Premium benefit: a 10% discount off of the usual and customary charge.

Benefit Frequency

Once every twelve (12) months.

Contact Lens Benefit

In Network Benefit

In lieu of the standard plastic lenses, a Member is entitled to non disposable, disposable or medically necessary contact lenses for the amounts below. The contact lens benefit includes materials only.

- Non disposable
  - — $130.00 allowance applied toward non disposable contact lenses. The Member is responsible for the balance over $130.00 at the time of service. In addition, the Member will receive a 15% discount on the balance amount.
- Disposable
  - — $130.00 allowance applied toward disposable contact lenses. The Member is responsible for the balance over $130.00 at the time of service.
- Medically Necessary
  - — $0 copay, paid in full.

Out of Network Benefit

In lieu of the standard plastic lenses, for contact lenses obtained from an out of network provider, a Member is entitled to the following:

- Non disposable
  - — Member is entitled to be reimbursed up to $104.00 for materials. The Member must pay the out of network provider at the point of service and file a complete claim to receive the reimbursement.
- Disposable
  - — Member is entitled to be reimbursed up to $104.00 for materials. The Member must pay the out of network provider at the point of service and file a

complete claim to receive the reimbursement. The Member will not receive an additional discount on the balance amount.

- Medically Necessary
  - Member is entitled to be reimbursed up to $200.00 for materials. The Member must pay the out of network provider at the point of service and file a complete claim to receive the reimbursement.
- Member Pays
  - There is no copayment for in network benefits only.
- Benefit Frequency
  - Once every twelve (12) months.

Frame Benefit

In-Network Benefit

A Member is entitled to a $130.00 allowance toward any frame. The Member is responsible for 80% of the balance over the $130.00 at the time of service.

Out-of-Network Benefit

A Member is entitled to a reimbursement of up to $65.00 toward any frame purchased from an out-of-network provider. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.

Member Pays

There is no copayment.

Benefit Frequency

Once every twenty-four (24) months.

Lens Benefit

In Network Benefit

A Member is entitled to paid in full single vision, bifocal, or trifocal lenses, all powers, all sizes.

Out of Network Benefit

A Member is entitled to be reimbursed for the following: up to $25.00 for single vision; up to $40.00 for bifocal; and up to $55.00 for trifocal lenses. The Member must pay the out of network provider in full at the point of service and file a complete claim to receive the reimbursement.

In Network Lens Options

A Member is entitled to lens options for the following additional amounts:

Standard Polycarbonate	$40.00
Ultra Violet Coating	$15.00
Standard Anti Reflective	$45.00
Tint (Solid & Gradient)	$15.00
Standard Scratch Resistance	$15.00
Standard Progressives (add-on to bifocal)	$65.00

Member Pays

There is a $20.00 copayment for the in network benefit only.

Benefit Frequency

Once every twelve (12) months.

Note: Benefits are not provided for services or materials provided by any other group benefit providing for vision care. Benefit allowances provide no remaining balance for future use within same benefit period. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit period.

Laser Vision Benefit

A Member is entitled to a 15% discount on LASIK and PRK treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a LasikPlus Center, which is part of the U.S. Laser Network, and the Member elects to obtain pre-operative and post-operative care not from the LasikPlus Center provider, the other provider may charge additional fees for the pre-operative and post-operative care which the Member will be responsible for and such fees are not subject to the 15% discount.

In lieu of the 15% discount outlined above, a Member is entitled to a 5% discount on promotional pricing for LASIK and PRK treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a Lasik Plus Center, which is part of the U.S. Laser Network, and the Member elects to obtain pre-operative and post-operative care not from the LasikPlus Center provider, the other provider may charge additional fees for the pre-operative and post-operative care which the Member will be responsible for and such fees are not subject to the 5% discount.

Accessing the Benefit

- To locate the nearest U.S. Laser Network provider, a Member must call 1-877-5LASER6.
- After the Member has located a U.S. Laser Network provider, the Member should contact the U.S. Laser Network provider and identify himself or herself as an EyeMed Member. The Member should schedule a consultation with a U.S. Laser Network provider to determine if he or she is a good candidate for laser vision correction.
- If it is determined that the Member is a good candidate for laser vision correction, the Member should schedule a treatment date with a U.S. Laser Network provider.
- To activate the benefit, the Member must call the U.S. Laser Network again at 1-877-5LASER6 with his or her scheduled treatment date.
- At the time the treatment is scheduled, the Member will be responsible to remit an initial refundable deposit to U.S. Laser Network. (If the Member should decide not to have the treatment, the deposit will be returned. Otherwise, the deposit will be applied to the total cost of the treatment.)
- At the time the Member remits the deposit, U.S. Laser Network will issue to the Member an authorization number confirming the EyeMed discount. This authorization number will be sent to the Member's U.S. Laser Network provider prior to treatment.
- On the day of the treatment, it is the responsibility of the Member to pay or arrange to pay the balance of the fee.
- After the treatment, the Member should follow all post-operative instructions carefully. In addition, the Member is responsible to schedule any required follow-up visits with a U.S. Laser Network provider to ensure the best results from the laser vision correction.

Additional Purchases and Out-of-Pocket Discount

Member will receive a 20% discount on remaining balance at Participating EyeMed Providers beyond plan coverage, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed's Providers professional services, disposable contact lenses or services provided by laser providers.

If a member chooses to receive:	
A comprehensive vision care examination:	the member pays $10
Any frame up to a value of $130:	the member pays $ 0
One pair of bifocal lenses:	the member pays $20
Ultraviolet coating:	the member pays $15
The total cost to the member is:	$45

If a member chooses to receive:	
A comprehensive vision care examination:	the member pays $10
Any frame up to a value of $130:	the member pays $ 0
A pair of single vision lenses:	the member pays $20
Standard anti-reflective coating:	the member pays $45
The total cost to the member is:	$75

Plan Limitations

Discounts do not apply for services or materials provided by any other group benefit providing vision care or orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; medical and/or surgical treatment of the eye, eyes, or supporting structures; corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan; services provided as a result of any Worker's Compensation law; plan non-prescription lenses and non-prescription sunglasses (except for 20% discount); two pair of glasses in lieu of bifocals.

Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance. Lost or broken materials are not covered.

The examples below illustrate how your benefit would be applied to the services received at any participating EyeMed provider's office or location.

The EyeMed network is always growing, and provider locations are subject to change. Therefore, EyeMed recommends that you call EyeMed's Member Services Department (1-866-723-0513) or using the Provider Locator service through EyeMed's web site *www.eyemedvisioncare.com* to locate the EyeMed Provider closest to you.

Tips for Filing Claims

EyeMed Providers

Before you go to a participating EyeMed Provider location for an eye exam, glasses or contact lenses, it is recommended that you call ahead for an appointment. When you arrive, show the receptionist or sales associate your EyeMed Identification Care, or if you should forget to take your card be sure to say that you are participating in the Airgas, Inc. vision care plan so that eligibility can be verified.

When you receive services at a participating EyeMed Provider location, you will not have to file a claim form. At the time services are rendered, you will have to pay the cost of any services or eyewear that exceeds any allowances. You also will owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Claim forms are available by contacting EyeMed's Member Services Department (1-866-723-0513 or on the web at *www.eyemed.com*. You must file your claim for out-of-network benefits within one year after receiving the service.

EyeMed Vision Care Customer Service can be reached seven days a week Monday through Saturday 7:30 am to 11:00 pm and Sunday 11:00 am to 8:00 pm Eastern Time at 1-866- 723-0513.

If you are not satisfied with the EyeMed Vision Care response and still believe that the claim form was incorrectly paid or denied, you should file a formal (ERISA) appeal to EyeMed Vision Care at the address below within 180 days after the claim was denied or any other adverse determination. Your written letter of appeal should include the following:

- The provision you feel was misinterpreted or inaccurately applied; and
- Additional information from your eye care provider that will assist EyeMed Vision Care in completing their review of your appeal, such as documents, records, questions or comments.

If you are sending an appeal to EyeMed Vision Care, it should be mailed to the following address:

EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place Mason, OH 45040

EyeMed Vision Care will review your appeal for benefits and notify you in writing of their decision, as well as the reason for the decision, with reference to specific plan provisions.

Life Insurance
Summary Plan Description

Airgas

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BASIC LIFE; OPTIONAL LIFE, SPOUSE LIFE AND DEPENDENT LIFE

Schedule of Insurance

Basic Life Benefit Amount (Employee Only):

Your benefits salary (see below) rounded to the next higher $1,000

Maximum Basic Life Benefit: $50,000

Optional Life

- Option 1: Your benefits salary, as determined by Airgas, rounded to the next higher $1,000
- Option 2: Your benefits salary, as determined by Airgas, rounded to the next higher $1,000 multiplied by 2 (two)
- Option 3: Your benefits salary, as determined by Airgas, rounded to the next higher $1,000 multiplied by 3 (three)
- Option 4: Your benefits salary, as determined by Airgas, rounded to the next higher $1,000, multiplied by 4 (four).

Maximum Combined Basic and Optional Life Benefit: $1,250,000

Guaranteed Issue Amount Maximum Amount: $750,000

Maximum Issue Amount of Optional life:

our annual Earnings, rounded to the next higher $1,000 if not already a multiple of $1,000, times 4, subject to a maximum of $1,200,000.

Combined Maximum Amount

$1,250,000 or 5 times Your annual Earnings

If Your amount of Combined Basic and Supplemental Life Insurance exceeds the Combined Maximum Amount, the Supplemental Amount of Life Insurance will be reduced, followed by a reduction in the Basic Amount of Life Insurance, if necessary.

Increases and Decreases in Amounts of Basic and Optional Life Benefits

Your benefits salary on the date you first become covered under this Plan will determine your benefits on that date. The term “benefits salary” for purposes of determining an annual amount is defined as your annual base salary if you are paid on a salaried basis, and your straight-time hourly rate multiplied by 2080 if you are paid on an hourly basis. If you are paid in part by salary and part by commission, "benefits salary" means your base pay plus your commissions for the previous 12 months. For new employees, base salary and hourly rate are determined as of date of hire. Your benefits salary will be adjusted annually effective each January 1 based on changes in your annual base salary, base salary and commissions or straight-time hourly rate, as the case may be, for the 12-month period ending on the preceding July 1st. **The benefits paid under this plan exclude overtime earnings.** For new employees, base salary and hourly rate are determined as of date of hire. Commissions are based on expected commission payments for the year.

Dependent Life Benefit Amount

Spouse	Child
Plan 1: $10,000	Plan 1: $5,000
Plan 2: $25,000	Plan 2: $10,000
Plan 3: $50,000	Plan 3: $15,000
Plan 4: $75,000	Plan 4: $20,000
Plan 5: $100,000	Plan 5: $25,000

Guaranteed Issue Amount for Spouce: $50,000

The spouse benefit is limited to 50% of the Employee’s combined Basic and Optional Life benefit.

Reduction in Amount of Life Insurance

Hartford will reduce the Amount of Life Insurance for You by any Amount of Life Insurance in force, paid or payable:

- in accordance with the Conversion Right;
- under the Portability provision; or
- under the Prior Policy.

Reduction in Coverage Due to Age
If You Are Age 65 or Older

The amounts of your Basic Life and Optional Life Benefits during your employment in an eligible capacity on and after age 65 will be determined by applying the appropriate percentage from the following table to the amount of such benefits in effect on the day before your 65th birthday.

Your Age	*Your % Reduction*	*Your Spouse’s % Reduction*
65	65%	0%
70	45%	100%
75	30%	0%
80	20%	0%

The reduction will be effective on the January 1st following the date You attain the ages shown in the table above. The reduction will apply to the Amount of Life Insurance immediately prior to the first reduction made.

Your spouse’s reduction will be effective at the end of the month following the date your spouse attains age 70.

Reductions also apply if:

- You become covered under The Policy; or
- Your coverage increases; on the January 1st of the year in which you attain age 65.

The reduced amount of coverage will be rounded to the next higher multiple of $1,000, if not already a multiple of $1,000. An appropriate adjustment in premium will be made.

ELIGIBILITY AND ENROLLMENT

Eligibility for Benefits

Personal Benefits Eligibility Date

Your Personal Benefits Eligibility Date is the later of:

- the day after the date you complete 30 days of continuous service in an eligible employee group of Airgas provided you are regularly scheduled to work at least 30 hours per week.
- As of your date of hire with Airgas, if you are a member of an acquired employee group, and are in an eligible employee group.

Enrollment

For Non-Contributory Coverage, Airgas will automatically enroll You for coverage. However, You will be required to name a beneficiary.

To enroll for Contributory Coverage, You must do so through the Your Benefit Resource website: *www.ybr.com/airgas* OR by contacting Your Benefits Resources Customer Care at 1-877-4AG-BENEFITS.

If You do not enroll for Your Dependent's coverage within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll, You may enroll for Your Dependent's coverage only:

- during an Annual Enrollment Period designated by the Policyholder; or
- within 31 days of the date You have a Change in Family Status.

Any Enrollment may be subject to the Evidence of Insurability Requirements provision.

Evidence of Insurability Requirements

Hartford requires Evidence of Insurability for initial coverage, if You:

- enroll more than 31 days after the date You are first eligible to enroll including electing initial coverage after a Change in Family Status;
- enroll for an Amount of Life Insurance greater than the Combined Guaranteed Issue Amount, regardless of when You enroll for coverage; or
- were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

If Your Evidence of Insurability is not satisfactory to Hartford:

- Your Amount of Life Insurance will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and
- You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Dependent Evidence of Insurability Requirements

Hartford requires Evidence of Insurability, for initial coverage, if You:

- enroll for Your Spouse more than 31 days after the date You are first eligible to enroll,including electing initial coverage after a Change in Family Status;
- enroll for an Amount of Spouse Life Insurance greater than the Spouse Guaranteed Issue Amount, regardless of when You enroll for coverage; or
- were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

If Your Spouse's Evidence of Insurability is not satisfactory to Hartford:

- Your Spouse's Amount of Life Insurance will equal the amount for which Your Spouse was eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and
- Your Spouse will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Evidence of Insurability

Evidence of Insurability must be satisfactory to Hartford and may include, but will not be limited to:

- a completed and signed application approved by Hartford;
- a medical examination;
- attending Physicians' statement; and
- any additional information Hartford may require.

Evidence of Insurability will be furnished at Hartford's expense except for Evidence of Insurability due to late enrollment. Hartford will then determine if You or Your Dependents are insurable for initial coverage or an increase in coverage under The Policy, as described in the Increase in Amount of Life Insurance provision.

You will be notified in writing of Hartford's determination of any Evidence of Insurability submission.

PERIOD OF COVERAGE

Effective Date

Non-Contributory Coverage, for which Evidence of Insurability is not required, will start on the date You become eligible.

Contributory Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:

- the date You become eligible, if You enroll on or before that date;
- the January 1st on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
- the date You enroll, if You do so within 31 days from the date You are eligible.

Any coverage for which Evidence of Insurability is required, will become effective on the later of:

- the date You become eligible; or
- the date Hartford approves Your Evidence of Insurability.

All Effective Dates of coverage are subject to the Deferred Effective Date provision.

Deferred Effective Date

If, on the date You are to become covered:

- under The Policy;
- for increased benefits; or
- for a new benefit;

You are not Actively at Work due to a physical or mental condition, such coverage will not start until the date You are Actively at Work.

Continuity from a Prior Policy

Your initial coverage under The Policy will begin, and will not be deferred if on the day before the Policy Effective Date, You were:

- insured under the Prior Policy; and
- Actively at Work or on an authorized family and medical leave; but on the Policy Effective Date, You were not Actively at Work, and would otherwise meet the Eligibility requirements of

The Policy. However, Your Amount of Insurance will be the lesser of the amount of life insurance:

- You had under the Prior Policy; or
- shown in the Schedule of Insurance; reduced by any coverage amount:
- that is in force, paid or payable under the Prior Policy; or
- that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:

- the last day of a period of 12 consecutive months after the Policy Effective Date;
- the date Your insurance terminates for any reason shown under the Termination provision;
- the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
- the date You are Actively at Work.

However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Employee under The Policy.

Dependent Effective Date

Coverage will start on the latest to occur of:

- The date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
- the January 1st on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
- the date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

Coverage for which Evidence of Insurability is required, will become effective on the later of:

- the date You become eligible for Dependent coverage; or
- the date Hartford approves Your Dependents' Evidence of Insurability.

In no event will Dependent coverage become effective before You become insured.

Dependent Deferred Effective Date

If, on the date Your Dependent, is to become covered:

- under The Policy;
- for increased benefits; or
- for a new benefit;

he or she is:

- confined in a hospital; or
- Confined Elsewhere;

such coverage will not start until he or she:

- is discharged from the hospital; or
- is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days.

This Deferred Effective Date provision will not apply to disabled children who qualify under the definition of Dependent Children.

Confined Elsewhere means Your Dependent is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

Dependent Continuity from a Prior Policy

If on the day before the Policy Effective Date, You were covered with respect to Your Dependents under the Prior Policy, the Deferred Effective Date provision will not apply to initial coverage under The Policy for such Dependents. However, the Dependent Amount of Insurance will be the lesser of the Amount of Life Insurance:

- they had under the Prior Policy; or
- shown in the Schedule of Insurance;
- reduced by any coverage amount:
- that is in force, paid or payable under the Prior Policy; or
- that would have been so payable under the Prior Policy had timely election been made.

Change in Coverage

After Your initial enrollment You may increase or decrease coverage for You or Your Dependents, or add a new Dependent to Your existing Dependent coverage:

- during any Annual Enrollment Period designated by Airgas; or
- within 31 days of the date of a Change in Family Status.

Effective Date for Changes in Coverage

Any decrease in coverage will take effect on the date of the change. Any increase in coverage will take effect on the latest of:

- the date of the change;
- the date requirements of the Deferred Effective Date provision are met;
- the date Evidence of Insurability is approved, if required; or
- the January 1st next following the last day of the Annual Enrollment Period, except for an increase as a result of a Change in Family Status.

Increase in Amount of Life Insurance

If You or Your Dependents are:

- already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You and Your Dependents must provide Evidence of Insurability for an increase of more than one level; or
- not already enrolled for Supplemental Life Insurance under The Policy, You and Your Dependents must provide Evidence of Insurability for any amount of Supplemental Life Insurance, including an initial amount.

In any event, if the Amount of Life Insurance You request is greater than the Guaranteed Issue Amount, You or Your Dependents, as applicable, must provide Evidence of Insurability.

If Your Evidence of Insurability is not satisfactory to Hartford, the Amount of Life Insurance You had in effect on the date immediately prior to the date You requested the increase will not change. If Your Dependents' Evidence of Insurability is not satisfactory to Hartford, the Amount of Life Insurance they had in effect on the date immediately prior to the date You requested the increase will not change.

Increase in Amount of Life Insurance

You must provide Evidence of Insurability if Your Benefits Base increase such that Your Amount of Life Insurance is greater than the Guaranteed Issue Amount. Additionally, once approved, Hartford requires Evidence of Insurability again if Your Amount of Life Insurance:

- is greater than the Guaranteed Issue Amount; and
- would increase solely because Your Benefits Base increased more than $25,000;
  - — during the last 12 consecutive month period; or
  - — since Your Evidence of Insurability was last approved; whichever occurs most recently.

However, if:

- You do not submit Evidence of Insurability; or
- Your Evidence of Insurability is not satisfactory to Hartford;

Your Amount of Life Insurance:

- will increase, but only up to the amount for which You were eligible without having to provide Evidence of Insurability; and
- will not increase again, or beyond that amount, until Your Evidence of Insurability is approved.

Termination

Your coverage will end on the earliest of the following:

- the date The Policy terminates;
- the date You are no longer in an eligible group for coverage, or The Policy no longer insures Your group;
- the date the premium payment is due but not paid;
- the date Airgas terminates Your employment; or
- the date You are no longer Actively at Work; unless continued in accordance with any of the Continuation Provisions.

Dependent Termination

Coverage for Your Dependent will end on the earliest to occur of:

- the date Your coverage ends;
- the date the required premium is due but not paid;
- the date You are no longer eligible for Dependent coverage;
- the date Hartford or the Employer terminate Dependent coverage; or
- the date the Dependent no longer meets the definition of Dependent;

unless continued in accordance with the continuation provisions.

Continuation Provisions

Coverage may be continued by Airgas beyond a date shown in the Termination provision, if Airgas Regional Company provides a plan of continuation which applies to all employees within the region in the same way. Coverage may not be continued under more than one Continuation Provision.

The amount of continued coverage applicable to You or Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:

- is subject to any reductions in The Policy;
- is subject to payment of premium;
- may be continued up to the maximum time shown in the provisions; and
- terminates if The Policy terminates.

In no event will the amount of insurance increase while coverage is continued in accordance with the following provisions. In all other respects, the terms of Your coverage and coverage for Your Dependents remain unchanged.

Leave of Absence: If You are on a documented leave for family medical reasons, disability or military your benefits will continue provided you pay your share of the premium. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Your coverage (including Dependent Life coverage) may be continued for up to 12 month(s). If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage(s) (including Dependent Life coverage) may be continued for up to 12 weeks, or longer if required by other applicable law, following the date Your leave commenced. If the leave of absence terminates prior to the agreed upon date, this continuation will cease immediately.

Continuation for Dependent Child(ren) with Disabilities

If Your Dependent Child(ren) reach the age at which they would otherwise cease to be a Dependent as defined, and they are:

- age 26 or older; and
- disabled; and
- primarily dependent upon You for financial support;then Dependent Child(ren) coverage will not terminate solely due to age. However:
  - — You must submit proof satisfactory to Hartford of such Dependent Child(ren)'s disability within 31 days of the date he or she reaches such age; and
  - — such Dependent Child(ren) must have become disabled before attaining age 26.

Coverage under The Policy will continue as long as:

- You remain insured;
- the child continues to meet the required conditions; and
- any required premium is paid when due.

However, no increase in the Amount of Life Insurance for such Dependent Children will be available. Hartford has the right to require proof, satisfactory to Hartford, as often as necessary during the first two years of continuation, that the child continues to meet these conditions. Hartford will not require proof more often than once a year after that.

Waiver of Premium

Waiver of Premium is a provision which allows You to continue Your and Your Dependent's Life Insurance coverage without paying premium, while You are Disabled and qualify for Waiver of Premium. If You qualify for Waiver of Premium, the amount of continued coverage:

- will be the amount in force on the date You cease to be an Active Employee;
- will be subject to any reductions provided by The Policy; and
- will not increase.

Eligible Coverages

This provision applies only to:

- Your Basic Life Insurance;
- Your Supplemental Life Insurance; and
- Dependent Life Insurance.

You are not eligible to apply for both the Portability Benefit and Waiver of Premium for the same coverage amount.

Disabled

Disabled means You are prevented by injury or sickness from doing any work for which You are, or could become, qualified by:

- education;
- training; or
- experience.

In addition, You will be considered Disabled if You have been diagnosed with a life expectancy of 6 months or less.

Conditions for Qualification

To qualify for Waiver of Premium You must:

- be covered under The Policy and be under age 60 when You become Disabled;
- be Disabled and provide Proof of Loss that You have been Disabled for 9 consecutive month(s), starting on the date You were last Actively at Work; and
- provide such proof within one year of Your last day of work as an Active Employee.

In any event, You must have been Actively at Work under The Policy to qualify for Waiver of Premium.

When Premiums are Waived

If Hartford approves Waiver of Premium, Hartford will notify You of the date Hartford will begin to waive premium. In any case, Hartford will not waive premiums for the first 9 month(s) You are Disabled. Hartford have the right to:

- require Proof of Loss that You are Disabled; and
- have You examined at reasonable intervals during the first 2 years after receiving initial Proof of Loss, but not more than once a year after that. If You fail to submit any required Proof of Loss or refuse to be examined as required by Hartford, then Waiver of Premium ceases. However, if Hartford denies Your application for Waiver of Premium, You may be eligible to:
  - — continue coverage under the Portability Benefit; or
  - — convert coverage in accordance with the Conversion Right;

for You and Your Dependents.

If You cease to be Disabled and return to work for a total of 5 days or less during the first 9 month(s) that You are Disabled, the 9 month(s) waiting period will not be interrupted. Except for the 5 days or less that You worked, You must be Disabled by the same condition for the total 9 month(s) period. If You return to work for more than 5 days, You must satisfy a new waiting period.

Benefit Payable before Approval of Waiver of Premium

If You or Your Dependent die within one year of Your last day of work as an Active Employee, but before You qualify for Waiver of Premium, Hartford will pay the Amount of Life Insurance which is in force for the deceased person provided:

- You were continuously Disabled;
- the Disability lasted or would have lasted 9 month(s) or more; and
- premiums had been paid for coverage.

Waiver Ceases

Hartford will waive premium payments and continue Your coverage, while You remain Disabled, until the date You attain age 65 if Disabled prior to age 60.

Hartford will waive premium payments for Your Dependent Life Insurance and continue such coverage, while You remain Disabled, until the earliest of the date:

- You die;
- You no longer qualify for Waiver of Premium;
- The Policy terminates;
- Your Dependents are no longer in an Eligible Group, or Dependent coverage is no longer offered; or
- Your Dependent no longer meets the definition of Dependent.

When the Waiver of Premium ceases:

- if You return to work in an Eligible Group, as an Active Employee, then You may again be eligible for coverage for Yourself and Your Dependents as long as premiums are paid when due; or
- if You do not return to work in an Eligible Group, coverage will end and You may be eligible to exercise the Conversion Right for You and Your Dependents if You do so within the time limits described in such provision. The Amount of Life Insurance that may be converted will be subject to the terms and conditions of the Conversion Right. Portability will not be available.

Effect of Policy Termination

If The Policy terminates before You qualify for Waiver of Premium:

- You may be eligible to exercise the Conversion Right, provided You do so within the time limits described in such provision; and
- You may still be approved for Waiver of Premium if You qualify.

If The Policy terminates after You qualify for Waiver of Premium:

- Your Dependent coverage will terminate; and
- Your coverage under the terms of this provision will not be affected.

BENEFITS

Life Insurance Benefit

If You or Your Dependents die while covered under The Policy, Hartford will pay the deceased person's Life Insurance Benefit after Hartford receives Proof of Loss, in accordance with the Proof of Loss provision. The Life Insurance Benefit will be paid according to the General Provisions of The Policy.

Suicide

If You or Your Dependent commit suicide while sane or insane, Hartford will not pay any Optional (Supplemental) Life Insurance or Dependent Life Insurance for the deceased person which was elected within the 2 year period immediately prior to the date of death. This applies to initial coverage and elected increases in coverage. It does not apply to benefit increases that resulted solely due to an increase in Earnings. This 2 year period includes the time group life insurance coverage was in force under the Prior Policy.

The basic life benefit will be paid in the event that the death is the result of suicide provided the death occurs 2 years after the coverage became effective and the employee meets all other benefit eligibility rules.

Accelerated Benefit

In the event that You or Your Dependents are diagnosed as Terminally Ill while the Terminally Ill person is covered under The Policy for an Amount of Life Insurance of at least $10,000, Hartford will pay the Accelerated Benefit amount as shown below, provided Hartford receives proof of such Terminal Illness. You must request in writing that a portion of the Terminally Ill person's Amount of Life Insurance be paid as an Accelerated Benefit.

The Amount of Life Insurance payable upon the Terminally Ill person's death will be reduced by any Accelerated Benefit Amount paid under this benefit.

You may request a minimum Accelerated Benefit amount of $3,000, and a maximum of $500,000. However, in no event will the Accelerated Benefit Amount exceed 80% of the Terminally Ill person's Amount of Life Insurance. This option may be exercised only once for You and only once for each of Your Dependents. For example, if You are covered for a Life Insurance Benefit Amount under The Policy of $20,000 and are Terminally Ill, You can request any portion of the Amount of Life Insurance Benefits from $3,000 to $16,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only $3,000 now, You cannot request the additional

$13,000 in the future. A person who submits proof satisfactory to Hartford of his or her Terminal Illness will also meet the definition of Disabled for Waiver of Premium. In the event:

- You are required by law to accelerate benefits to meet the claims of creditors; or
- if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an Assignment of rights and interest with respect to You or Your Dependent's Amount of Life Insurance, in order to receive the Accelerated Benefit, Hartford must receive a release from the assignee before any benefits are payable.

Terminal Illness or Terminally Ill means a life expectancy of 6 months or less.

Proof of Terminal Illness and Examinations

Hartford reserves the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician. If You or Your Dependents do not submit proof of Terminal Illness satisfactory to Hartford, or if You or Your Dependents refuse to be examined by a Physician, as Hartford may require, then Hartford will not pay an Accelerated Benefit.

No Longer Terminally Ill

If You or Your Dependents are diagnosed by a Physician as no longer Terminally Ill and:

- return to an Eligible Group, coverage will remain in force, provided premium is paid;
- do not return to an Eligible Group, but You continue to meet the definition of Disabled, coverage will remain in force, subject to the Waiver of Premium provision; or
- are not in an Eligible Group, but You do not continue to meet the definition of Disabled, coverage will end and You may be eligible to exercise the Conversion Right, if You do so within the time limits described in such provision. In any event, the amount of coverage will be reduced by the Accelerated Benefit paid.

Conversion Right

If Life Insurance coverage or any portion of it under The Policy ends for any reason, You and Your Dependents may have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for any Amount of Life Insurance for which You or Your Dependents were not eligible and covered under The Policy. If coverage under The Policy ends because:

- The Policy is terminated; or
- Coverage for an Eligible Group is terminated;

then You or Your Dependent must have been insured under The Policy for 5 years or more, in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:

- $10,000; or
- the Life Insurance Benefit under The Policy less any Amount of Life Insurance for which You or Your Dependent may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage. If coverage under The Policy ends for any other reason, the full amount of coverage which ended may be converted.

Insurer, as used in this provision, means Hartford or another insurance company which has agreed to issue conversion policies according to this Conversion Right.

Conversion

To convert Your coverage or coverage for Your Dependents, You must:

- complete a Notice of Conversion Right form; and
- have Your Employer sign the form.

The Insurer must receive this within:

- 31 days after Life Insurance terminates; or
- 15 days from the date Your Employer signs the form; whichever is later. However, we will not accept requests for conversion if they are received more than 91 days after Life Insurance terminates.

After the Insuret verifies eligibility for coverage, the Insurer will send You a Conversion Policy proposal. You must:

- complete and return the request form in the proposal; and
- pay the required premium for coverage within the time period specified in the proposal.

Any individual policy issued to You or Your Dependents under the Conversion Right:

- will be effective as of the 32nd day after the date coverage ends; and
- will be in lieu of coverage for this amount under The Policy.

Conversion Policy Provisions

The Conversion Policy will:

- be issued on one of the Life Insurance policy forms the Insurer is issuing for this purpose at the time of conversion; and
- base premiums on the Insurer's rates in effect for new applicants of Your Group and age at the time of conversion. The Conversion Policy will not provide:
- the same terms and conditions of coverage as The Policy;
- any benefit other than the Life Insurance Benefit; and
- term insurance.

However, Conversion is not available for any Amount of Life Insurance which was, or is being, continued:

- in accordance with the Waiver of Premium provision; or
- under a certificate of insurance issued in accordance with the Portability provision; or
- in accordance with the Continuation Provisions;

until such coverage ends.

Death within the Conversion Period

Hartford will pay the deceased person's Amount of Life Insurance You would have had the right to apply for under this provision if:

- coverage under The Policy terminates;
- You or Your Dependent die within 31 days of date coverage terminates; and
- Hartford receives Proof of Loss.

If the Conversion Policy has already taken effect, no Life Insurance Benefit will be payable under The Policy for the amount converted.

Portability Benefits

Portability is a provision which allows You and Your Dependents to continue coverage under a Group Portability policy when coverage would otherwise end due to certain Qualifying Events.

Qualifying Events

Qualifying Events for You are:

- Your employment terminates for any reason prior to Normal Retirement Age; or
- Your membership in an Eligible Group under The Policy ends.

Qualifying Events for Your Dependents are:

- Your employment terminates, for any reason prior to Normal Retirement Age; or
- Your death;
- Your membership in a Group eligible for Dependent coverage ends;
- He or she no longer meets the definition of Dependent. However a Dependent Child who reaches the limiting age under The Policy is not eligible for Portability.

Electing Portability

You may elect Portability for Your coverage after Your Optional (Supplemental) coverage ends because You had a Qualifying Event. You may also elect Portability for Your Dependent coverage if Your Dependent has a Qualifying Event. The Policy must still be in force in order for Portability to be available. In order for Dependent Child coverage to be continued under this provision, You or Your Spouse must elect to continue coverage.

To elect Portability for You or Your Dependents, You must:

- complete an application; and
- submit the application to Hartford, with the required premium.

This must be received within:

- 31 day after Life Insurance terminates; whichever is later. However, Portability requests will not be accepted if they are received more than 91 days after Life Insurance terminates.

After Hartford verifies eligibility for coverage, Hartford will issue a certificate of insurance under a Portability policy. The Portability coverage will be:

- issued without Evidence of Insurability;
- issued on one of the forms then being issued by Hartford for Portability purposes; and
- effective on the day following the date Your or Your Dependent's coverage ends.

The terms and conditions of coverage under the Portability policy will not be the same terms and conditions that are applicable to coverage under The Policy.

Limitations

You may elect to continue 50%, 75%, or 100% of the Amount of Life Insurance which is ending for You or Your Dependent. This amount will be rounded to the next higher multiple of $1,000, if not already a multiple of $1,000. However, the Amount of Life Insurance that may be continued will not exceed:

- $250,000 for You;
- $50,000 for Your Spouse ; or
- $10,000 for Your Dependent Child(ren).

If You elect to continue 50% or 75% now, You may not continue any portion of the remaining amount under this Portability provision at a later date. In no event will You or Your Spouse be able to continue an Amount of Life Insurance which is less than $5,000.Portability is not available for any Amount of Life Insurance for which You or Your Dependents were not eligible and covered. In addition Portability is not available if You or Your Dependents are entering active military service.

Effect of Portability on other Provisions

Portability is not available for any Amount of Life Insurance which was, or is being, continued in accordance with the:

- Conversion Right;
- Waiver of Premium Provision; or
- Continuation provisions;

under The Policy. However, If:

- You elect to continue only a portion of terminated coverage under this Portability provision; or
- the Amount of Life Insurance exceeds the maximum Portability amount;

then the Conversion Right may be available for the remaining amount.

The Waiver of Premium provision will not be available if You elect to continue coverage under this Portability provision.

GENERAL PROVISIONS

Notice of Claim

The person who has the right to claim benefits, must give Hartford, written notice of a claim within 30 days after the date of death. If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address and the Policy Number (Airgas Policy Number 675809).

Claim Forms

YBR will send forms to the claimant to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If the forms are not received within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of the claim.

Proof of Loss

Proof of Loss may include, but is not limited to, the following:

- a completed claim form;
- a certified copy of the death certificate (if applicable);
- Your Enrollment form;
- Your Beneficiary Designation (if applicable);
- documentation of:
  - — the date Your Disability began;
  - — the cause of Your Disability; and
  - — the prognosis of Your Disability;
- any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- the names and addresses of all:
  - — Physicians or other qualified medical professionals You have consulted;
  - — hospitals or other medical facilities in which You have been treated; and
  - — pharmacies which have filled Your prescriptions within the past three years;
- Your signed authorization for Hartford to obtain and release medical, employment and financial information (if applicable); or
- Any additional information required by Hartford to adjudicate the claim.

All proof submitted must be satisfactory to Hartford.

Sending Proof of Loss

Written proof of Loss should be sent within 90 days.

Physical Examination and Autopsy

While a claim is pending Hartford has the right at Hartford's expense:

- to have the person who has a loss examined by a Physician when and as often as Hartford reasonably require; and
- to have an autopsy performed in case of death where it is not forbidden by law.

Claim Payment

When Hartford determines that benefits are payable, Hartford will pay the benefits in accordance with the Claims to be Paid provision.

Claims to be Paid

Life Insurance Benefits will be paid in accordance with the life insurance Beneficiary Designation. If no beneficiary is named, or if no named beneficiary survives You, Hartford may, at Hartford's option, pay:

- the executors or administrators of Your estate; or
- all to Your surviving spouse; or
- if Your spouse does not survive You, in equal shares to Your surviving Children; or
- if no child survives You, in equal shares to Your surviving parents.

In addition, Hartford may, at Hartford's option, pay a portion of Your Life Insurance Benefit up to $250 to any person equitably entitled to payment because of expenses from Your burial.

Payment to any person, as shown above, will release Hartford from liability for the amount paid. If any beneficiary is a minor, Hartford may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Hartford's option and in Hartford's opinion is providing financial support and maintenance for the minor. Hartford will pay:

- $200 at Your death; and
- monthly installments of not more than $200.

Payment to any person as shown above will release Hartford from all further liability for the amount paid.

Hartford will pay the Life Insurance Benefit at Your Dependents' death to You, if living. Otherwise, it will be paid, at Hartford's option, to Your surviving Spouse or the executor or administrator of Your estate. If benefits are payable and meet Hartford's guidelines, then Hartford may pay benefits into a draft book account (checking account) which will be owned by:

- You, if living; or
- Your beneficiary, in the event of Your death.

The account owner may elect a lump sum payment by writing a check for the full amount in the account. However, an account will not be established for a benefit payable to Your estate.

Hartford will make any payments, other than for loss of life, to You. Hartford may make any such payments owed at Your death to Your estate. If any payment is owed to:

- Your estate;
- a person who is a minor; or
- a person who is not legally competent,

then Hartford may pay up to $1,000 to a person who is related to You and who, at Hartford's sole discretion, is entitled to it. Any such payment shall fulfill Hartford's responsibility for the amount paid.

Beneficiary Designation

You may designate or change a beneficiary by doing so through the Your Benefits Resources website *www.ybr.com/airgas* or by calling Your Benefits Resources Customer Care toll-free 1-877-4AG-BENEFITS. Only satisfactory designations made with Your Benefits Resources prior to Your death will be accepted. Beneficiary designations will become effective as of the date completed on line. Hartford will not be liable for any amounts paid before being notified by YBR of the named beneficiary. In no event may a beneficiary be changed by a Power of Attorney.

Claim Denial

If a claim for benefits is wholly or partly denied, You or Your Beneficiary will be furnished with written notification of the decision. This written notification will:

- give the specific reason(s) for the denial;
- make specific reference to the provisions on which the denial is based;
- provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
- provide an explanation of the review procedure.

Claim Appeal

On any claim, the claimant or his or her representative may appeal to Hartford for a full and fair review. To do so, he or she:

- must request a review upon written application within:
  - 180 days of receipt of claim denial if the claim requires Hartford to make a determination of disability; or
  - 60 days of receipt of claim denial if the claim does not require Hartford to make a determination of disability; and
- may request copies of all documents, records, and other information relevant to the claim; and
- may submit written comments, documents, records and other information relating to the claim.

Hartford will respond in writing with Hartford's final decision on the claim.

Policy Interpretation

Hartford has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Incontestability

In the absence of Insurance Fraud, no statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You. No statement made relating to Your Dependents being insurable will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during the Dependent's lifetime. In order to be used, the statement must be in writing and signed by You or Your representative.

Assignment

You have the right to absolutely assign Your rights and interest under The Policy including, but not limited to the following:

- the right to make any contributions required to keep the insurance in force;
- the right to convert; and
- the right to name and change a beneficiary.

Hartford will recognize any absolute assignment made by You under The Policy, provided:

- it is duly executed; and
- a copy is acknowledged and on file with Hartford.

Hartford and the Policyholder assume no responsibility:

- for the validity or effect of any assignment; or
- to provide any assignee with notices which Hartford may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under The Policy.

Legal Actions

Legal action cannot be taken against Hartford:

- sooner than 60 days after the date Proof of Loss is furnished; or
- more than 6 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

Workers' Compensation

The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Insurance Fraud

Insurance fraud occurs when You, Your Dependents and/or Airgas provide Hartford with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Hartford. It is a crime if You, Your Dependents and/or Airgas commit insurance fraud. Hartford will use all means available to Hartford to detect, investigate, deter and prosecute those who commit insurance fraud. Hartford will pursue all available legal remedies if You, Your Dependents and/or Airgas perpetrate insurance fraud.

Misstatements

If material facts about You or Your Dependents were not stated accurately:

- the premium may be adjusted; and
- the true facts will be used to determine if, and for what amount, coverage should have been in force.

State Law

To the extent applicable state law requires the insurer to provide additional benefits or other items not generally available under the plan; the insurer has agreed to provide them. If you have a question about a specific state law, contact Hartford.

DEFINITIONS

Active Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

Actively at Work means at work with Airgas on a day that is one of Airgas' scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your job:

- in the usual way; and
- for Your usual number of hours.

Hartford will also consider You to be Actively At Work on any regularly scheduled vacation day or holiday, only if You were Actively At Work on the preceding scheduled work day.

Commissions means the annual average of commissions You received from Airgas over:

- the 12 month period immediately prior to the date You were last Actively at Work; or
- the total period of time You worked for Airgas, if less than the above period.

Contributory Coverage means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.

Dependent Child(ren) means:

1) Your children, stepchildren, legally adopted children; or
2) any other children related to You by blood or marriage or domestic partnership; provided such children are;
   1) from live birth but not yet 26 years; or
   2) age 26 or older and disabled. Such children must have become disabled before attaining age 26. You must submit proof, satisfactory to Us, or such children's disability.

- Your unmarried natural or adopted children up to age 26 (or up to age 23 if a full time student) who do not live with you but for whom you are required by a Qualified Medical Child Support Order ("QMCSO") to provide health insurance coverage.
- Children of the domestic partner

Benefit Salary Your benefits salary on the date you first become covered under this Plan will determine your benefits on that date. The term "benefits salary" for purposes of determining an annual amount is defined as your annual base salary if you are paid on a salaried basis, and your straight-time hourly rate multiplied by 2080 if you are paid on an hourly basis. If you are paid in part by salary and part by commission, "benefits salary" means your base pay plus your commissions for the previous 12 months. For new employees, base salary and hourly rate are determined as of date of hire. Your benefits salary will be adjusted annually effective each January 1 based on changes in your annual base salary, base salary and commissions or straight-time hourly rate, as the case may be, for the 12-month period ending on the preceding July 1st. For new employees, base salary and hourly rate are determined as of date of hire. Commissions are based on expected commission payments for the year

Employer means Airgas.

Guaranteed Issue Amount means the Amount of Life Insurance for which Hartford does not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

Non-Contributory Coverage means coverage for which You are not required to contribute toward the cost. Non-Contributory Coverage is shown in the Schedule of Insurance.

Prior Policy means the group life insurance Policy carried by Your Policyholder on the day before the Policy Effective Date and will only include the coverage which is transferred to Hartford.

Related means Your Spouse/Domestic Partner, or other adult living with You, or Your sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Spouse means Your spouse who:

1) is not legally separated or divorced from You ; and

2) is not in active full-time military service.

Spouse will include Your Domestic Partner provided You:

1) have executed a Domestic Partner affidavit satisfactory to Us, establishing that You and Your partner are Domestic Partners for purposes of The Policy; or

2) have registered as Domestic Partners with a government agency or office where such registration is available. You will continue to be considered Domestic Partners provided You continue to meet the requirements described in the Domestic Partner affidavit or required by law.

Physician means a person who is:

1) a doctor of medicine, Osteopathy, Psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;

2) licensed to practice in the jurisdiction where care is being given;

3) practicing within the scope of that license; and

4) not You or Related to You by blood or marriage.

The Policy means the policy which Hartford issued to the Policyholder under the Policy Number shown on the face page.

Hartford or Our means the insurance company named on the face page of The Policy.

You or Your means the person to whom this certificate is issued.

Accidental Death & Dismemberment Summary Plan Description

Airgas

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SCHEDULE OF BENEFITS

Accidental Death and Dismemberment Benefit (AD&D)

Basic AD&D Principal Sum

Principal Sum Amount

1 times Earnings, subject to a Maximum Amount of $50,000 rounded to the next higher $1,000

Supplemental AD&D Principal Sum

Principal Sum

The Principal Sum applicable to you is the amount for which:

- You are eligible to request as determined below;
- You elected through Your Benefits Resources (YBR)
- the required premium is paid.

Principal Sum Amount

1, 2, 3, or 4 times Benefit Base, subject to a Maximum Amount of $1,200,000 rounded to the next higher $1,000

Principal Sum for each of Your Eligible Dependents

The Principal Sum that applies to each person covered under The Policy as Your Dependent, on the date of accident, is determined by multiplying Your Principal Sum by the percentage determined below.

	Spouse	*Each Dependent Child*
Spouse only	50%	0%
Spouse & Dependent Child(ren)	50%	20%
Dependent Child(ren) only	0%	20%

Aggregate Limitation: $1,250,000

If the total of all benefits payable for all persons per accident, in the absence of this provision exceeds the above amount, each benefit amount will be proportionately reduced so that the total will equal the above amount.

Eligibility and Enrollment

Eligibility for Coverage

You will become eligible for coverage on the latest of:

- the Policy Effective Date;
- the date You become a member of an Eligible Group; or
- the date You complete the Eligibility Waiting Period for coverage shown in the Schedule of Insurance, if applicable.

Eligibility for Dependent Coverage

You will become eligible for Dependent coverage on the later of:

- the date You become insured for employee coverage; or
- the date You acquire Your first Dependent.

You may not cover Your Dependent if such Dependent is covered as an Employee under The Policy. No person can be insured as a Dependent of more than one Employee under The Policy.

Enrollment

You will be automatically enrolled into Basic AD&D which provides a benefit equal to 1x your benefits salary up to a maximum amount of $50,000.

To enroll for Optional AD&D You must do so through the Your Benefit Resource website: *www.ybr.com/airgas* OR by contacting Your Benefits Resources Customer Care at 1-877-4AG-BENEFITS.

If You do not enroll for Your Dependent's coverage within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll, You may enroll for Your Dependent's coverage only:

- during an Annual Enrollment Period designated by the Policyholder; or
- within 31 days of the date You have a Change in Family Status.

Any Enrollment may be subject to the Evidence of Insurability Requirements provision.

Period of Coverage

Effective Date

Coverage will start on the latest to occur of:

- The date You become eligible, if You enroll on or before that date; or
- the first day of January on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
- the date You enroll if You do so within 31 days of the date You are eligible.

Continuity from a Prior Policy

Your initial coverage under The Policy will begin, and will not be deferred if on the day before the Effective Date, You were insured under the Prior Policy, but on the Effective Date, You were not Actively at Work, but would otherwise meet the Eligibility requirements of The Policy. However, Your Amount of Insurance will be the amount of accidental death and dismemberment principal sum:

- You had under the Prior Policy; or
- shown in the Schedule of Insurance;
- reduced by any coverage amount:
- that is in force, paid or payable under the Prior Policy; or
- that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:

- the last day of a period of 12 consecutive months after the Effective Date;
- the date Your insurance terminates for any reason shown under the Termination provision;
- the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
- the date You are Actively at Work.

However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Employee under The Policy.

Dependent Effective Date

Contributory Coverage will start on the latest to occur of:

- The date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
- January 1st following the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
- the date You are first eligible, if You enroll within 31 days from the date You are eligible for Dependent coverage.

In no event will Dependent coverage become effective before You become insured.

Change in Coverage

After Your initial enrollment You may increase or decrease coverage for You or Your Dependents or add a new Dependent to Your existing Dependent coverage:

- during any Annual Enrollment Period designated by the Policyholder; or
- within 31 days of the date of a Change in Family Status.

Effective Date for Changes in Coverage

Any decrease in coverage will take effect on the date of the change. Any increase in coverage will take effect on the date of the change.

Termination

Your coverage will end on the earliest of the following:

- the date The Policy terminates;
- the date You are no longer in a group eligible for coverage, or the Policy no longer covers Your group;
- the date the required premium is due but not paid;
- the date Airgas terminates Your employment;
- the date You are no longer Actively at Work;

unless continued in accordance with one of the Continuation Provisions.

Dependent Termination

Coverage for Your Dependent will end on the earliest to occur of:

- the date Your coverage ends;
- the date the required premium is due but not paid;
- the date You are no longer eligible for Dependent coverage;
- the date Hartford or the Airgas terminate Dependent coverage; or
- the date the Dependent no longer meets the definition of Dependent;

unless continued in accordance with the continuation provisions

Continuation Provisions

Coverage can be continued by Airgas beyond a date shown in the Termination provision, if Airgas provides a plan of continuation determined on a regional basis and each region applies the continuation policy to all employees the same way. Coverage may not be

continued under more than one Continuation Provision. The amount of continued coverage applicable to You or Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:

- is subject to any reductions in The Policy;
- is subject to payment of premium;
- may be continued up to the maximum time shown in the provisions; and
- terminates if The Policy terminates.

In no event will the amount of insurance increase while coverage is continued in accordance with the following provisions.

In all other respects, the terms of Your coverage and coverage for Your Dependents remain unchanged.

Leave of Absence: If You are on a documented leave of absence, other than Family and Medical Leave or Military Leave of Absence, Your coverage (including Dependent Accidental Death and Dismemberment coverage) may be continued in accordance with the regional policy to a maximum of 12 months. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You or Your Dependent enter active military service and are granted a military leave of absence in writing, Your coverage (including Dependent Accidental Death and Dismemberment coverage) may be continued in accordance with legal requirements and the regional policy to a maximum of 12 months. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Disability Insurance: If You are working for the Policyholder and:

- are covered by; and
- meet the definition of disabled under;
  - — Group Disability Insurance Policy, issued by Hartford Your coverage (including Dependent Accidental Death and Dismemberment coverage) may be continued in accordance with regional policy
  - — Sickness or Injury: If You are not Actively at Work due to sickness or injury, all of Your coverages (including Dependent Accidental Death and Dismemberment coverage) may be continued by your region:
- for a period up to twelve consecutive months from the date You were last Actively at Work; or
- if such absence results in a leave of absence in accordance with state and/or federal family and medical leave laws, then the combined continuation period will not exceed twelve consecutive months.

Family and Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage (including Dependent Accidental Death and Dismemberment coverage) may be continued for up to 12 weeks, or longer if required by other applicable law, or permitted by regional company practice following the date Your leave commenced. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

Continuation for Dependent Child(ren) with Disabilities

If Your Dependent Child(ren) reach the age at which they would otherwise cease to be a Dependent as defined, and they are:

- age 26 or older; and
- disabled; and
- primarily dependent upon You for financial support;

then Dependent Child(ren) coverage will not terminate solely due to age. However:

- You must submit proof satisfactory to Hartford of such Dependent Child(ren)'s disability within 31 days of the date he or she reaches such age; and
- such Dependent Child(ren) must have become disabled before attaining age 26.

Coverage under The Policy will continue as long as:

- You remain insured;
- the child continues to meet the required conditions; and
- any required premium is paid when due.

However, no increase in the Amount of Dependent Accidental Death and Dismemberment Insurance for such Dependent Children will be available. Hartford has the right to require proof, satisfactory to Hartford, as often as necessary during the first two years of continuation, that the child continues to meet these conditions. Hartford will not require proof more often than once a year after that.

Benefits

Accidental Death and Dismemberment Benefit

If You or Your Dependents sustain an Injury that results in any of the following Losses, except loss of Life, within 365 days of the date of accident, Hartford will pay the injured person's amount of Principal Sum, or a portion of such Principal Sum, as shown opposite the Loss after Hartford receives Proof of Loss, in accordance with the Proof of Loss provision. The loss period does not apply to Loss of Life. This Benefit will be paid according to the General Provisions of The Policy. Hartford will not pay more than the Principal Sum to any one person, for all Losses due to the same accident. The of Principal Sum is the amount of Accidental Death and Dismemberment you elected during enrollment. The amount of Your Dependent's Principal Sum is shown as a percentage of Your Principal Sum in the Schedule of Insurance.

Loss means with regard to:

- hands and feet, actual severance through or above wrist or ankle joints;
- sight, speech and hearing, entire and irrecoverable loss thereof;
- thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
- movement, complete and irreversible paralysis of such limbs.

For Loss of	*Benefit*
Life	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing in Both Ears	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia)	Principal Sum
Movement of Both Lower Limbs (Paraplegia)	Three-Quarters of Principal Sum
Movement of Three Limbs (Triplegia)	Three-Quarters of Principal Sum
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	One-Half of Principal Sum
Either Hand or Foot	One-Half of Principal Sum
Sight of One Eye	One-Half of Principal Sum
Speech or Hearing in Both Ears	One-Half of Principal Sum
Movement of One Limb (Uniplegia)	One-Quarter of Principal Sum
Thumb and Index Finger of Either Hand	One-Quarter of Principal Sum

Exposure and Disappearance

Exposure to the elements will be presumed to be Injury if:

- it results from the forced landing, stranding, sinking or wrecking of a conveyance in which You or Your Dependents were an occupant at the time of the accident; and
- The Policy would have covered an Injury resulting from the accident Hartford will presume that You or Your Dependents suffered Loss of life if:
  - — the person's body has not been found within one year after the disappearance of a conveyance in which he or she was an occupant at the time of its disappearance;
  - — the disappearance of the conveyance was due to its accidental forced landing, stranding, sinking or wrecking; and
  - — The Policy would have covered an Injury resulting from the accident.

Seat Belt Benefit

If You or Your Dependents sustain an Injury that results in a Loss payable under the Accidental Death and Dismemberment Benefit, Hartford will pay an additional Seat Belt Benefit of 10% of Principal sum to a maximum amount of $10,000, if the Injury occurred while the injured person was:

- a passenger riding in; or
- the licensed operator of;

a properly registered Motor Vehicle and was wearing a Seat Belt at the time of the Accident as verified on the police accident report.

This Benefit will be paid:

- after Hartford receives Proof of Loss, in accordance with the Proof of Loss provision; and
- according to the General Provisions of The Policy.

The Seat Belt Benefit is the lesser of:

- an amount resulting from multiplying the injured person's amount of Principal Sum by the Seat Belt Benefit Percentage; or
- the Maximum Amount for this Benefit.

If it cannot be determined that the injured person was wearing a Seat Belt at the time of Accident, a Minimum Benefit will be payable under the Seat Belt Benefit.

Accident, for the purpose of this Benefit only, means the unintentional collision of a Motor Vehicle during which the injured person was wearing a Seat Belt.

Seat Belt means:

- an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Motor Vehicle, or

proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications; or

- a child restraint device that meets the standards of the National Safety Council and is properly secured and used in accordance with applicable state law and installed according to the recommendations of its manufacturer for children of like age and weight.

The Seat Belt Benefit will not be payable if the injured person is operating the Motor Vehicle at the time of Injury while:

- Intoxicated; or
- taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician.

Intoxicated means:

- the blood alcohol content;
- the results of other means of testing blood alcohol level; or
- the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Child Education Benefit

If You or Your Spouse sustains an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Benefit, Hartford will pay an additional Child Education Benefit of 2% of Principal sum to a maximum amount of $5,000 to Your Dependent Child(ren). This Benefit will be paid:

- after Hartford receives proof that your Dependent Child(ren) qualify as a Student, as defined in this Benefit; and
- according to the General Provisions of The Policy.

If You die, the Child Education Benefit provides an annual amount equal to the lesser of:

- the amount resulting from multiplying Your Principal Sum by the Child Education Percentage; or
- the Maximum Amount for this Benefit.

If Your Spouse dies, the Child Education Benefit provides an annual amount equal to the lesser of:

- the amount resulting from multiplying Your Spouse's amount of Principal Sum by the Child Education Percentage; or
- the Maximum Amount for this Benefit.

The Child Education Benefit is payable to each of Your Dependent Child(ren):

- on the date; and
- for whom;

Hartford has received proof satisfactory to Hartford that he or she is a Student. If he or she is a minor, Hartford will pay the benefit to the Student's legal guardian. Hartford will pay the Child Education Benefit to a qualifying Student until the first to occur of:

- Hartford's payment of the fourth Child Education Benefit to or on behalf of that person; or
- the end of the 12th consecutive month during which Hartford have not received proof satisfactory to Us that he or she is a Student.

Hartford will not pay more than one Child Education Benefit to any one Student during any one school year.

Hartford will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision of The Policy if:

- a Principal Sum is payable because of Your death or Your Spouse's death; and
- no person qualifies as a Student.

Student means Your Dependent Child(ren) who is covered on the date of Your or Your Spouse's death and:

- is a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning on the date of Your or Your Spouse's death; or
- became a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning within 365 days after Your or Your Spouse's death and was a student in the 12th grade on the date of Your or Your Spouse's death. If the institution establishes full-time status in any other manner, Hartford reserve the right to determine whether the student qualifies as a Student.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Day Care Benefit

If You or Your Spouse sustains an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Benefit, Hartford will pay an additional Day Care Benefit of 3% of principal sum to a maximum of $5,000 for each of your Dependent Children who are covered if such Dependent Child is under age 7 at the time of Your or Your Spouse's death.

This Benefit will be paid:

- after Hartford receives proof of enrollment in a Day Care Program as described in this Benefit; and
- according to the General Provisions of The Policy.

Hartford will make one Day Care Benefit payment each year, for a maximum of 4 Day Care Benefit payments, for each Dependent Child. The Benefit will be paid to the person who has primary responsibility for the Dependent Child's Day Care expenses.

Proof of enrollment satisfactory to Hartford for each Dependent Child in a Day Care Program includes, but will not be limited to, the following:

- a copy of the Dependent Child's approved enrollment application in a Day Care Program;
- cancelled check(s) evidencing payment to a Day Care facility or Day Care provider;
- a letter from the Day Care facility or Day Care provider stating that the Dependent Child:
  - — is attending a Day Care Program; or
  - — has been enrolled in a Day Care Program and will be attending within 365 days of the date of the death.

Proof of enrollment must be sent to Hartford prior to the last day of the 12th month following the date of death.

If you die, the Day Care Benefit pays an amount equal to the lesser of:

- the amount resulting from multiplying Your Principal sum by the Day Care Benefit Percentage; or
- the Maximum Amount for this Benefit.

If Your Spouse dies, the Day Care Benefit pays an amount equal to the lesser of:

- the amount resulting from multiplying Your Spouse's amount of Principal sum by the Day Care Benefit Percentage; or
- the Maximum Amount for this Benefit.

Hartford will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision for payment of benefits for Loss of life if:

- a Principal Sum is payable because of the deceased person's death; and
- no person qualifies as a Child eligible for the Day Care Benefit.

Day Care or Day Care Program means a program of child care which:

- is operated in a private home, school or other facility;
- provides, and makes a charge for, the care of children; and
- is licensed as a day care center or is operated by a licensed day care provider, if such licensing is required by the state or jurisdiction in which it is located; or
- licensing is not required, provides childcare on a daily basis for 12 months a year.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Spouse Education Benefit

If You sustain an Injury that results in a Loss of life, payable under the Accidental Death and Dismemberment Benefit, Hartford will pay an additional Spouse Education Benefit of 100% of Principal sum to a maximum amount of $5,000 to Your surviving Spouse. Your Spouse must be covered under The Policy in order to receive this Benefit. This Benefit will be paid:

- after Hartford received proof satisfactory to artford that the Spouse has enrolled in an Occupational Training program; and
- according to the General Provisions of The Policy.

The Spouse Education Benefit is the least of:

- the Expense Incurred for Occupational Training;
- the amount resulting from multiplying Your Principal Sum by the Spouse Education Benefit Percentage; or
- the Maximum Amount for this Benefit.

If a Principal Sum is payable because of Your death and there is no surviving Spouse, Hartford will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision.

Your surviving Spouse must enroll in Occupational Training:

- for the purpose of obtaining an independent source of income; and
- within one (1) year of Your death.

Occupational Training means any:

- education;
- professional; or
- trade training;

program which prepares the Spouse for an occupation for which he or she was not previously qualified.

Expense Incurred means:

- the actual tuition charged, exclusive of room and board; and
- the actual cost of the materials needed;for the Occupational Training.

The expense must be incurred within two (2) years of the date of Your death.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Accident Hospital Income Benefit

If You or Your Dependents are Confined in a Hospital during one or more Periods of Confinement and the:

- Confinement is due to Injury;
- first day of Confinement occurs within 30 days after the accident; and
- the Confinement exceeds the Waiting Period;

Hartford will pay the Monthly Accident Hospital Income Benefit of $2500 or a portion thereof, for each month the injured person is Confined after meeting a 4 day waiting period.

This Benefit will be paid:

- after Hartford receive Proof of Loss, in accordance with the Proof of Loss provision; and
- according to the General Provisions of The Policy. Hartford will not pay for any Day of Confinement which:
  - is during the Waiting Period at the beginning of Confinement;
  - exceeds the Payment Period; or
  - occurs more than two (2) years after the date of accident.

Hartford will pay for the days during the Waiting Period if:

- the Waiting Period states that "payment is retroactive"; and
- the Confinement exceeds the Waiting Period.

The Waiting Period is applied only once for any one accident if the injured person is confined more than once due to the same Injury.

Confined or Confinement means being an inpatient in a Hospital due to Injury.

Day of Confinement means a day of inpatient confinement in a Hospital for which a daily room and board charge is made for a full day of confinement.

Period of Confinement means the interval of time during which an injured person is Confined as an inpatient in a Hospital. A Period of Confinement begins on the date of admission to the Hospital and ends on the date of release from the Hospital. If a Benefit is payable, and the injured person is subsequently Confined to a Hospital for the same Injury within 90 days, Hartford will consider it the same Period of Confinement. The specific amounts for this Benefit are shown in the Schedule of Insurance.

Exclusions

The Policy does not cover any loss caused or contributed to by:

- intentionally self-inflicted Injury;
- suicide or attempted suicide, whether sane or insane;
- war or act of war, whether declared or not;
- Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;

(Hartford will refund the pro rata portion of any premium paid for You or Your Dependents while You or Your Dependents are in the armed forces on full-time active duty, for a period of two months or more. Written notice must be given to Us within 12 months of the date You or Your Dependents enter the armed forces);

- Injury sustained while On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
- Injury sustained while On any aircraft:
  - — as a pilot, crewmember or student pilot;
  - — as a flight instructor or examiner;
  - — if it is owned, operated or leased by or on behalf of the Policyholder, or any Airgas or organization whose eligible persons are covered under The Policy;
  - — being used for tests, experimental purposes, stunt flying, racing or endurance tests; or
- Injury sustained or contracted in consequence of being under the influence of any narcotic; unless administered on the advice of a Physician;
- Injury sustained while committing or attempting to commit a felony; or
- Injury sustained or contracted in consequence of being Intoxicated.

Intoxicated means:

- the blood alcohol content;
- the results of other means of testing blood alcohol level; or
- the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

General Provisions

Notice of Claim

You, or the person who has the right to claim benefits, must give Hartford, written notice of a claim within 30 days after:

- the date of death; or
- the date of loss.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address and the Policy Number. (Airgas Policy No. 675809).

Claim Forms

YBR will send forms to the claimant to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If the forms are not received within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of the claim.

Proof of Loss

Proof of Loss may include, but is not limited to, the following:

- a completed claim form;
- a certified copy of the death certificate (if applicable);
- Your Enrollment form;
- Your Beneficiary Designation (if applicable);
- any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- the names and addresses of all:
  - — Physicians or other qualified medical professionals You have consulted;
  - — hospitals or other medical facilities in which You have been treated; and
  - — pharmacies which have filled Your prescriptions within the past three years;

- Your signed authorization for Us to obtain and release medical, employment and financial information (if applicable); or
- Any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

Sending Proof of Loss

Written Proof of Loss must be sent within 90 day(s) after the loss. All Proof of Loss should be sent to Us. However, all claims should be submitted to Us within 90 day(s) of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:

- it was not possible to give proof within the required time; and
- proof is given as soon as possible; but
- not later than 1 year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

Physical Examination and Autopsy

While a claim is pending Hartford has the right at Hartford's expense:

- to have the person who has a loss examined by a Physician when and as often as Hartford reasonably requires; and
- to have an autopsy performed in case of death where it is not forbidden by law.

Claim Payment

When Hartford determines that benefits are payable, Hartford will pay the benefits in accordance with the Claims to be Paid provision, but not more than 90 day(s) after such Proof of Loss is received.

Claims to be Paid

Benefits for Loss of Life will be paid in accordance with the Beneficiary Designation. If no beneficiary is named, payment will be made according to the beneficiary designation under the group life policy issued to the Policyholder and in effect at the time of death. If no beneficiary is named, or if no named beneficiary survives You, Hartford may, at Hartford's option, pay:

- the executors or administrators of Your estate; or
- all to Your surviving Spouse; or
- if Your Spouse does not survive You, in equal shares to Your surviving Child(ren); or
- if no Child survives You, in equal shares to Your surviving parents.

In addition, Hartford may, at Hartford's option, pay a portion of Your Accidental Death Benefit up to $500 to any person equitably entitled to payment because of expenses from Your burial. Payment to any person, as shown above, will release Hartford from liability for the amount paid. If any beneficiary is a minor, Hartford may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Hartford's option and in Hartford's opinion is providing financial support and maintenance for the minor. Hartford will pay:

- $200 at Your death; and
- monthly installments of not more than $200.

Payment to any person as shown above will release Hartford from all further liability for the amount paid.

Hartford will pay the Accidental Death and Dismemberment Insurance Benefit at Your Dependents' death to You, if living.

Otherwise, it will be paid, at Hartford's option, to Your surviving Spouse or the executors or administrators of Your estate.

Hartford will make any payments, other than for loss of life, to You. Hartford may make any such payments owed at Your death to Your estate. If any payment is owed to:

- Your estate;
- a person who is a minor; or
- a person who is not legally competent, then Hartford may pay up to $1,000 to a person who is related to You and who, at Hartford's sole discretion, is entitled to it. Any such payment shall fulfill Hartford's responsibility for the amount paid.

Beneficiary Designation: How do I designate or change my beneficiary?

You may designate or change a beneficiary by doing so through the Your Benefits Resources website *www.ybr.com/airgas* or by calling Your Benefits Resources Customer Care toll-free 1-877-4AG-BENEFITS. Only satisfactory designations made with Your Benefits Resources prior to Your death will be accepted. Beneficiary designations will become effective as of the date completed the designation on line. Hartford will not be liable for any amounts paid before being notified by YBR of the named beneficiary. In no event may a beneficiary be changed by a Power of Attorney.

Claim Appeal

On any claim, the claimant or his or her representative may appeal to Hartford for a full and fair review. To do so, he or she:

- must request a review upon written application within:
  - 180 days of receipt of claim denial if the claim requires Hartford to make a determination of disability; or
  - 60 days of receipt of claim denial if the claim does not require Hartford to make a determination of disability; and
- may request copies of all documents, records, and other information relevant to the claim; and
- may submit written comments, documents, records and other information relating to the claim.

Hartford will respond in writing with Hartford's final decision on the claim.

Policy Interpretation

Hartford has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Assignment

Except for the dismemberment benefits under the Accidental Death and Dismemberment Benefit, You have the right to absolutely assign Your rights and interest under The Policy including, but not limited, to the following:

- the right to make any contributions required to keep the insurance in force;
- the right to convert; and
- the right to name and change a beneficiary.

Hartford will recognize any absolute assignment made by You under The Policy, provided:

- it is duly executed; and
- a copy is acknowledged and on file with Us.

Hartford and the Policyholder assume no responsibility:

- for the validity or effect of any assignment; or
- to provide any assignee with notices which Hartford may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under The Policy.

Legal Actions

Legal action cannot be taken against Hartford:

- sooner than 60 days after the date Proof of Loss is furnished; or
- more than 3 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

Workers' Compensation

The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

State Law

To the extent applicable state law requires the insurer to provide additional benefits or other items not generally available under the plan; the insurer has agreed to provide them. If you have a question about a specific state law, contact Hartford.

Insurance Fraud

Insurance Fraud occurs when You, Your Dependents and/or Airgas provide Hartford with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Hartford. It is a crime if You, Your Dependents and/or Airgas commit Insurance Fraud. Hartford will use all means available to Hartford to detect, investigate, deter and prosecute those who commit Insurance Fraud. Hartford will pursue all available legal remedies if You, Your Dependents and/or Airgas perpetrate Insurance Fraud.

Misstatements

In the absence of Insurance Fraud, if material facts about You or Your Dependents were not stated accurately:

- the premium may be adjusted; and
- the true facts will be used to determine if, and for what amount, coverage should have been in force.

GLOSSARY

Active Employee means an employee who works for the Airgas on a regular basis in the usual course of the Airgas' business. This must be at least the number of hours shown in the Schedule of Insurance.

Actively at Work means at work with Airgas on a day that is one of Airgas's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your job:
- in the usual way; and
- for Your usual number of hours.

Hartford will also consider You to be Actively At Work on any regularly scheduled vacation day or holiday, only if You were Actively At Work on the preceding scheduled work day. Actively at Work does not include everyday travel to and from work.

Airworthiness Certificate means:
- the "Standard" Airworthiness Certificate issued by the United States Federal Aviation Administration (FAA); or
- a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

Civil or Public Aircraft means a civil or public aircraft which:
- has a current and valid Airworthiness Certificate;
- is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and
- is not operated by the militia, or armed forces of any state, national government or international authority.

Common Carrier means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by that concern. Common Carrier will not mean any such conveyance which is hired or used for a sport, gamesmanship, contest, sightseeing, observatory and/or recreational activity, regardless of whether such conveyance is licensed.

Contributory Coverage means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.

Earnings means Benefit Salary Your benefits salary on the date you first become covered under this Plan will determine your benefits on that date. The term "benefits salary" for purposes of determining an annual amount is defined as your annual base salary if you are paid on a salaried basis, and your straight-time hourly rate multiplied by 2080 if you are paid on an hourly basis. If you are paid in part by salary and part by commission, "benefits salary" means your base pay plus your commissions for the previous 12 months. For new employees, base salary and hourly rate are determined as of date of hire. Your benefits salary will be adjusted annually effective each January 1 based on changes in your annual base salary, base salary and commissions or straight-time hourly rate, as the case may be, for the 12-month period ending on the preceding July 1st (or for changes in base salary or hourly rate, the date during the first week of July, if any, that your regional company elects to apply). "Benefits salary", for example, would be determined for the 2010 plan year by including any changes to annual base salary, base salary and commissions or straight time hourly rate for the period July 2, 2008 – July 1, 2009 and become effective January 1, 2010 and end on December 31, 2010. For new employees, base salary and hourly rate are determined as of date of hire. Commissions are based on expected commission payments for the year

Airgas means the Policyholder.

FAA means:
- the Federal Aviation Administration of the United States; or
- the equivalent aviation authority for the country of the aircraft's registry, if the governmental authority is recognized by the United States.

Hospital means an institution which:
- operates pursuant to law;
- primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
- operates facilities for medical and surgical diagnosis and treatment by or under the supervision of Physicians; and
- provides 24-hour nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:
- a nursing home, convalescent home, or skilled nursing facility;
- a place for rest, custodial care, or for the aged;
- a clinic; or
- a place for the treatment of mental illness, alcoholism, or substance abuse.

However, a place for the treatment of mental illness, alcoholism or substance abuse will be regarded as a Hospital if it is:
- part of an institution that meets the above requirements; and
- listed in the American Hospital Association Guide as a general Hospital.

Injury means bodily injury resulting:
- directly from an accident; and
- independently of all other causes;

which occurs while You or Your Dependents are covered under The Policy.

Loss resulting from:
- sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
- medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

Military Transport Aircraft means a transport aircraft operated by:
- the United States Air Mobility Command (AMC); or
- a national military air transport service of a governmental authority recognized by the United States.

Motor Vehicle means a self-propelled, four (4) or more wheeled:
- private passenger: car, station wagon, van or sport utility vehicle;
- motor home or camper; or
- pick-up truck;

not being used as a Common Carrier.

A Motor Vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers or any other type of equipment vehicles.

On means, when used with reference to any conveyance (land, water or air), in or on, boarding or alighting from the conveyance.

Physician means a person who is:
- a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that Hartford recognize or are required by law to recognize;
- licensed to practice in the jurisdiction where care is being given;
- practicing within the scope of that license; and
- not Related to You by blood or marriage.

Prior Policy means the group accidental death and dismemberment insurance Policy carried by the Policyholder on the day before the Policy Effective Date and will only include the coverage which is transferred to Hartford.

Related means Your Spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, grandchild, or step-child.

Spouse means Your spouse who is not legally separated or divorced from You.

The Policy means the policy which Hartford issued to the Policyholder under the Policy Number shown on the face page.

Hartford, Us, or Hartford's means the insurance company named on the face page of The Policy.

You or Your means the person to whom this certificate is issued.

Short Term Disability Insurance
Summary Plan Description

Airgas

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SHORT TERM DISABILITY

The following is a description of the short-term disability benefits program included in the Airgas Comprehensive Welfare Benefit Plan. This section of your Summary Plan Description is intended to be your source for information about the short-term disability benefit.

The benefit description in this section is for summary purposes only. Every effort has been made to ensure that the information correctly reflects the terms of the plan documents. In all cases, however, the official plan documents will control administration and operation of this program and contracts

Eligibility for Coverage

You will become eligible for coverage on the later of:

• the day after the date you complete 30 days of continuous service in an eligible employee group of Airgas provided you are regularly scheduled to work at least 30 hours per week.

• As of your date of hire with Airgas, if you are a member of an acquired employee group, and are in an eligible employee group.

Enrollment

All eligible Active Employees will be enrolled automatically.

Effective Date

Coverage begins on the date You become eligible.

Waiting Period

Benefits under this Program begin to be payable after you are absent from work due to a "qualified absence" for more than seven consecutive calendar days.

Other Paid Time Off

You may be required to use your sick days, personal days and paid vacation time before you receive short-term disability benefits based on your work location and applicable state law.

Qualified Absence

To receive benefits under this Program, you must be receiving regular treatments from a physician for an injury or illness, which prevents you from engaging in any work for compensation as determined by The Hartford our claims administrator. In addition, the injury or illness must not be an injury or illness

- for which you are entitled to benefits under any Worker's Compensation Law, Occupational Disease Law or similar legislation which provides benefits to you;
- which you sustained or contracted while on duty with any military, naval, air or armed force, to include reserve training and national guard duty, of any jurisdiction or international organization;
- which resulted from an act of war;
- which was intentionally self-inflicted (regardless of whether you were sane or insane at the time of infliction); or
- which you incurred while engaging in a criminal act (whether a felony or misdemeanor) or while participating in a riot or public disturbance.

Benefit Amount

Basic Plan: The maximum benefit amount is $300 per week. For any week in which you are eligible for benefits for less than the entire work week, you will receive 20% of the weekly benefit amount for each day in that week that you are eligible for benefits.

The benefit duration is determined based on your length of service with Airgas on the date your disability begins. If you have less than one year of service with Airgas the maximum duration of your benefit is 8 weeks. For service of one full year and above the maximum benefit duration is 26 weeks.

Your Benefit amount will be reduced by amounts you receive on account of illness or disability from a governmental plan that provides disability benefits.

Please note that the annual benefits base salary does not include bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation.

Maximum Coverage

You may receive benefits for a maximum of twenty-six (26) weeks in any period of fifty-two (52) weeks. For this purpose the fifty-two weeks begins with the first day for which you receive benefits under the Program and each anniversary of that date. Also, for purposes of determining the maximum period for which you may receive benefits, any period during which you receive benefits on account of disability from a governmental plan will be treated as if the benefits were paid under this Program and will count against the limit.

Medical Certification

The Hartford, as claim administrator, may require that you provide written reports from your physician certifying that you are unable to work due to an injury or illness which this Program covers. In addition The hartford at no expense to you, may require as a pre-condition of your initially receiving benefits or continuing to receive benefits that you be examined by a physician it selects. The Hartford reserves the absolute and unlimited right to deny your claim for benefits or terminate your benefits if you do not agree to such examination or if the physician it selected determines that in his or her opinion you are able to return to work.

Family and Medical Leave Act

As a condition for benefits, you will be required to treat the period for which you receive benefits under this Program as a Family and Medical Leave Act absence.

Termination of Employee Status

If your employment with Airgas terminates for any reason other than gross misconduct while you are receiving benefits under this Program, you will remain eligible for the maximum benefit period (up to 26 weeks total) or until you are no longer disabled, whichever occurs first.

Administration

If you will be out of work more than seven consecutive calendar days due to accidental injury or sickness and are eligible to participate in this Program, you may apply for short term disability benefits. The process for applying for benefits is:

- You (or a family representative) must notify your immediate supervisor and your Human Resource Specialist.
- Associates may initiate their Short Term Disability claims one of three ways:
  - Telephonically – 800-549-6514, 8am – 8pm EST
  - Electronically – www.TheHartford.com – 24/7access
  - Digitally – The app can be downloaded for free to any mobile device by finding "My Benefits at The Hartford" in the Apple® App Store(SM) or Google Play™ Store.

Note: If you are disabled longer than originally stated by the physician (or an estimated return date was not given) on the initial Claim The Hartford may send you a supplemental disability claim form. As a condition to continue receiving the benefit, The Hartford may also request information (which may include medical certification from either your physician and/or its physician) from you approximately every four weeks. Your Human Resource Specialist will be copied on the request for information.

- When you are ready to return to work, you should notify your Human Resource Specialist. This notice must be accompanied by a release from your doctor stating that you are ready to return to work.
- You (or a family representative) and your Human Resource Specialist should be in regular communication regarding your status. If it appears that you may have a long period of absence that may extend beyond the maximum 26 weeks of short-term disability benefits, the process of applying for a Long Term Disability benefit (if available) may be started at the 18th week of Short Term Disability.

Taxes

Any amounts that must be deducted, under the tax law of any jurisdiction, will be withheld from your benefit payments.

State Requirements

If the laws of any jurisdiction require that you receive disability benefits greater than the benefits this Program provides, Airgas will pay those benefits in place of the benefits under this Program.

Your Health & Welfare Benefits While on Disability

Medical, dental, vision, life, LTD, AD&D insurance and your Health Care Flexible Spending Account (HCFSA) will continue for the duration of your STD. When you are no longer receiving a payroll check from Airgas, you will be responsible for the employee cost of your benefits. Your Benefits Resources™ (YBR) will send a Status Change Notice to your home and will begin to bill you for the cost of your benefits. Your initial bill is mailed within 7 days of YBR receiving notice of your billing status. After the initial bill, ongoing billing statements are generated on the 10th of the month and mailed on the 15th; YBR bills one month in advance. For more information regarding YBR's billing process, please call 877-424-2363.

If you are enrolled in the HCFSA, your YSA debit card may be suspended during your leave. When you return to an active employment status your YSA debit card will be reactivated. However, you can continue to submit your claims online via your YBR account or fax or mail

your claims. If your leave extends beyond December 31st your HCFSA will terminate at year-end and you will be eligible to re-enroll upon your return-to-work.

The Dependent Care FSA will end on your status effective date, minus one day. You may re-enroll upon your return to active employment status.

401(k) Plan and/or ESPP deductions will continue if you are being paid by Airgas. They will stop while you are receiving STD payments from The Hartford, but will automatically re-start when you return to work and are actively paid by Airgas again.

Long Term Disability Insurance
Summary Plan Description

Airgas

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LONG TERM DISABILITY INSURANCE

Schedule of Insurance

The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered injury, Sickness or pregnancy.

Eligibility Waiting Period for Coverage

Coverage begins on your 31st day of employment.. The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time Active Employee with the Employer under the Prior Policy.

Elimination Period

Option 1: 180 day(s)
Option 2: 180 day(s)

Maximum Monthly Benefit

Option 1: $2,500
Option 2: $10,000

Minimum Monthly Benefit

Minimum Monthly Benefit: $100

Benefit Percentage

Option 1: 50%
Option 2: 60%

Maximum Duration of Benefits Options 1 and 2

Age When Disabled PRIOR TO AGE 60	*Benefits Payable* TO AGE 65, OR FOR 60 MONTHS, IF GREATER
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Additional Benefits

Family Care Credit Benefit, Survivor Income Benefit, Workplace Modification Benefit—
(See Benefits Section)

ELIGIBILITY AND ENROLLMENT

Eligibility for Coverage

You are eligible to enroll in the Plan if you are a regular full-time Employee who is scheduled to work at least 30 hours per week. Coverage is effective on the 31st day of your employment. If you are eligible and a member of an acquired employee group, your coverage may be effective the date of your hire. If you are a member of a collective bargaining unit, you may not be eligible for Benefits described in this SPD. Please contact your Human Resources representative for more information.

Enrollment

For coverage under Option 1, all eligible Active Employees will be enrolled automatically.

For coverage under Option 2, You must enroll. To enroll for in Option 2, You must do so through the Your Benefit Resource website: *www.ybr.com/airgas* OR by contacting Your Benefits Resources Customer Care at 1-877-4AG-BENEFITS.

If You do not enroll within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll, You may enroll only:

- during an Annual Enrollment Period designated by the Policyholder; or
- within 31 days of the date You have a Change in Family Status.

PERIOD OF COVERAGE

Effective Date

Option 1 which is the non contributory portion of the coverage begins on the date You become eligible.

Option 2 which requires a contribution will start on the earliest of:

- the date You become eligible, if You enroll or have enrolled by then; or
- the date of your qualifying event that allows , if You enroll within 31 days after the date You are eligible; or
- the January 1st following the Annual Enrollment Period if You enroll during an Annual Enrollment Period.

Deferred Effective Date

If You are absent from work due to:

- accidental bodily injury;
- sickness;
- Mental Illness;
- Substance Abuse; or
- pregnancy;

on the date Your insurance, or increase in coverage, would otherwise have become effective, Your insurance, or increase in coverage will not become effective until You are Actively at Work one full day.

Changes in Coverage

You may change Your benefit option only:

- during an Annual Enrollment Period; or
- within 31 days of a Change in Family Status.

At such time You may decrease coverage, or increase coverage to a higher option.

If You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on January 1st following the Annual Enrollment Period.

If You enroll for a change in benefit option within 31 days following a Change in Family Status, the change will take effect on the date of the qualifying event.

Any such increase in coverage is subject to the following provisions:

- Deferred Effective Date; and
- Pre existing Conditions Limitations.
- change in employment.

Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, subject to the following provisions:

- Deferred Effective Date; and
- Pre existing Conditions Limitations.

Continuity From a Prior Policy

If You were:

- insured under the Prior Policy; and
- not eligible to receive benefits under the Prior Policy;

on the day before the Policy Effective Date, the Deferred Effective Date provision will not apply

If You become insured under The Policy on the Policy Effective Date and were covered under the Prior Policy on the day before the Policy Effective Date, the Pre-existing Conditions Limitation will end on the earliest of:

- the Policy Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
- the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

The amount of Monthly Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of:

- the Monthly Benefit which was paid by the Prior Policy; or
- the Monthly Benefit provided by The Policy.

The Pre-existing Conditions Limitation will apply after the Policy Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of group or a change in The Policy.

If You received monthly benefits for disability under the Prior Policy, and You returned to work as a Full-time Active Employee before the Policy Effective Date, then, if within 6 months of Your return to work:

- You have a recurrence of the same disability while covered under The Policy; and
- there are no benefits available for the recurrence under the Prior Policy;

the Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.

Termination

Your coverage will end on the earliest of the following:

- the date The Policy terminates;
- the date The Policy no longer insures Your group;
- the date the premium payment is due but not paid;
- the last day of the period for which You make any required premium contribution;
- the date Airgas terminates Your employment; or
- the date You cease to be a Full time Active Employee in an eligible group for any reason;

unless continued in accordance with any of the Continuation Provisions.

Continuation Provisions

Coverage can be continued by Airgas beyond a date shown in the Termination provision, if Airgas provides a plan of continuation which applies to all l company employees the same way. Continued coverage:

- is subject to any reductions in The Policy;
- is subject to payment of premium by the Employer; and
- terminates if:
  - — The Policy terminates; or
  - — coverage for Your group terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

- — Leave of Absence: If You are on a documented leave of absence, other than Family or Medical Leave, coverage will cease immediately.
- — Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 12 weeks, or longer if required by other applicable law, following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Coverage while Disabled

If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

- during the Elimination Period while You remain Disabled by the same Disability; and
- after the Elimination Period for as long as You are entitled to benefits under The Policy.

Waiver of Premium

No premium will be due for You:

- after the Elimination Period; and
- for as long as benefits are payable.

Extension of Benefits for Total Disability

If You are entitled to benefits while Disabled and The Policy terminates, benefits:

- will continue as long as You remain Disabled by the same Disability; but
- will not be provided beyond the date The Hartford would have ceased to pay benefits had the insurance remained in force. Termination of The Policy for any reason will have no effect on The Hartford's liability under this provision.

BENEFITS

Disability Benefit

The Hartford will pay You a Monthly Benefit if You:

- become Disabled while insured under The Policy;
- are Disabled throughout the Elimination Period;
- remain Disabled beyond the Elimination Period; and
- submit Proof of Loss to Hartford.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. However, benefits will not exceed the Maximum Duration of Benefits.

The Maximum Duration of Benefits for Own Occupation, and as a result Your Current Monthly Earnings are less that 80% of Your Indexed Pre-disability Earnings, is 24 months. After 24 months, Disabled means Any Occupation.

Mental Illness And Substance Abuse Benefits

If You are Disabled because of:

- Mental Illness that results from any cause;
- any condition that may result from Mental Illness;
- alcoholism which is under treatment; or
- the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance; then, subject to all other provisions of The Policy, The Hartford will limit the Maximum Duration of Benefits. Benefits will be payable:
  - — for as long as you are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
  - — if not confined, or after you are discharged and still Disabled, for a total of 24 month(s) for all such disabilities during your lifetime.

Recurrent Disability

Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, if the number of days You return to work as an Active Employee are less than one-half (1/2) the number of days of Your Elimination Period. Any day within such period of Recovery, will not count toward the Elimination Period. After the Elimination Period, if You return to work as an Active Employee and then become Disabled and such Disability is:

- due to the same cause; or
- due to a related cause; and
- within 6 month(s) of the return to work;

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force. If You return to work as an Active Employee for 6 month(s) or more, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits.

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Recover or Recovery means that You are no longer Disabled and have returned to work with the Employer and premiums are being paid for You.

Calculation of Monthly Benefit

If You remain Disabled after the Elimination Period, but work while You are Disabled, The Hartford will determine Your Monthly Benefit for a period of up to 12 consecutive months as follows:

- multiply Your Pre-Disability Earnings by the Benefit Percentage;
- compare the result with the Maximum Benefit; and
- from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit.

However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds 100% of Your Pre-disability Earnings, The Hartford will reduce Your Monthly Benefit by the amount of excess. The 12 consecutive month period will start on the last to occur of:

- the day You first start work; or
- the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, The Hartford will calculate Your Monthly Benefit as follows:

- multiply Your Monthly Income Loss by the Benefit Percentage;
- compare the result with the Maximum Benefit; and
- from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

Please note that your Monthly Earnings are based on your annual benefits base salary which does not include bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation.

If the sum of Your Monthly Benefit, Current Monthly Earnings and Other Income Benefits exceeds 100% of Your Pre-disability Earnings, The Hartford will reduce Your Monthly Benefit by the amount of the excess. However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit. If an overpayment occurs, The Hartford may recover all or any portion of the overpayment, in accordance with the Overpayment Recovery provision.

Minimum Monthly Benefit

Your Monthly Benefit will not be less than $100 per month.

Partial Month Payment

If a Monthly Benefit is payable for a period of less than a month, The Hartford will pay 1/30 of the Monthly Benefit for each day You were Disabled.

Your Health & Welfare Benefits While on Disability

Medical, dental, vision, and life insurance continue for six (6) months from the end of short term disability (STD) coverage as long as you pay via Direct Bill from YBR. If you do not pay the bill, your coverage will be canceled and COBRA coverage is not available. At the end of six (6) months of paid premiums, you will be mailed paperwork for COBRA coverage and Life insurance conversion. **Life insurance conversion paperwork must be returned no later than 31 days from the end of coverage or 15 days from the date of notice**. The Hartford will automatically apply for Waiver of Premium for you upon being approved for LTD. You will be notified if you are approved. For more information, you can contact YBR at 877-424-2363.

You will receive COBRA to continue your FSA account through the end of the current year. AD&D coverage ends the last day of STD coverage. 401(k) contributions only continue when you are being actively paid by Airgas.

Termination of Payment

Benefit payments will stop on the earliest of:

- the date You are no longer Disabled, as defined by The Hartford;

  The Hartford defines Disabled as Your Occupation, for the 24 months following the Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Indexed Pre-disability Earnings; and after that, **Any Occupation**.

- the date You fail to furnish Proof of Loss;
- the date You are no longer under the Regular Care of a Physician;
- the date You refuse The Hartford's request that You submit to an examination by a Physician or other qualified medical professional;
- the date of Your death;
- the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
- the last day benefits are payable according to the Maximum Duration of Benefits Table; or
- the date Your Current Monthly Earnings exceed:
  - 80% of Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation; or
  - 60% of Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Any Occupation;
- the date You refuse to participate in a Rehabilitation program, or refuse to cooperate with or try:
  - modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
  - adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
  - modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
  - adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodates Your medical limitation.

Family Care Credit Benefit

If You are working as part of a program of Rehabilitation, The Hartford will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from work as a part of a program of Rehabilitation, subject to the following limitations:

- Family Care means the care or supervision of:
  - Your children under age 13; or
  - a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
- the maximum monthly deduction allowed for each qualifying child or family member is:
  - $350 during the first 12 months of Rehabilitation; and
  - $175 thereafter; but in no event may the deduction exceed the amount of Your monthly earnings;
- Family Care Credits may not exceed a total of $2,500 during a calendar year;
- the deduction will be reduced proportionally for periods of less than a month;
- the charges for Family Care must be documented by a receipt from the caregiver;
- the credit will cease on the first to occur of the following:
  - You are no longer in a Rehabilitation program; or
  - Family Care Credits for 24 months have been deducted during Your Disability; and
- no Family Care provided by someone Related to the family member receiving the care will be eligible as a deduction under this provision. Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly

Income Loss. In no event will You be eligible to receive a Monthly Benefit under The Policy if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed 80% of Your Indexed Pre-disability Earnings.

The Hartford has the right, at their expense, to have You examined or evaluated by:

- a Physician or other health care professional; or
- a vocational expert or rehabilitation specialist;

of The Hartford's choice so that The Hartford may evaluate the appropriateness of any proposed modification.

Workplace Modification means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of The Policy.

Cafeteria Plan Election Restriction

The Policy is a part of a Cafeteria Plan sponsored by Airgas and governed by the requirements of Section 125 of the Internal Revenue Code. The rules of the Cafeteria Plan will supersede any provisions of The Policy which are in conflict with them. Cafeteria Plans are subject to the following restriction: The benefits You elect during the enrollment period will remain in effect until the next enrollment period. Section 125 allows exception to this rule only in specified situations, including Change in Family Status and commencement or termination of employment.

EXCLUSIONS AND LIMITATIONS

Exclusions

The Policy does not cover, and The Hartford will not pay a benefit for any Disability:

- unless You are under the Regular Care of a Physician;
- that is caused or contributed to by war or act of war (declared or not);
- caused by Your commission of or attempt to commit a felony;
- caused or contributed to by Your being engaged in an illegal occupation; or
- caused or contributed to by an intentionally self inflicted injury.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

- was sponsored by Airgas; and
- was terminated before the Effective Date of The Policy;

no benefits will be payable for the Disability under The Policy.

Pre-existing Condition Limitation

The Hartford will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled:

- You have not received Medical Care for the condition for 90 consecutive day(s) while insured under The Policy; or
- You have been continuously insured under The Policy for 365 consecutive day(s).

Pre-existing Conditions means:

- any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
- any manifestations, symptoms, findings, or aggravations relating to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse;

for which You received Medical Care during the 90 day(s) period that ends the day before:

- Your effective date of coverage; or
- the effective date of a Change in Coverage.

Medical Care is received when a physician or other health care provider:

- is consulted or gives medical advice; or
- recommends, prescribes or provides Treatment.

Treatment includes, but is not limited to:

- medical examinations, tests, attendance, or observation; and
- use of drugs, medicines, medical services, supplies or equipment.

GENERAL PROVISIONS

Notice of Claim

The STD to LTD transition will be seamless if The Hartford has a Short Term claim. If the associate is not eligible for Short Term Disability due to a workers' compensation injury or illness, or any other reason, then a paper LTD application is required. Paper LTD applications should be submitted to The Hartford on or about the 4th month of disability, if a return to work is not expected. An Associate may also initiate a Long Term Disability claim on the employee website, www.thehartfordatwork.com.

Proof of Loss

Proof of Loss may include but is not limited to the following:

- documentation of:
  - — the date Your Disability began;
  - — the cause of Your Disability;
  - — the prognosis of Your Disability;
  - — Your Pre-disability Earnings, Current Monthly Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
  - — evidence that You are under the Regular Care of a Physician;
- any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- the names and addresses of all:
  - — Physicians or other qualified medical professionals You have consulted;
  - — hospitals or other medical facilities in which You have been treated; and
  - — pharmacies which have filled Your prescriptions within the past three years;
- Your signed authorization for The Hartford to obtain and release:
  - — medical, employment and financial information; and
  - — any other information The Hartford may reasonably require;
- Your signed statement identifying all Other Income Benefits; and
- proof that You and Your dependents have applied for all Other Income Benefits which are available.

All proof submitted must be satisfactory to Hartford.

Additional Proof of Loss

To assist The Hartford in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, The Hartford has the right to require You to:

- meet and interview with our representative; and
- be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of The Hartford's choice.

Any such interview, meeting or examination will be:

- at The Hartford's expense; and
- as reasonably required by The Hartford .

Your Additional Proof of Loss must be satisfactory to The Hartford . Unless The Hartford determines You have a valid reason for refusal, The Hartford may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by The Hartford's representative.

Sending Proof of Loss

Written Proof of Loss must be sent to The Hartford within 90 days after the start of the period for which The Hartford is liable for payment. If proof is not given by the time it is due, it will not affect the claim if:

- it was not possible to give proof within the required time; and
- proof is given as soon as possible; but
- not later than 1 year after it is due, unless You are not legally competent.

The Hartford may request Proof of Loss throughout Your Disability. In such cases, The Hartford must receive the proof within 30 day(s) of the request.

Claim Payment

When The Hartford determine that You;

- are Disabled; and
- eligible to receive benefits;

The Hartford will pay accrued benefits at the end of each month that You are Disabled. The Hartford may, at Our option, make an advance benefit payment based on The Hartford's estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss satisfactory to The Hartford is received.

Claims to be Paid

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

- Your estate;
- a person who is a minor; or
- a person who is not legally competent;

then The Hartford may pay up to $1,000 to a person who is Related to You and who, at The Hartford's sole discretion, is entitled to it. Any such payment shall fulfill The The Hartford's responsibility for the amount paid.

Claim Denial

If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

- give the specific reason(s) for the denial;
- make specific reference to The Policy provisions on which the denial is based;
- provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
- provide an explanation of the review procedure.

Claim Appeal

On any claim, You or Your representative may appeal to The Hartford for a full and fair review. To do so You:

- must request a review upon written application within:
  - 180 days of receipt of claim denial if the claim requires The Hartford to make a determination of disability; or
  - 60 days of receipt of claim denial if the claim does not require The Hartford to make a determination of disability; and a
- may request copies of all documents, records, and other information relevant to Your claim; and
- may submit written comments, documents, records and other information relating to Your claim.

The Hartford will respond to You in writing with The Hartford's final decision on the claim.

Social Security

You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of The Hartford's request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

- to follow the process established by the Social Security Administration to reconsider the denial; and
- if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

Benefit Estimates

The Hartford reserves the right to reduce Your Monthly Benefit by estimating the Social Security disability benefits You or Your spouse and children may be eligible to receive. When The Hartford determines that You or Your Dependent may be eligible for benefits, The Hartford may estimate the amount of these benefits. The Hartford may reduce Your Monthly Benefit by the estimated amount. Your Monthly Benefit will not be reduced by estimated Social Security disability benefits if:

- You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
- You have signed a form authorizing the Social Security Administration to release information about awards directly to The Hartford; and
- You have signed and returned The Hartford's reimbursement agreement, which confirms that You agree to repay all overpayments.

If The Hartford has reduced Your Monthly Benefit by an estimated amount and:

- You or Your Dependent are later awarded Social Security disability benefits, The Hartford will adjust Your Monthly Benefit when The Hartford receives proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
- Your application for Social Security disability benefits has been denied, The Hartford will adjust Your Monthly Benefit when You provide The Hartford proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals. If Your Social Security Benefits were lower than The Hartford estimated, and The Hartford owes You a re-

fund, The Hartford will make such refund in a lump sum. If Your Social Security Benefits were higher than The Hartford estimated, and If Your Monthly Benefit has been overpaid, You must make a lump sum refund to The Hartford equal to all overpayments, in accordance with the Overpayment Recovery provision.

Overpayment

An overpayment occurs:

- when The Hartford determine that the total amount The Hartford have paid in benefits is more than the amount that was due to You under The Policy; or
- when payment is made by The Hartford that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

- retroactive awards received from sources listed in the Other Income Benefits definition;
- failure to report, or late notification to The Hartford of any Other Income Benefit(s) or earned income;
- misstatement;
- fraud; or
- any error The Hartford may make.

Overpayment Recovery

The Hartford has the right to recover from You any amount that The Hartford determines to be an overpayment. You have the obligation to refund to The Hartford any such amount. The Hartford's rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under The Policy. If benefits are overpaid on any claim, You must reimburse The Hartford within 30 days. If reimbursement is not made in a timely manner, The Hartford have the right to:

- recover such overpayments from:
  - — You;
  - — any other organization;
  - — any other insurance company;
  - — any other person to or for whom payment was made; and
  - — Your estate;
- reduce or offset against any future benefits payable to You or Your survivors, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
- refer Your unpaid balance to a collection agency; and
- pursue and enforce all legal and equitable rights in court.

Subrogation

If You:

- suffer a Disability because of the act or omission of a Third Party;
- become entitled to and are paid benefits under The Policy in compensation for lost wages; and
- do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time; then The Hartford will be subrogated to any rights You may have against the Third Party and may, at The Hartford's option, bring legal action against the Third Party to recover any payments made by The Hartford in connection with the Disability.

Reimbursement

The Hartford has the right to request to be reimbursed for any benefit payments made or required to be made under The Policy for a Disability for which You recover payment from a Third Party. If You recover payment from a Third Party as:

- a legal judgment;
- an arbitration award; or
- a settlement or otherwise;

You must reimburse The Hartford for the lesser of:

- the amount of payment made or required to be made by The Hartford ; or
- the amount recovered from the Third Party less any reasonable legal fees associated with the recovery.

Third Party means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy.

Legal Actions

Legal action cannot be taken against The Hartford:

- sooner than 60 days after the date proof of loss is given; or
- more than 3 years after the date Proof of Loss is required to be given according to the terms of The Policy.

Insurance Fraud

Insurance Fraud occurs when You and/or Airgas provide The Hartford with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive The Hartford. It is a crime if You and/or Airgas commit Insurance Fraud. The Hartford will use all means available to The Hartford to detect, investigate, deter and prosecute those who commit Insurance Fraud. The Hartford will pursue all available legal remedies if You perpetrate Insurance Fraud.

Misstatements

If material facts about You were not stated accurately:

- Your premium may be adjusted; and
- the true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement, except fraudulent misstatements, made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

Policy Interpretation

The Hartford has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

DEFINITIONS

Actively at Work means at work with Airgas on a day that is one of Airgas' scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:
- in the usual way; and
- for Your usual number of hours.

The Hartford will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.

Active Employee means an Employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

Any Occupation means any occupation for which You are qualified by education, training or experience, and that has an earnings potential greater than the lesser of:
- the product of Your Indexed Pre-disability Earnings and the Benefit Percentage; or
- the Maximum Monthly Benefit.

Commissions means the monthly average of monetary commissions You received from Airgas over:
- the 12 month period immediately prior to the last day You were Actively at Work before You became Disabled; or
- the total period of time You worked for Airgas, if less than the above period.

Current Monthly Earnings means Monthly earnings You receive from:
- Airgas; and
- other employment; while You are Disabled.

However, if the other employment is a job You held in addition to Your job with Airgas, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceeds Your average earnings from the other employer over the 6 month(s) period just before You became Disabled will count as Current Monthly Earnings. Current Monthly Earnings also includes the pay You could have received for another job or a modified job if:
- such job was offered to You by Airgas, or another employer, and You refused the offer; and
- the requirements of the position were consistent with:
  - — Your education, training and experience; and
  - — Your capabilities as medically substantiated by Your Physician.

Disability or Disabled means You are prevented from performing one or more of the Essential Duties of:
- Your Occupation during the Elimination Period;
- Your Occupation, for the 24 month(s) following the

Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Indexed Pre-disability Earnings; and
- after that, Any Occupation.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, but Your Current Monthly Earnings are greater than 80% of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of 12 months from the original date of Disability, or until such time as Your Current Monthly Earnings are less than 80% of Your Pre-disability Earnings, whichever occurs first. For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by Airgas, or another employer, and You refused the offer.

Your Disability must result from:
- accidental bodily injury;
- sickness;
- Mental Illness;
- Substance Abuse; or
- pregnancy.

Your failure to pass a physical examination required to maintain a license to perform the duties of Your occupation, alone, does not mean that You are Disabled.

Elimination Period means the longer of the number of consecutive days at the beginning of any one period of Disability which must elapse before benefits are payable or the expiration of any Employer sponsored short term Disability benefits or salary continuation program, excluding benefits required by state law.

Employer (Airgas) means the Policyholder.

Essential Duty means a duty that:
- is substantial, not incidental;
- is fundamental or inherent to the occupation; and
- cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled work week is an Essential Duty.

Indexed Pre-disability Earnings means Your Pre-disability Earnings adjusted annually by adding the lesser of:
- 10%; or
- the percentage change in the Consumer Price Index (CPI-W).

The percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W. The adjustment is made January 1st each year after You have been Disabled for 12 consecutive month(s), provided You are receiving benefits at the time the adjustment is made.

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, The Hartford may use another nationally published index that is comparable to the CPI-W.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations. For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:
- Mental Retardation;
- Pervasive Developmental Disorders;
- Motor Skills Disorder;
- Substance-Related Disorders;
- Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
- Narcolepsy and Sleep Disorders related to a General Medical Condition.

Monthly Benefit means a monthly sum payable to You while You are Disabled, subject to the terms of The Policy.

Monthly Income Loss means Your Pre-disability Earnings minus Your Current Monthly Earnings.

Other Income Benefits means the amount of any benefit for loss of income, provided to You or Your family, as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You or Your family are eligible or that are paid to You, or Your family or to a third party on Your behalf, pursuant to any:
- temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
- governmental law or program that provides disability or unemployment benefits as a result of Your job with Airgas;
- plan or arrangement of coverage, whether insured or not, which is received from Airgas as a result of employment by or association with Airgas or which is the result of membership in or association with any group, association, union or other organization;
- disability benefits under:
  — the United States Social Security Act or alternative

plan offered by a state or municipal government;
— the Railroad Retirement Act;
— the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
— similar plan or act; that You, Your spouse and/or children, are eligible to receive because of Your Disability; or

- disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
  — that begins after You become Disabled; or
  — that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

- disability benefit under Airgas's Retirement plan;
- temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
- portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings; or
- retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
  — You were receiving it prior to becoming Disabled; or
  — You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;

(Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your after-tax contributions.); or

- retirement benefits under:
  — the United States Social Security Act or alternative plan offered by a state or municipal government;
  — the Railroad Retirement Act;
  — the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan;
  — similar plan or act; that You, Your spouse and/or children receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to The Hartford of:

- the amount attributed to loss of income; and
- the period of time covered by the lump sum or settlement.

The Hartford will pro rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, The Hartford will assume the entire sum to be for loss of income, and the time period to be 24 month(s). The Hartford may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim. The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

- takes effect after the date benefits become payable under The Policy; and
- is a general increase which applies to all persons who are entitled to such benefits.

Physician means a person who is:

- a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that The Hartford recognizes or are required by law to recognize;
- licensed to practice in the jurisdiction where care is being given;
- practicing within the scope of that license; and
- not Related to You by blood or marriage.

Pre-disability Earnings means 1/12 of Your annual base salary, including average commissions over the prior 12 months, but not bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation in effect as of July 1st just prior to You becoming Disabled. However, if You are an hourly paid Employee, Pre-Disability Earnings means straight time hourly rate multiplied by 2080 divided by 12. Your straight time hourly rate used will be that in effect on the July 1st immediately prior to the date You were last Actively at Work.

Prior Policy means the long term disability insurance carried by the Policyholder on the day before the Policy Effective Date.

Regular Care of a Physician means that You are being treated by a Physician:

- whose medical training and clinical experience are suitable to treat Your disabling condition; and
- whose treatment is:
  — consistent with the diagnosis of the disabling condition;
  — according to guidelines established by medical, research, and rehabilitative organizations; and
  — administered as often as needed to achieve the maximum medical improvement.

Rehabilitation means a process of The Hartford's working together with You in order for The Hartford to plan, adapt, and put into use options and services to meet

Your return to work needs. A Rehabilitation program may include, when The Hartford consider it to be appropriate, any necessary and feasible:
- vocational testing;
- vocational training;
- alternative treatment plans such as:
  - support groups;
  - physical therapy;
  - occupational therapy; or
  - speech therapy;
- work-place modification to the extent not otherwise provided;
- job placement;
- transitional work; and
- similar services.

Related means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Retirement Plan means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:
- a profit sharing plan;
- thrift, savings or stock ownership plans;
- a non-qualified deferred compensation plan; or
- an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.

Spouse includes an individual who is in a registered domestic partnership with You in accordance with the laws of California, Oregon or Washington State. References to Your marriage or divorce will include Your registered domestic partnership or dissolution of Your registered domestic partnership.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:
- impairments in social and/or occupational functioning;
- debilitating physical condition;
- inability to abstain from or reduce consumption of the substance; or
- the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

Surviving Children includes children of Your California, Oregon or Washington States registered domestic partners.

The Policy means the Policy which The Hartford issued to the Policyholder under the Policy Number shown on the face page.

Hartford, The Hartford's, or The Hartford means the insurance company named on the face page of The Policy.

Your Occupation means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

Flexible Spending Accounts
Summary Plan Description

Airgas

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INTRODUCTION

This booklet, which is a part of the summary plan description (SPD) for the Airgas, Inc. Comprehensive Welfare Benefits Plan, is intended to provide an overview of your flexible spending account benefits, including Your Spending Account™ resources, and doesn't attempt to cover all details. Special situations that affect a limited number of participants may not be covered in this SPD. Because flexible spending accounts are subject to Internal Revenue Service (IRS) regulations, it's important to read this SPD carefully so you can learn more about spending accounts—how they work, and how they can save you money through tax savings. You may want to consult with a tax advisor about your decision to participate.

Each of the benefits described in this SPD is governed by the terms of a separate legal plan document or contract. If there is a conflict between this SPD and the legal plan document or contract controlling the operation of Your Spending Account, the legal document or contract will govern.

Benefits Assistance and Resources

Your Spending Account™ is the administrator of the Airgas flexible spending account program, and is authorized by Airgas to make benefit determinations in accordance with plan provisions. If you have any questions about flexible spending accounts, visit Your Spending Account online at *www.ybr.com/benefits* for more information. If you have questions concerning administrative services provided by Your Spending Account, you may contact the administrator via the following:

Mail Your Spending Account
P.O. Box 785040
Orlando, FL 32878-5040

Online *www.ybr.com/airgas*

Phone 1-877-424-2363

Fax 1-888-211-9900

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time Employee who is scheduled to work at least 30 hours per week. If you are a member of a collective bargaining unit, you may not be eligible for benefits described in this SPD. Please contact your Human Resources representative for more information.

Although your dependents can't enroll in the plan, you may submit eligible expenses you incur on their behalf for reimbursement from your spending account(s). Your eligible dependents are defined in the general text of your SPD. Please note, however, you may only submit expenses for eligible dependents that qualify as "dependents" for federal income tax purposes.

Enrollment and Participation

The plan year runs from January 1 through December 31.

For new hires, your participation begins once you've enrolled in a flexible spending account. You also have the option of enrolling in a flexible spending account during annual enrollment. In this case, your participation will begin at the start of the new plan year on January 1st. Your initial contribution to the plan will begin with the first paycheck following the date that your enrollment is processed by Your Spending Account. Thereafter, your contributions will be deducted from future paychecks in equal installments throughout the remaining months in the plan year if you're a new hire, or throughout the entire plan year if you enrolled during annual enrollment

You may enroll in the plan through the following ways:

- *Visiting www.ybr.com/airgas*
- Calling Your Benefits Resources (YBR), at 1-877-424-2363.

To participate, you must complete the enrollment process as instructed. After the enrollment deadline, you cannot make any new elections or changes, unless you have a qualified status change (see Qualified Status Changes) that establishes a need for you to adjust your flexible spending account contributions.

The benefits you receive by participating in a flexible spending account depend on your personal circumstances and financial situation. Because your circumstances can change from year to year, it's important to reevaluate your need to participate during annual enrollment.

Qualified Status Changes

Generally, outside the annual enrollment period, you can only change your contribution amounts or participation in your account(s) during the year if you have a qualified status change.

How to Change Your Election and/or Participation During the Year

If you have a life status change—for example, if you get married—you can make certain midyear changes to your coverage under the plan.

To make coverage changes, you must contact Your Benefit Resources (YBR) at 1-877-424-2363 or on the web at *www.ybr.com/airgas*.

If you have a life status change during the year and need to change your coverage outside of the annual enrollment period, you must do so within 31 days of the event that makes the change necessary. Otherwise, you can't make a coverage change before the next annual enrollment period unless you or your eligible family member has another qualified status change.

How A Flexible Spending Account Works

A flexible spending account is an employer-sponsored benefit program that allows you to set aside money on a pre-tax basis to pay for a variety of eligible health care and dependent care expenses. In general, there are two types of spending accounts—a Health Care Spending Account and a Dependent Care Spending Account. Airgas offers both the Health and Dependent Care Spending Account arrangements.

Flexible spending accounts can help you save money by reducing your taxable income. As the money you contribute to your spending account(s) is deducted from your paychecks, your taxable income is reduced—this means you'll pay less in taxes.

Here's a step-by-step overview of how participation in a flexible spending account works.

- Enroll in a flexible spending account as a new hire or during annual enrollment. You must enroll in the plan to participate. If you're currently participating and want to continue your participation for the following plan year, you must reenroll during the annual enrollment period. Participation in the plan doesn't carry over automatically from year to year.
- Make contributions to your account(s). When you enroll, you choose how much to contribute to your account(s) for the plan year based on the minimum and maximum amounts allowed. Once your contribution amount has been set, it will be deducted in equal installments from each paycheck on a before-tax basis.
- Pay for expenses as you incur them. Depending on the type of expense, you'll need to pay for products and services rendered, or have proof that you've incurred the expense before you submit a claim for reimbursement from your account(s).
- Submit a claim for reimbursement of eligible expenses. To receive reimbursement for eligible health care and/or dependent care expenses, you must first submit a claim form to Your Spending Account .
- Receive reimbursement from Your Spending Account. Once your claim has been processed, you'll receive notification from Your Spending Account regarding the status of your claim. If your claim is approved for reimbursement, you'll either receive a check or an electronic funds transfer to your designated bank account, if you're enrolled in direct deposit payment.

Additional Information You Should Know

- The IRS "use it or lose it" rule requires you to use all the money in your account(s) to pay for eligible expenses during the plan year. If you don't incur enough eligible expenses to deplete your account by the end of the plan year, you'll forfeit any money that remains in your account(s).
- The contribution amount you elect during enrollment is in effect until the end of the plan year and can't be changed unless you experience a qualified status change (such as marriage, divorce, or the birth of a child) as defined by the IRS and accepted by Airgas.
- You must submit your claims for eligible expenses incurred during the current plan year by March 31st of the following year.
- You can only submit claims for reimbursement of eligible expenses that you incur during the current plan year.
- You can enroll in both the Health Care and Dependent Care Spending Accounts, however, you'll need to allocate your annual contributions for each account separately and cannot combine/transfer the funds from one account with the other to pay for eligible expenses.

Need More Information?

Visit the Your Spending Account Web site at *www.ybr.com/airgas* to learn more about flexible spending accounts. The Web site is available 24 hours a day, seven days a week, and is accessible from any computer with Internet access. If you have additional questions or need assistance using the Web site, you can call a Your Spending Account service center representative toll free. Representatives are available Monday through Friday during regular business hours.

Debit Card Program
How the YSA Card Program Works

If you're eligible, you'll receive a package containing one YSA card issued in your name, activation instructions, a Cardholder Agreement, Additional Disclosures, and information explaining approved use of the card. You may request additional cards for your spouse and/or eligible dependent(s) through the Your Spending Account Web site.

The YSA card remains active as long as your account is in good status, you continue to participate in a Health Care Spending Account, and you remain actively employed. Your card will be cancelled upon termination of employment—inactive participants may not use the YSA card. By signing and using the card, you certify that:

- You'll only use the card for your own eligible health care expenses and those of your eligible dependents under the plan
- Incurred expenses were for health care services or supplies purchased on or after the date your Health Care Spending Account took effect.
- Your expenses don't include any amounts that are otherwise payable by plans for which you or your dependents are eligible.
- Any expense paid with the card has not been, or will not be, reimbursed by another source.

You can present your YSA card for eligible health care expenses anywhere Debit VISA cards are accepted. The YSA card has been designed for use at merchants and providers that primarily sell health care products and services (for example, pharmacies, physician's offices, hospitals, and dentist's offices). Each time you use the card at an approved merchant location for an eligible health care expense, you'll be required to provide your signature. If your transaction prompts you to choose between "credit" and "debit," you must choose the credit option—otherwise your transaction won't be processed. With each YSA card purchase, your available Health Care Spending Account balance is reduced by that amount. Other ineligible expenses, such as cosmetics or food items, must be paid for separately.

Important: Save your itemized receipts.
Because all Your Spending Account VISA card (YSA card) transactions must be verified as eligible health care expenses, you may be required to provide Your Spending Account with supporting documentation to validate your expenses. Make sure that you save all of your itemized receipts (indicating the date of service, the name of the service provider, the name of the person receiving service, the name of the product or service, and any amount paid by other coverage). Refer to the Cardholder Agreement for more information.

The YSA card can remain active for up to three years—as long as you maintain active status and/or are eligible for benefits. However, the card can only be used in plan years during which you've made contributions to a Health Care Spending Account. For example, if you enroll for the first time and receive a card but don't enroll the second year, the balance on the card will be zero. If you decided to reenroll the third year, the existing card would reflect your new available balance. Keep in mind that the contribution amount for one plan year can't be accessed through the YSA card after the end of that year. If you enroll in the plan the following year, a new contribution amount will be available through the YSA card at the start of the second plan year.

Note: After the end of any given year, expenses incurred in the prior plan year can only be submitted through the manual claim process. If you reenrolled, your YSA card will be replenished based on the new contribution amount you choose.

Lost or Stolen Cards

If your YSA card is lost or stolen—or you believe that there has been any unauthorized use of your card—you must contact YBR at 877-424-2363. After normal business hours, you may call 1-866-438-5797 to report a lost or stolen card.

Validation of YSA Card Transactions

All YSA card transactions must be validated electronically at the point of sale or by submitting paper documentation afterward. This process involves requesting itemized receipts or other supporting documentation from you to verify that the card transaction is for an eligible health care expense. You should retain your itemized receipts for all transactions, as they may be required for validation purposes.

Automatic Validation with Approved Merchants

When you purchase eligible health care items by using your YSA card with approved merchants, your transaction can be validated automatically without having to provide an itemized receipt or supporting documentation. To be "approved," a merchant must have an inventory information approval system (IIAS) installed. These IIAS-certified merchants have the ability to identify eligible items at the point of sale, which eliminates the need for additional documentation. They have programmed their systems to only allow eligible items and services to be processed on the YSA card.

Any ineligible items must be paid for with another form of payment. For a complete listing of eligible expenses and approved merchants, visit the Your Spending Account Web site. Please note that the listing is subject to change at anytime.

Automatic Validation for Other Medical Providers

Your YSA card can also be used for other types of health care transactions without the need for submission of itemized receipts or further review. These transactions include recurring expenses, copayments, a specific merchant category code, and prescription purchases covered by Caremark. Below is a brief explanation of each type of transaction.

Recurring Transactions

If you purchase an eligible health care item or service using your YSA card, that same item or service will be validated automatically the next time you purchase it with your YSA card (at the same provider and for the same dollar amount). In addition, any recurring YSA card transactions will carry over to the new plan year for participants who reenroll in a flexible spending account—this means you'll be able to continue purchasing the same health care item or service (provided that the dollar amount does not change) without having to submit supporting documentation to Your Spending Account again the following plan year.

Copayments

Your YSA card will be programmed to recognize your plan's copayment amounts without any additional validation being required (for example, a $20 copayment at a physician's office).

Prescriptions Covered by Airgas' health care plan

Caremark has partnered with Your Spending Account. If you have coverage with Caremark through Airgas' plan, your prescription purchases will typically be validated automatically—simply present your YSA card at the time of purchase. Although your expense should be validated automatically, it is good practice to save your itemized receipts in case Your Spending Account requests proof of payment.

Supporting Documentation

Manual claim submission and supporting documentation are sometimes required for the purchase of any prescription drug or health care service or item that isn't validated automatically. These types of purchases are conditionally reimbursed, pending validation of the expenses. The process for supporting documentation is outlined below:

- The merchant is reimbursed for the amount of the charge, and your available Health Care Spending Account balance is reduced.
- You'll be sent a letter or e-mail informing you that itemized receipts or other documentation are required to validate the YSA card transaction.
- If the documentation you provided is insufficient, you'll be sent a letter or e-mail instructing you to provide more documentation.

Expenses for which you don't provide adequate documentation are considered ineligible and treated as overpayments. See the Overpayment Process section for more information.

Overpayment Process

If you purchase products or services with your YSA card that are ineligible for reimbursement through your Health Care Spending Account, you'll receive notification from Your Spending Account that your transaction has been deemed an overpayment.

The primary situations that could result in an overpayment are:

- You fail to respond to validation requests for YSA card transactions after the initial request was sent by Your Spending Account.
- Your YSA card transactions were authorized at the point of sale, and then later deemed ineligible after the validation process was completed.

Claim adjustments were made because of contribution amount changes, ineligible expenses, or improper processing of the claim.

Once an overpayment has been identified, the following actions will be taken immediately:

- Your YSA card will be suspended and will remain suspended when your overpayment exceeds $100.

Your Spending Account will allow you to resolve an overpayment on your account in one of the following ways. You'll be given the option to:

- Resubmit your claim with additional information;
- Submit a new claim; or
- Repay your overpayment by mailing a check to Your Spending Account.
- The overpayment will remain active on the account until all amounts are recovered.
- If the overpayment amount isn't recovered through the options above, Airgas will determine whether further action should be taken:

Overpayment Treated as Employee's Income

The overpayment may be reported as taxable income on the employee's Form W-2 after all other recovery options have been exhausted. Airgas may consider handling this in the current or future tax year.

Deduct Overpayments from Employees' Pay

Airgas may choose to recover the overpayment by adjusting the employee's paycheck. The debit card agreement—accepted by the employee when he or she signed the back of the YSA card— supports this approach. The agreement states the employer can rectify overpayments by garnishing wages. This approach cannot be used for terminated employees, since they are not on active payroll.

When Not to Use Your YSA Card—Coinsurance

If you enrolled in a plan that has coinsurance and you visit your doctor, wait until after your doctor submits a claim to your health plan to pay for any coinsurance using your YSA card. Doctors often have negotiated reduced rates, so using your YSA card at the time of service may result in an overpayment. Once your health plan pays its portion of the claim, your doctor will bill you for your portion. At that time, you may use your YSA card to pay your portion of the bill. Remember to save your receipt in case Your Spending Account requests it.

Important Information Regarding Errors, Liability, and Related Disclosures

The following disclosures relate to issues concerning the YSA card. Any other issues that relate to your flexible spending account (such as benefit eligibility, participation, enrollment, claims, or validation) that are governed under the terms of your flexible spending account and the Employee Retirement Income Security Act of 1974 (ERISA) will be subject to the dispute procedures available under the plan offered by or through Airgas.

Consumer Liability

You must notify Your Spending Account immediately if you believe your card has been lost or stolen. Call YBR at 1-877-424-2363 to prevent the loss of all of the money you have accrued under the plan, although there's no guarantee that such a loss won't occur. If you believe your YSA card has been lost or stolen and you notify Your Spending Account within two business days after you learn of the loss or theft, you will not lose any money ($0) if someone used your card without your permission. After normal business hours, you may call 1-866-438-5797 to report a lost or stolen card.

If you view a transaction online or if the periodic statement you receive shows YSA card transactions that you did not authorize, you must notify Your Spending Account within 60 days of the statement date (or the date when it was first made available electronically). If you don't inform Your Spending Account within this time frame, you may not recover any money you lost after the 60 days. If there is a valid reason that prevented you from contacting Your Spending Account (such as a long trip or a hospital stay), the time period for notification will be extended.

Documentation

Information regarding YSA card transactions under the plan will either be made available on the

Your Spending Account Web site or be mailed to you in a periodic statement.

Your Spending Account Liability

If Your Spending Account doesn't complete a transaction on time or for the correct amount, according to the Cardholder Agreement, it will be liable for your losses or damages. However, some exceptions apply. Your Spending Account will not be liable if, for example:

- You don't have enough available funds in your account under the Airgas plan (through no fault of Your Spending Account) to make the transaction; or
- Circumstances beyond Your Spending Account's control (such as fire or flood) prevented the completion

of the transaction, despite reasonable precautions that had been taken.

- Any other exceptions stated in the Cardholder Agreement apply.

Confidentiality

Your Spending Account may disclose information to third parties about your YSA card account or the transactions that you make using the card under the following circumstances:

- When it's necessary for completing transactions;
- To verify the existence and condition of your YSA card account for a third party;
- To comply with a government agency or court order;
- As provided in the Cardholder Agreement or in the plan; or
- If you give Your Spending Account your written permission.

In Case of Errors Relating to Your YSA Card

Call Your Spending Account at the number provided on the back of your card as soon as possible if you think a YSA card transaction in the statement or receipt is wrong, or if you need more information about a transaction listed in the statement or receipt. Your Spending Account must receive notification of any errors no later than 60 days after you received the first statement (either via the Your Spending Account Web site or by mail) in which the problem or error appeared. When you contact Your Spending Account, be prepared to:

- Provide your name, Social Security number (when applicable), and YSA card number;
- Describe the error or the YSA card transaction that you're unsure about, and explain the reason you believe there's an error or why you need more information; and
- Provide the dollar amount of the suspected error. If you call Your Spending Account, you may be required to send your complaint or question in writing within ten business days.

Your Spending Account will coordinate with the YSA card issuer to determine whether an error occurred within 10 business days after it receives notification from you, and will correct any error promptly. If more time is needed to correct the error, however, Your Spending Account may take up to 45 days to investigate your complaint or question. If this additional time is necessary, Your Spending Account will credit the monies held by Airgas for the amount that you think is in error, so that you will have use of the total amount during the investigation.

If Your Spending Account requests that you put your complaint or question in writing and it doesn't receive the information within ten business days, Your Spending Account may not provide this credit. Your Spending Account will inform you of the results within three business days after completing the investigation. If Your Spending Account decides that there was no error, a written explanation will be mailed to you. You may ask for copies of the documents that were used in the investigation.

HEALTH CARE SPENDING ACCOUNT DETAILS

The Health Care Spending Account is for health care expenses that aren't covered by any medical, dental, or vision care plan offered by Airgas or your spouse's employer. The plan permits you to contribute a minimum of $50 and a maximum of $2,500 to your Health Care Spending Account on plan year basis.

Dependent Eligibility

You can use your Health Care Spending Account to pay for eligible health care expenses for yourself and anyone who qualifies as your tax dependent. Under the Health Care Spending Account, the term "dependent," as defined by the plan and IRS regulations, includes:

- Your legal spouse (including common-law spouses in states that recognize common-law marriages); or
- Your unmarried children who meet Airgas' age requirements, and whom you claim as dependents for federal income tax purposes. The definition of an eligible child includes "qualifying child" or "qualifying relative".

A qualifying child is an individual who:

- Is your
  - — son, daughter, stepchild or eligible foster child;
  - — grandchild;
  - — brother or sister (or stepsibling); or
  - — niece or nephew;
- Resides with you for more than half of the calendar year;
- Does not provide over half of his or her own support; and
- Will not turn age 19 during the year (or turn age 24 during the year if a full-time student).

A qualifying relative is an individual who:

- Receives over half of his or her support from you;
- Is not your "qualifying child" or anyone else's "qualifying child";
- Does not have gross income equal to or in excess of $3,300 for 2006 (including the taxable portion of his or her Social Security income, if any); and
- If unrelated to you, lives with you for the entire year. Thus, unless the individual falls within one of the following categories, the individual must also reside with you during the entire calendar year:
- Your child or a descendant of your child;
- A brother or sister (including stepsiblings) of yours;
- A parent or ancestor of either of your parents;
- Your stepparents;
- Your niece or nephew; or
- Your in-laws (son, daughter, father, mother and brother/sister in-law).

Reimbursable Health Care Expenses

Only expenses that aren't covered by medical, dental, or vision care plans and are incurred during the plan year are eligible for reimbursement. For a complete listing of eligible expenses, visit the Your Spending Account Web site. Please note that the listing is subject to change at anytime.

Examples of expenses eligible for reimbursement through a Health Care Spending Account may include, but aren't limited to, the following:

- Deductibles;
- Copayments;
- Charges for routine physical examinations and tests;
- Inoculations;
- Charges in excess of reasonable and customary limits set by the health plan(s);
- Prescription drugs and medicines;
- Charges for services and supplies not covered by the plan(s);
- Charges in excess of annual health plan limit(s);
- Eye examinations and treatment, including LASIK surgery;
- The cost of eyeglasses, contact lenses, and prescription sunglasses;
- The cost of hearing aids and batteries; and
- Prepaid orthodontia treatment; and

Examples of expenses that aren't eligible for reimbursement:

- HMO and medical insurance premium payments;
- Health club fees
- Dietary supplements;
- Disability and life insurance premium payments;
- Living expenses;
- Cosmetics;
- Cosmetic surgery, unless it's for the treatment of a disfiguring illness or injury;
- Cosmetic dental procedures, such as bleaching and implants;
- Over-the-counter vitamins (unless medically necessary);
- Weight-loss treatments, unless prescribed by a physician to cure a specific illness;
- Long-term care; and
- Health care expenses which are reimbursable under any other health plan or insurance.
- Over-the-counter (nonprescription) drugs, including allergy medicines, antacids, and pain relievers.

Note: Keep in mind that you can only be reimbursed for eligible expenses that were incurred while contributing to a Health Care Spending Account.

Tax Implications for Health Care Spending Accounts

Currently, you can only deduct any eligible health care expenses exceeding 7.5% of your adjusted gross income from your income tax, provided you're itemizing deductions. However, when you receive reimbursement from a Health Care Spending Account for these expenses, you give up the opportunity to take a tax deduction on your federal income tax return. Therefore, you have to choose whether you want to take the tax deduction or receive reimbursement through a Health Care Spending Account.

Generally speaking, if you don't itemize your tax deductions or if your health care expenses are less than 7.5% of your adjusted gross income, it may be more beneficial to participate in a Health Care Spending Account.

Consult a tax advisor to determine what is best for your situation.

Continuation Rights

If you lose Airgas sponsored group health coverage due to the following situations, you may be eligible to continue temporary participation in your Health Care Spending Account:

- You are terminated from employment.
- You lose eligibility due to an employment status change (for example, an unpaid leave of absence).

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides special rules that may allow you to continue participating in your current health plan temporarily (on an after-tax basis) when your participation would have otherwise ended due to certain circumstances. If you qualify for health care coverage continuation through COBRA, you'll receive additional information from YBR about continuing to participate in your Health Care Spending Account.

DEPENDENT CARE SPENDING ACCOUNT DETAILS

The Dependent Care Spending Account covers eligible dependent care expenses so that you (or you and your spouse, if you're married) can work (or look for work) or your spouse can attend school full time. For the current plan year, you may contribute a minimum of $50 and a maximum of $5,000 to your Dependent Care Spending Account.

Dependent Eligibility

Under the Dependent Care Spending Account, the term "dependent," as defined by the plan and IRS regulations, includes:

- Any child under age 13 whom you can claim as a dependent for federal income tax purposes. The definition of an eligible child includes:
  - — Your natural born child;
  - — Your stepchild who lives with you;
  - — Your legally adopted child; and
  - — A child for whom you're an appointed legal guardian, as defined by a court order.
  - — A child for whom you're required to provide medical coverage, according to a Qualified Medical Child Support Order (QMCSO), and who is otherwise eligible.
- Your spouse or other dependent, regardless of age:
  - — Whom you can claim as a dependent for federal income tax purposes;
  - — Who is physically or mentally incapable of caring for himself or herself; and
  - — Who spends at least eight hours a day in your home.

Reimbursable Dependent Care Expenses

To be eligible for reimbursement, your dependent care expenses must meet all of the following requirements:

The expenses must be provided primarily for the well-being and protection of the dependent;

The day care provider must meet certain tax-identification requirements and comply with state and local laws; and

The care/service must be necessary for you to work and, if you're married, for your spouse to work, look for work, or attend school full time (unless your spouse is disabled).

For a complete listing of eligible expenses, visit the Your Spending Account Web site. Please note that the listing is subject to change at anytime.

Examples of expenses eligible for reimbursement through a Dependent Care Spending Account may include, but aren't limited to, the following:

- Nursery school tuition;
- Day care centers (including adult day care facilities);
- In-home day care providers; and
- Before- and after-school care (if not included with tuition).

Examples of expenses that aren't eligible for reimbursement:

- Food and clothing;
- Entertainment;
- Education;
- Overnight camp;
- Health care expenses (these expenses can be reimbursed through a Health Care Spending Account);
- Payments to a housekeeper while at home from work due to illness;
- Full-time nursing home care; and
- Expenses reimbursable under any other plan or program.

If you're enrolled in a Dependent Care Spending Account, you can only be reimbursed up to the amount that's available in your account (based on current contributions). If you incur expenses that exceed your available funds, future claims will be reimbursed as additional funds accumulate in your account.

Tax Implications for Dependent Care Spending Accounts

You may not claim any other benefit for the amount of your pre-tax salary reductions under the Dependent Care Spending Accounts, although your dependent care expenses in excess of that amount may be eligible for the dependent care tax credit.

For example, if you elect $3,000 in the Dependent Care Spending Account and are reimbursed $3,000, but you have dependent care expenses totaling $5,000, then you could count the $2,000 excess when calculating the dependent care tax credit if you have two or more dependents.

Would it be better to include the Dependent Care Spending Account benefits in my income and claim the dependent care tax credit, instead of treating the reimbursements as tax free?

For most individuals, participating in a dependent care spending account will produce the greater federal tax savings, but there are some for whom the opposite is true. Because the preferable method for treating benefits payments depends on certain factors such as a person's tax filing status (for example, married, single, head of household, number of dependents, earned income, etc.), each person must determine his or her own tax position individually in order to make the decision. For more information on this subject, visit the IRS website at *www.irs.gov* or consult with a tax advisor to determine what is best for your situation.

What is the maximum I may elect to contribute to the Dependent Care Spending Account?

- You may elect to contribute up to $5,000 per calendar year to the Dependent Care Spending Account if:
- You are married and file a joint federal income tax return;
- You are married and file a separate federal income tax return, and meet the following conditions:
  - — your household constitutes the primary residence of a dependent for whom you are eligible to receive reimbursements under the Dependent Care Spending Account;
  - — you furnish over half the cost of maintaining this household during the taxable year; and
  - — during the last six months of the taxable year, your spouse was not a member of this household; or
- You are single or head of household for federal tax purposes.

If you are married and reside with your spouse but you file separate federal income tax returns, the maximum amount you can contribute to the Dependent Care Spending Account is $2,500 per calendar year. The amount you may elect cannot exceed either your or your spouse's earned income for the calendar year (your spouse is deemed to have earned income of $250—or $500 if you have two or more dependents—for each month in which your spouse is

— physically or mentally incapable of self-care; or

— a full-time student).

CLAIMS FOR REIMBURSEMENT

As you incur eligible expenses during the plan year, you can submit claims to Your Spending Account for reimbursement. To do this, you must complete a claim form and include acceptable documentation of your eligible expenses when it's requested. Make sure to submit your claims incurred during the current plan year by the end of the run-out period , March 31st following the close of the plan year.

Submitting Your Claim to Your Spending Account

There are several ways to submit your claim for reimbursement.

Online

Your Spending Account offers the convenience of submitting your claim form online. To get started, log on to the Web site. You'll then be asked to enter relevant claim information. Once you've entered the requested information, you'll be able to review your claim before you submit it. The final steps to submitting your claim are to print a copy, sign it, and fax or mail it to Your Spending Account with the required documentation of your expenses (such as itemized receipts) for processing.

Fax or Mail

If you don't have Internet access, you can obtain a paper claim form on Airnet or by calling Your Spending Account. Once you've completed and signed the claim form, you'll need to include itemized receipts or other required documentation of your expenses with your form when you fax or mail it to Your Spending Account for processing.

Fax your claim to:	1-888-211-9900
Mail your claim to:	Your Spending Account P.O. Box 785040 Orlando, FL 32878-5040

Important: Whether you submit a claim through the Web site or by fax/mail, you must provide itemized receipts or other required documentation for products purchased or services rendered. If you don't provide supporting documentation, your claim won't be processed and you won't be reimbursed.

Supporting Documentation

You must provide proper supporting documentation so that your claim can be approved. This includes itemized receipts or other documentation.

For Health Care Claims

An itemized receipt must include the following:

- Date of service;
- Name of service provider;
- Name of patient (not required for over-the-counter drugs);
- Name of drug, product, or service; and
- Amount paid.

Handwritten receipts should include the service provider's signature. For prescription drugs, remember to submit the receipt that the pharmacist has attached to the prescription, not the cash register receipt. For faster processing, fax your signed and completed claim form and supporting documentation to Your Spending Account. Your claim will be processed as soon as possible.

If you've lost a receipt, contact your doctor or pharmacy to request a copy or call your health plan for an EOB. If you don't provide the necessary information, the processing of your claim may be delayed or your account may be placed into an overpayment status. Visit the Your Spending Account Web site for more documentation requirements.

CLAIMS APPEAL PROCESS

Request for Claim Review

If any portion of your submitted claim isn't eligible for reimbursement, you'll receive notification from Your Spending Account. If you believe that your claim (or a portion of it) was denied incorrectly, please call YBR at 1-877-424-2363 and speak to a representative. If the Service Center determines that the claim (or a portion of it) was correctly denied, you may request a review of the denial at no cost by completing and submitting a Claim Review Form to Airgas, in Radnor. You may request the Claim Review Form from the Service Center and it will be mailed to you as soon as possible.

When completing the Claim Review Form, please state the reason you believe the claim for benefits was improperly denied. You may submit any comments, questions, documents, or information that you deem appropriate. Airgas will review your claim and will consider the applicable terms and provisions of the Plan and amendments to the Plan, information and evidence that is presented by you and any other information it deems relevant.

Defective Requests for Claim Review for

In the case of your failure to follow the Plan's procedures for filing a valid Request for Claim Review, you will be notified of the failure and the proper procedures to be followed in filing a Request for Claim Review].

Notice of Extension of Review Time

Airgas may extend the period for making the benefit determination by 15 days if it determines that such an extension is necessary due to matters beyond its control.

If an extension is necessary due to your failure to submit necessary information, the notice of extension will describe the required information. You will be given at least 45 days from receipt of the notice within which to provide the specified information, and the 30 day extension period in which the decision is required to be made will be suspended from the date on which the notification is sent to you until the earlier of

- the date you respond to the request for additional information, or
- the due date established by Airgas to provide the requested information.

Manner and Content of Notification of Denied Request for Claim Review

You will be provided with written notice of any denial in accordance with applicable U.S. Department of Labor regulations. The notification will include:

- The specific reason or reasons for the denial;
- Reference to the specific provision(s) of the Plan on which the determination is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the denial, the notice will either
  - include the specific rule, guideline, protocol or other similar criterion of the Plan that was relied upon or
  - provide a statement that such rule, guideline, protocol or similar criterion was relied upon, and that a copy will be provided free of charge to you upon request;
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will provide either
  - an explanation of the scientific or clinical judgment relied upon for the determination, or
  - a statement that such explanation will be provided free of charge upon request; and
- A description of the Plan's review procedures and the time limits applicable to such procedures, and if a claim involving urgent care, of the expedited review process.

Appeal of Denied Request for Claim Review

If any portion of your Request for Claim Review is denied, and you believe that it was denied in error, you have the right to appeal that decision to Airgas within 180 days of the date you received the denial notification. If you don't submit a request for review during this period, no further action will be taken and you will not be able to file a further appeal.

When submitting your second level appeal please state the reason you believe the claim for benefits was improperly denied. You may submit any comments, questions, documents, or information that you deem appropriate. Airgas will review your Level II Appeal and will consider the applicable terms and provisions of the Plan and amendments to the Plan, information and evidence that is presented by you and any other information it deems relevant, within 60 days of receipt and provide you with a written explanation of the benefit determination.

Defective Appeals

In the case of your failure to follow the Plan's procedures for filing a valid appeal, you will be notified of the failure and the proper procedures to be followed in filing an appeal. This notice will be provided to you as soon as possible.

Your appeal will receive a full and fair review by someone other than the person who initially made the unfavorable benefit determination or his or her subordinate. You have the right to request copies of all documents, records, and other information used in evaluating your claim at no cost. If an internal rule, guideline, protocol, or another standard was relied on in making the unfavorable benefit determination, upon request, Airgas will provide you with a copy free of charge. If the unfavorable benefit determination was made based on a lack of medical necessity, an experimental treatment, or another similar exclusion or limit, upon request, Airgas will provide an explanation of the scientific or clinical judgment for the unfavorable benefit determination free of charge.

If Airgas denies your appeal and you aren't satisfied with the decision, you'll have rights under Section 502(a) of the Employment Retirement Income Security Act of 1974 (ERISA) to bring a civil action in federal court. Your state may have additional internal appeal and/or external review processes available to you to resolve disputes. Additionally, 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.

GENERAL TAX INFORMATION

The main advantage of a flexible spending account is tax savings. A flexible spending account lets you set money aside for qualified health care and/or dependent care expenses before taxes are deducted from your paycheck. The money you contribute toward your account(s) will lower your taxable income, so you'll pay less in taxes. Here's an annual tax savings example:

John is married to Laura, and they have two children. They have a combined gross annual salary of $50,000, and want to know how much they will save if they contribute $3,000 to a Health Care Spending Account.

The advantages of participating in a flexible spending account on a before-tax basis—or claiming the tax deduction/credit on an after-tax basis—depend on the amount of your expenses and your financial situation. You should consult a tax advisor for specific information about the tax implications of participating in a flexible spending account.

	Using a Health Care Spending Account	Using After-Tax Dollars to Pay for Expenses
Annual salary	$50,000	$50,000
Before-tax dollars used for expenses	–$3,000	–$0
Taxable income	$47,000	$50,000
Estimated federal taxes	$623	$1,073
Estimated Social Security taxes	$3,596	$3,825
Total estimated taxes	$4,219	$4,898
Tax savings*	$679	—
Pay after taxes	$42,781	$45,102
After-tax dollars used for expenses	$0	$3,000
Annual take-home pay	$42,781	$42,102
Increased take-home pay	$679	—

*This example is based on 2007 tax tables and makes certain assumptions; your individual situation may be different.

The example above demonstrates the advantage of paying for eligible expenses on a before-tax basis instead of spending after-tax dollars. Actual savings will vary depending on your individual financial situation.

Flexible Spending Accounts and Social Security

If your annual salary is less than the Social Security maximum taxable wage (as determined by the IRS), you'll see a decrease in the amount of Social Security taxes taken from your paycheck when you contribute to a flexible spending account. When you contribute before-tax dollars to Your Spending Account(s), you reduce the amount of federal income taxes deducted from your Social Security benefit. You may want to consider this when you're deciding whether to participate in a flexible spending account.

Note: If you're reimbursed from your spending account(s) for expenses, you can't use those same expenses to receive a tax deduction on your federal income tax return.

When Participation Ends

You will no longer be eligible to participate in the plan if you:

- You are terminated from employment.
- You lose eligibility due to an employment status change (for example, an unpaid leave of absence).

Coverage in the plan ends on the same day you or your dependent(s) loses eligibility for coverage. However, you or your eligible dependent(s) may still file claims against any remaining account balance(s) through the end of the run-out period. These claims must be for expenses incurred during your participation in the plan.

If you become ineligible to participate in the plan, your contributions to your account(s) will stop automatically with your last paycheck.

Leaves of Absence

If you're on a paid leave of absence, your participation in the plan may continue. If you're on an unpaid leave of absence, your participation in the plan will likely end until you return to work, but you can still make claims against your account balance(s) for the period in which you were enrolled. If you return to work in a subsequent calendar year, you'll have to reenroll to continue participation in the plan.

Note: You can continue to submit spending account claims until client run-out period date] for eligible expenses that you incur before your coverage ends. Any amount(s) left in your account(s) after this date will be forfeited to Airgas.

Note: Participants that are not actively at work are not allowed to continue to participate in the dependent care spending account. When the participant returns to work, the account coverage will not be automatically reinstated. Instead, the participant will need to process a qualified status change to elect the Daycare Spending Account as of the date they return to an Active status.

Participant Rights

As a participant in Airgas' flexible spending account plan, you're entitled to certain rights and protections under ERISA. This section provides you with some administrative information that's important for you to know and doesn't constitute a part of the plan.

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at Airgas' location and at other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report filed by the plan with the U.S. Department of Labor and available in the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to Airgas, copies of documents governing the operation of the plan, including insurance contracts and an updated SPD. Airgas may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. Airgas is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For example:

- If you request a copy of plan documents or the latest annual report from the plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require Airgas to provide the materials and pay you a specified monetary amount each day until you receive the materials, unless the materials weren't sent because of reasons beyond Airgas' control.
- If you have a claim for benefits that is denied or ignored, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file a suit in a federal court.
- If plan fiduciaries misuse the plan's money or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if it finds your claim is without merit.

Assistance With Your Questions

If you have any questions about your plan, contact Your Spending Account. If you have any questions about your rights under ERISA or if you need assistance in obtaining documents from Airgas contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

ADMINISTRATIVE INFORMATION

Plan Administrator: Your Spending Account

The plan shall be under the supervision of Airgas. To the fullest extent permitted by law, Airgas shall have the discretion to determine all matters relating to eligibility, coverage, and benefits under the plan. Airgas shall also have the discretion to determine all matters relating to the interpretation and operation of the plan.

Any determination by Airgas, or any authorized representative, shall be final and binding, in the absence of clear and convincing evidence that it acted arbitrarily and capriciously.

Type of Plan

The plan is self-funded and paid by Airgas' general assets.

Right of Recovery

If any claim or benefit is overpaid, the plan reserves the right to recover the overpayment or to reduce future payments. The person receiving the benefit must produce any instruments or papers necessary to ensure this right of recovery.

Fraud Protection

If you knowingly and intentionally defraud the plan, file a statement of claim that contains any materially false information, conceal information in order to mislead, or commit a fraudulent act against the plan, this is a crime and is subject to criminal and civil penalties.

Employment Contract: Employee Rights Not Implied

Your participation in the plan doesn't give you the right to be retained in employment with Airgas, nor does it interfere with the right of Airgas to discharge or terminate you without regard to the effect the discharge or termination would have on your rights under the plan.

Plan Documents

This document summarizes the major features of the plan. It's intended to meet the requirement for a summary plan description under ERISA. Airgas has a copy of the plan document, which governs your rights if there is a difference between it and this SPD.

Amendment and Termination of the Plan

Airgas has established the plan with the intention and expectation that it will be continued indefinitely, but it doesn't have any obligation whatsoever to maintain the plan for any given length of time. In addition, Airgas may, at any time, amend or terminate the plan, in whole or in part, with respect to any or all of its participants and/or beneficiaries. Any such amendment or termination shall be communicated in writing and signed by an officer of the employer or his or her authorized representative. No vested rights of any nature are provided under the plan.

Qualified Medical Child Support Order

The Medical Insurance Plan and the Health Care Spending Account will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain without charge, a copy of such procedures from the Plan Administrator.

Newborns' and Mothers' Health Protection Act of 1996

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

Lifeworks Employee Assistance Program (EAP) Plan

Summary Plan Description

Airgas

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EMPLOYEE ASSISTANCE PROGRAM

The following is a description of the Employee Assistance Program (EAP) benefits included in the Airgas Comprehensive Welfare Benefit Plan. This Summary Plan Description (SPD) is intended to be your source for information about the EAP benefits.

The benefit description in this section is for summary purposes only. Every effort has been made to ensure that the information correctly reflects the terms of the plan documents. In all cases, however, the official plan documents and contracts will control administration and operation of this program.

ELIGIBILITY FOR COVERAGE

You and your covered dependents will become eligible for coverage on the later of:

- The day after the date you complete 30 days of continuous service in an eligible employee group of Airgas provided you are regularly scheduled to work at least 30 hours per week.
- As of your date of hire with Airgas, if you are a member of an acquired employee group, and are in an eligible employee group.

ENROLLMENT

All eligible Active Employees will be enrolled automatically.

EFFECTIVE DATE

Coverage begins on the date you become eligible.

SUMMARY OF COVERAGE

Advice you can count on. LifeWorks is an employee resource program brought to you and your family free of charge by Airgas to help you manage personal issues at work or at home. Lifeworks services are confidential.

Call 888-267-8126 / TTY/TDD 800-346-9188

For Spanish speaking associates, please call 888-732-9020.

Call anytime to speak with a caring, professional consultant or visit **www.lifeworks.com** (user id: airgas; password: airgas) to explore our online resources.

LifeWorks consultants are available 24 hours a day, 7 days a week, 365 days a year.

In-person sessions with a local counselor - completely free. LifeWorks provides access to a national network of experienced, professional counselors who can help you, no matter where you are or what kind of situation you're facing.

Our plan provides **3 sessions of EAP counseling or the new Life Coaching sessions to every employee and dependent**. These can be either face-to-face or phone consultations for a variety of issues (including legal or financial as well as retirement).

LIFE COACHING

To help you deal with a major life change or tackle a key life goal.

Practical solutions on issues that matter to you.

- **Health** (diet and nutrition, exercise, weight management, sleep, back and neck pain, heart health)
- **Parenting and Child Care** (preparing for parenthood, adoption, special needs, working and parenting)
- **Education** (helping children succeed in school, choosing a school, applying to college, special education needs)
- **Helping Aging Parents** (elder housing, community services, caregiver support)
- **Emotional Well-being** (depression, relationship issues, grief and loss, domestic abuse, stress)
- **Addiction and Recovery** (substance abuse, gambling, and other addictions).

LifeWorks' researchers will provide information on everyday tasks that we often do not have time to get to because of everything else we have to do such as:

- finding a home or apartment
- home repair services
- vacation or recreation information
- volunteer opportunities
- pet grooming
- finding a veterinarian, pet kennels or pet trainers
- car maintenance and repair
- buying or leasing a car

For the topics listed above, and many more topics, the resources include:

- quick tips
- booklets
- audio recordings
- podcasts for employees and managers
- newsletters
- recorded seminars
- interactive self-assessments
- web links to other resources
- toolkits on specific topics such as addiction, divorce, managing stress, or the challenges of a changing workforce

Managers can log in and click the Work tab "For Managers" for access to the online resources for managers and a variety of podcasts and information. (Login: airgas, Password: airgas)

Check on the website for the annual **Manager Communication Plan** which you can use as a training resource to build management skills for new managers, for those who need to brush up on some basic skills or for those managers dealing with a particularly challenging work issue or work change. A new manager could use these monthly webinars as part of their development plan. Managers can call the Managers Help Line directly at 1-800-608-7515 for assistance with employee issues.

DEFINITIONS

Ceridian. Employer has engaged a third party, Ceridian, to assist in providing benefits under the EAP.

Claim. A "Claim" is a written request on a prescribed Claim Form for an EAP benefit or benefits. It includes a written request on a prescribed claim form received after the Claimant is notified that he or she was ineligible for the EAP or requested EAP Services for which he or she is ineligible or which are not covered by the EAP. A participant is not required to submit a Claim for EAP benefits that are covered by the EAP (instead the EAP provider submits the Claim on your behalf). A communication regarding benefits that is not made in accordance with these procedures will not be treated as a Claim under these procedures. Any request for EAP benefits that is not made in accordance with these claims procedures is considered an incorrectly filed claim.

Claimant. You become a "Claimant" when you make a request for an EAP benefit or benefits in accordance with these claims procedures.

Employer. "Employer" means Airgas, Inc.

EAP. The "EAP" is the Employer Employee Assistance Program. The EAP is intended to qualify as an excepted benefit under applicable guidance, including final regulations issued jointly by the Department of Labor, Internal Revenue Service and Department of Health and Human Services (79 Fed. Reg. 59130 (Oct. 1, 2014)).

EAP Services. The EAP provides the following services, some of which may be considered medical care:

EAP Assessment: the EAP will provide 24-hour access via telephone to a consultant who can initially assess a participant's needs.

Assessment and Referral: based on the EAP Assessment, an EAP consultant will provide further assessment, consultation, resources and/or referrals to assist a participant with emotional wellbeing and work-life issues. Based on the assessment, a participant may be referred to Short-term Solution-focused Counseling, clinical services outside the EAP, such as the participant's health insurance plan, other community resources, and/or provided with publications and educational materials.

Short-term Solution-focused Counseling ("Counseling"): for participants with emotional wellbeing issues, the EAP will provide three (3) sessions of Counseling or the new Life Coaching sessions to every employee and dependent with a licensed mental health counselor. Based on participant preference, service eligibility and clinical appropriateness, the Counseling may be provided either face-to-face or via video.

The EAP does not provide services in the following situations:

- the individual's condition is high-risk or requires urgent care, including but not limited to presenting a risk of harm to self or others, and advanced-stage alcohol or drug usage (such individuals will be directed to call 9-1-1 or to otherwise seek care outside the EAP)
- the individual's condition has been diagnosed or the individual is already receiving care or treatment for a condition the Counseling might otherwise treat

The EAP does not provide services to the following individuals:

- under five years of age in any instance
- under 13 years of age without parental permission and engagement
- between 13 and 18 years of age without parental permission or a statement of emancipation

Plan Administrator/Named Fiduciary. Employer is the "Plan Administrator" and "Named Fiduciary" under the EAP responsible for making final claim and appeal decisions. Employer has the discretionary authority to interpret the EAP in order to make benefit decisions as it may determine in its sole discretion. Employer also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the EAP.

You. "You" means an EAP participant: an individual who is eligible to participate in the EAP and who has satisfied the requirements to enroll (if any).

CLAIMS AND APPEALS PROCEDURES

Claimants are entitled to full and fair review of any claims made under the EAP. The procedures described in this section are intended to comply with applicable regulations by providing reasonable procedures governing the filing of claims for EAP benefits, notification of benefit decisions, and appeal of adverse benefit determinations.

Type of Claims. All EAP Claims submitted by you are considered pre-service claims because the EAP specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the care. No urgent care claims can arise under the EAP because the EAP Services specifically exclude urgent care services.

How to File a Claim for Benefits. A Claim for EAP benefits is made when a Claimant submits a written Claim Form to Ceridian at:

Ceridian Lifeworks – Customer Recovery Department

480 Norristown Road – STE E

Blue Bell, PA 19422-2334

888-267-8126

Claim forms. Claim forms may be obtained by contacting Ceridian at the address or phone number above. A Claim Form will be treated as received by the EAP (a) on the date it is hand-delivered to Ceridian at the address indicated above; or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope addressed to Ceridian at the above address. The postmark on any such envelope will be proof of the date of mailing. Unless otherwise indicated, when used in these claims procedures, the term "day" means a calendar day. Any questions about these claims procedures may be directed to Ceridian at the above address and phone number.

Designating an Authorized Representative. An authorized representative may act on behalf of a Claimant with respect to a Claim or appeal under these claims procedures. No person (including a treating health care professional) will be recognized as an authorized representative until the EAP receives an Appointment of Authorized Representative form signed by the Claimant.

An Appointment of Authorized Representative form may be obtained by emailing **LWClaims@ceridian.com**, and completed forms must be submitted to Ceridian at the address above. Once an authorized representative is appointed, the EAP shall direct all information, notification, etc. regarding the Claim to the authorized representative. The Claimant shall be copied on all notifications regarding decisions, unless the Claimant provides specific written direction otherwise. Where appropriate, references in these claims procedures to Claimant include the Claimant's authorized representative.

Incorrectly Filed Claims. These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that the Claimant shall be notified as soon as possible but no later than 5 days following receipt by the EAP of the incorrectly filed claim. The notice shall explain that the request is not a Claim and describe the proper procedures for filing a Claim. The notice may be oral unless written notice is specifically requested by the Claimant.

Incomplete Claims. If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim. If a claim is incomplete, the EAP may deny the claim or may take an extension of time, as described below. If the EAP takes an extension of time, the extension notice shall include a description of the missing information and shall specify a period, of no less than 45 days, within which the necessary information must be provided. The timeframe for deciding the Claim shall be suspended from the date the extension notice is received by the Claimant until the date the missing necessary information is provided to the EAP. If the requested information is provided, the EAP shall decide the Claim within the extended period specified in the extension notice. If the

requested information is not provided within the time specified, the Claim may be decided without that information.

Claim Administration. In its consideration of a Claim, Ceridian will consult the EAP plan document/summary plan description, and all other documents that may have a bearing on the interpretation of the EAP or benefit, including past interpretations or claims of the same general type and applicable guidance from the Internal Revenue Service, the Department of Labor, or other governmental or private publications or authorities that may assist in interpreting language or administrative procedures of the EAP. Ceridian's decisions are ministerial in nature and do not involve or require discretionary authority; such authority rests solely with the Plan Administrator/Named Fiduciary.

Adverse Benefit Determination. A decision on a Claim is "adverse" if it is (a) a denial, reduction, or termination of; or (b) a failure to provide or make payment (in whole or in part) for, an EAP benefit.

Standard Timeframes for Deciding Initial Benefit Claims. The EAP shall decide an initial pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the Claim.

Extensions of Time. Despite the specified timeframes, nothing prevents the Claimant from voluntarily agreeing to extend the above timeframes. In addition, if the EAP is not able to decide a claim within the above timeframes due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the Claimant is notified in writing prior to the expiration of the initial timeframe applicable to the Claim. The extension notice shall include a description of the matters beyond the EAP's control that justify the extension and the date by which a decision is expected.

Notification of Initial Benefit Decision by EAP. Written notification of the EAP's decision on a Claim shall be provided to the Claimant whether or not the decision is adverse.

Notification of Adverse Benefit Decision. Written notification shall be provided to the Claimant of the EAP's adverse decision on a Claim. The information set forth in the notice will be provided in a manner calculated to be understood by the Claimant, and will include the following:

- a statement of the specific reason(s) for the adverse benefit determination;
- reference(s) to the specific EAP provision(s) on which the decision is based;
- a description of any additional material or information necessary to perfect the Claim and why such information is necessary;
- a description of the EAP appeal procedures and time limits for appeal of the decision, the right to obtain information about the claims procedures, and the right to sue in federal court after exhausting the EAP's claims procedures;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- if the decision involves scientific or clinical judgment, either (a) an explanation of the scientific or clinical judgment applying the terms of the EAP to the Claimant's medical circumstances; or (b) a statement that such explanation will be provided at no charge upon request; and
- if the decision is based on an EAP standard (such as a medical necessity standard), a description of that standard.

How to File an Appeal. A Claimant has a right to appeal an adverse benefit determination under these claims procedures. An appeal of an adverse benefit determination is filed when a Claimant submits a written Request for Review form (available from Ceridian) to Ceridian at the address above. A Request for Review form will be treated as received by the EAP (a) on the date it is hand-delivered to Ceridian at the indicated address; or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the indicated name and address. The postmark on any such envelope will be proof of the date of mailing.

Appeal Deadline. The appeal of an adverse benefit determination must be filed within 180 days following the Claimant's receipt of the notification of adverse benefit decision. Failure to comply with this important deadline will cause the Claimant to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

How Appeals Will Be Decided. The appeal of an adverse benefit determination will be reviewed and decided by Employer, as Named Fiduciary under the EAP. The person who reviews and decides an appeal will be a different individual than the person who made the initial benefit decision and will not be a subordinate of the person who made the initial benefit decision. The review by Employer will take into account all information submitted by the Claimant, whether or not presented or available at the initial benefit decision. Employer will give no deference to the initial benefit decision.

Consultation with Expert. In the case of a Claim denied on the grounds of a medical judgment, Employer will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same individual who was consulted, if any, regarding the initial benefit decision or a subordinate of that individual.

Access to Relevant Information. A Claimant shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits.

Timeframes for Deciding Appeals. Employer shall decide the appeal of a claim within a reasonable time appropriate to the circumstances, but no later than thirty (30) days after receipt by the EAP of the Request for Review form.

Notification of Decision on Appeal. Written notification of the decision on appeal shall be provided to the Claimant whether or not the decision is adverse.

Notification of Adverse Appeal Decision. The notification provided to the Claimant of an adverse determination on appeal shall include the following, written in a manner calculated to be understood by the Claimant:

- the specific reason(s) for the appeal decision;
- a reference to the specific EAP provision(s) on which the decision is based;
- a statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- a statement of the right to sue in federal court;
- a statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination;
- if the decision involves scientific or clinical judgment, disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the EAP to the Claimant's medical circumstances; or (b) a statement that such explanation will be provided at no charge on request; and
- Contact information for the DOL's Employee Benefits Security Administration and any applicable state consumer assistance program.

Judicial Review. Upon completion of these procedures, the Claimant may request judicial review of the final decision on the Claim. Any action brought by, or on behalf of, a Claimant for EAP benefits must be filed not later than 24 months after you knew or reasonably should have known of the facts behind your claim or, if earlier, within six months after completion of the EAP's internal claims procedures.

WHEN COVERAGE ENDS

Subject to the COBRA provisions below, your coverage and your family members' coverage will end when you terminate employment, go on an unpaid leave of absence (that is not a Family and Medical Leave Act leave), when you or your family members no longer meet the eligibility requirements, or when you pass away. Coverage for you and your family members will also terminate if the EAP is terminated or amended such that you or your family members lose eligibility for coverage. EAP coverage for you or your family members will, however, continue after one of the events described in the COBRA section.

COBRA ADMINISTRATION

This information regarding COBRA Administration applies only to the Employee Assistance Program (EAP) and does not describe or alter coverage under any other plan or program under COBRA or otherwise.

The EAP is a group health plan that is generally subject to COBRA. COBRA allows participants who lose coverage due to a qualifying event to continue coverage for a period of 18 to 36 months, depending on circumstances.

Under the EAP, each qualified beneficiary is automatically entitled to 36 months of free coverage after a qualifying event. No election or other action is required to secure this coverage and no fees or premiums apply.

In addition, during this 36-month period, other individuals (such as a new spouse or dependent) who experience an event that generally triggers EAP eligibility shall also become covered under the EAP for the remainder of the 36-month period.

The termination of the 36-month extension of eligibility is not a qualifying event under COBRA because the sponsoring employer will have provided continuation of EAP coverage equal to or exceeding the applicable COBRA continuation period with respect to each qualified beneficiary.

Airgas, Inc. 401(k) Plan
Summary Plan Description

This document constitutes part of a prospectus covering securities that have been registered under the Securities Act of 1933.
Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved the stock of Airgas, Inc. to be offered and issued under the prospectus or determined if the prospectus is truthful or complete. Any representation to the contrary is a criminal offense.
This document is dated November 11, 2015.

Airgas

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AIRGAS, INC. 401(K) PLAN SUMMARY PLAN DESCRIPTION INTRODUCTION TO YOUR PLAN

The Airgas, Inc. 401(k) Plan ("Plan") has been adopted to provide you with the opportunity to save for retirement on a tax-advantaged basis. This Plan is a type of qualified retirement plan commonly referred to as a 401(k) Plan. As a participant in the Plan, you may elect to contribute a portion of your compensation to the Plan.

Summary Plan Description

This Summary Plan Description ("SPD") contains information regarding when you may become eligible to participate in the Plan, your Plan benefits, your distribution options, and many other features of the Plan. You should take the time to read this SPD to get a better understanding of your rights and obligations under the Plan.

In this summary, Airgas has addressed the most common questions you may have regarding the Plan. If this SPD does not answer all of your questions, please contact the Administrator or other plan representative. The Administrator is responsible for responding to questions and making determinations related to the administration, interpretation, and application of the Plan. The name and address of the Administrator can be found at the end of this SPD in the "General Information About the Plan" section.

This SPD describes the Plan's benefits and obligations as contained in the legal Plan Document, which governs the operation of the Plan. The Plan Document is written in much more technical and precise language and is designed to comply with applicable legal requirements. If the non-technical language in this SPD and the technical, legal language of the Plan Document conflict, the Plan Document always governs. If you wish to receive a copy of the legal Plan Document, please contact the Administrator.

The Plan and your rights under the Plan are subject to federal laws, such as the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code, as well as some state laws. The provisions of the Plan are subject to revision due to a change in laws by the Internal Revenue Service (IRS) or Department of Labor (DOL). Airgas may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, Airgas will notify you.

Please refer to the 401(k) Plan Disclosure Document, which has been provided to you, for information on the following matters:

- Description and performance of investment options.
- Resale restrictions for executive officers.
- Requirements under Section 16 for executive officers
- Airgas' insider trading policy
- Documents incorporated by reference into the Disclosure Document

Types of Contributions

The following types of contributions may be made under this plan:

- employee salary deferral contributions, including both pre-tax 401(k) and after-tax Roth 401(k) contributions
- employee rollover contributions
- employer matching contributions

ARTICLE I
PARTICIPATION IN THE PLAN

Participation

Provided you are not an Excluded Employee, you may begin participating under the Plan once you have satisfied the eligibility requirements. The following describes the eligibility requirements. You should contact the Administrator if you have questions about the timing of your Plan participation.

Excluded Employees. If you are a member of a class of employees identified below, you are an Excluded Employee and you are not entitled to participate in the Plan for purposes of salary deferral contributions, rollover contributions and employer matching contributions. The Excluded Employees are:

- certain nonresident aliens who have no earned income from sources within the United States
- leased employees
- employees whose employment is governed by the terms of a collective bargaining agreement between Employee representatives (within the meaning of Code Section 7701(a)(46)) and the Employer under which retirement benefits were the subject of good faith bargaining between the parties; unless such agreement expressly provides for coverage in this Plan, in which case the extent and terms of participation shall be as set forth in the relevant collective bargaining agreement. See Appendix IV for a list of bargaining units eligible to participate and receive the employer matching contribution.

Eligibility Conditions. Provided you are not an Excluded Employee, you will be eligible to participate for purposes of salary deferral and rollover contributions as soon as administratively possible following your date of hire. Provided you are not an Excluded Employee and have completed one (1) Year of Service you are eligible to receive the employer matching contribution.

In determining whether you satisfy the minimum service requirements to participate under the Plan, all service you perform for Airgas or an affiliate will generally be counted. However, there are some exceptions to this general rule.

Break in Service Rules. If you terminate employment and are rehired, you may lose credit for prior service under the Plan's Break in Service rules.

You will have a Break in Service if you are not employed with Airgas for a period of at least twelve consecutive months. However, if you are absent from work for certain leaves of absence such as a maternity or paternity leave, the twelve consecutive month period beginning on the first anniversary of your first day of such absence will not constitute a Break in Service.

Service with Another Employer. For eligibility purposes, service with a business entity of which Airgas or a Participating Employer acquires 80% or more of the equity interests or business assets shall be credited if you were employed by that business entity and became an employee of Airgas or another Participating Employer as a result of the acquisition.

Military Service. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994, your qualified military service may be considered service with the Employer. If you may be affected by this law, ask the Administrator for further details.

If you leave Airgas to enter “qualified military service” recognized under USERRA, and you return to active employment with Airgas following such qualified military service, you may be able to make up contributions to the Plan.

Under USERRA, you can make pre-tax, Roth after-tax and catch-up 401(k) contributions (if eligible) to the Plan for your period of qualified military service as if you had continued to work for Airgas and received at least the rate of pay you were receiving before your military service. These contributions are in addition to any regular pre-tax, Roth after-tax and/or catch-up 401(k) contributions that you elect to make after your return from qualified military service. The amount of pre-tax, Roth after-tax and/or catch-up 401(k) contributions you may make up cannot exceed the amount you would have been permitted to contribute during your qualified military service. You have a period equal to three times the length of your military leave, but no more than five years, after your return to active employment to make up contributions.

In addition, Airgas will make matching contributions on your make-up pre-tax contributions and/or Roth after-tax contributions, based on what would have been made had the pre-tax contributions and/or Roth after-tax contributions been made during your qualified military service.

Please note that you must affirmatively elect such make up contributions; they will not be automatically made on your behalf. If you are eligible to contribute make up contributions to the Plan, you should contact your Human Resources Manager, the Plan Administrator, or Vanguard Participant Services for information on how you can elect to contribute make up contributions to the Plan.

If you terminate employment and are subsequently rehired, then you will be able to participate in the Plan on your date of rehire provided your prior service had not been disregarded under the Break in Service rules and you are otherwise eligible to participate in the Plan.

Catch-up Military Service Contributions. For more information refer to Military Service under Participation.

ARTICLE II
EMPLOYEE CONTRIBUTIONS

Salary Deferral Contributions. As a participant under the Plan, you may elect to reduce your compensation by a specific percentage and have that amount contributed to the Plan as a salary deferral contribution. There are two types of salary deferral contributions: pre-tax 401(k) contributions and after-tax Roth 401(k) contributions. For purposes of this SPD, "salary contributions" generally means both pre-tax 401(k) contributions and after-tax Roth 401(k) contributions. Regardless of the type of contribution you make, the amount you contribute is counted as compensation for purposes of Social Security taxes.

Pre-Tax 401(k) Contributions. If you elect to make pre-tax 401(k) contributions, then your taxable income is reduced by the contributions so you pay less in federal income taxes. Later, when the Plan distributes the contributions and earnings to you, you will pay taxes on those contributions and the earnings.

Therefore, with a pre-tax 401(k) contribution, federal income taxes on the contributions and on the earnings are only postponed. Eventually, you will have to pay taxes on these amounts.

Roth After-Tax 401(k) Contributions. If you elect to make Roth after-tax 401(k) contributions, the contributions are subject to federal income taxes in the year of contribution. However, the contributions and, in most cases, the earnings on the contributions are not subject to federal income taxes when distributed to you. In order

for the earnings to be tax free, you must meet certain conditions.

Contribution Procedure. The amount you elect to contribute will be deducted from your pay in accordance with a procedure established by the Administrator. You may elect to contribute a portion of your salary as of your Entry Date. Such election will become effective as soon as administratively feasible after it is received by the Administrator. Your election will remain in effect until you modify or terminate it.

Contribution Modifications. You are permitted to change or revoke your salary contribution election at any time during the Plan Year. You may make any other modification as of each payroll period. Any modification will become effective as soon as administratively feasible after it is received by the Administrator.

Deferral Contribution Limit. As a participant, you may elect to contribute not less than 1% and not more than 50% of your compensation each year instead of receiving that amount in cash. Your total contributions in any taxable year may not exceed a dollar limit which is set by law. The IRS limit for 2015 is $18,000. The dollar limit may increase for cost-of-living adjustments in the future. See the paragraph below on Annual dollar limit.

Catch-up Contributions. If you are at least age 50 or will attain age 50 before the end of the calendar year, then you may elect to contribute additional amounts (called "catch-up contributions") to the Plan as of the January 1st of that year. The additional amounts may be contributed regardless of any other limitations on the amount that you may contribute to the Plan. The maximum "catch-up contribution" that you can make in 2015 is $6,000. The maximum may increase for cost-of-living adjustments in the future.

Catch-up Contributions – Military Service. For more information refer to Military Service under Participation.

Automatic Deferral Contributions. The Plan includes an automatic salary contribution feature. Accordingly, unless you make an alternative salary contribution election, Airgas will automatically withhold a portion of your compensation, currently 2%, from your pay each payroll period and contribute that amount to the Plan as a pre-tax 401(k) contribution.

Automatic Contribution Provisions. The following provisions apply to these automatic contributions:

- You may complete a salary contribution agreement to select an alternative contribution amount or to elect not to contribute under the Plan in accordance with the contribution procedures of the Plan.
- The amount to be automatically withheld from your pay each payroll period will be equal to 2% of your compensation.
- While you are a participant, the contribution amount will automatically increase by 1% each year up to a maximum of 20% of your compensation. The increase occurs every October in each subsequent Plan Year after your initial automatic contribution, unless you elect otherwise.
- If you were eligible to actively participate in the Encompass Plan as of December 12, 2014, and had a valid election of 0% at the time of the merger of the Encompass Plan into the Airgas Plan, you will be automatically enrolled in the Airgas Plan effective as of February 15, 2015, unless you affirmatively elect otherwise.

Contact the Administrator if you have any questions concerning the application of this automatic contribution provision.

Annual Dollar Limit. You should also be aware that the annual dollar limits on the amount you may contribute to pre-tax contributions, pre-tax catch-up contributions and Roth after-tax contributions apply to all such similar Plans that you participated during the year. Generally, if an annual dollar limit is exceeded, then the excess must be returned to you in order to avoid adverse tax consequences.

If you were in more than one plan during the calendar year, you must decide which plan or arrangement you would like to return the excess. If you decide that the excess should be distributed from this Plan, you must communicate this in writing to the Administrator no later than the February 1st following the close of the calendar year in which such excess deferral contributions were made. However, if you were only contributing to this Plan, the Administrator will then return the excess contributions and any earnings to you by April 15th.

Allocation of Contributions. The Administrator will allocate the amount you elect to contribute to an account maintained on your behalf. You will always be 100% vested in this account. This means that you will always be entitled to all amounts that you contribute. This money will, however, be affected by any investment gains or losses. If there is an investment gain, then the balance in your account will increase. If there is an investment loss, then the balance in your account will decrease.

Distribution of Contributions. The purpose of the Plan is to help you save for retirement as such, the IRS limits distribution from 401(k) Plans. The rules regarding distributions of amounts attributable to your salary contributions are explained later in this SPD.

Rollover Contributions. At the discretion of the Administrator, if you are a Participant who is currently employed or an Eligible Employee, you may be permitted to deposit into the Plan distributions you have received from other

retirement plans and certain IRAs. Such a deposit is called a "rollover" and may result in tax savings for you. You may ask the Administrator or Trustee of the other plan or IRA to directly transfer (a "direct rollover") to this Plan all or a portion of any amount that you are entitled to receive as a distribution from such plan. Alternatively, if you received a distribution from a prior plan, you may

elect to deposit any amount eligible to be rolled over within 60 days of your receipt of the distribution. You should consult qualified counsel or a financial advisor to determine if a rollover is permitted and in your best interest. A list of permitted rollovers is included at Appendix II of this SPD.

Rollover Account. Your rollover will be accounted for in a separate "rollover account." You will always be 100% vested in your "rollover account" (see the Article in this SPD entitled "Vesting"). This means that you will always be entitled to all amounts in your rollover account. Rollover contributions will be affected by any investment gains or losses. In addition, any Roth after-tax 401(k) contributions that are accepted as rollovers in this Plan will be accounted for separately..

Withdrawal of Rollover Contributions. You may withdraw the amounts in your "rollover account" at any time.

ARTICLE III
EMPLOYER CONTRIBUTIONS

In addition to any contributions you elect to make, Airgas will make additional contributions to the Plan.

Matching Contribution. Airgas will make a matching contribution equal to 50% of your salary deferral contributions up to 4% of your compensation after one year of service. Salary contributions for each payroll period that exceed 4% of your compensation for such period will not be considered in determining the matching contribution.

Matching Contribution Military Service Catch-up. For more information refer to Military Service under Participation.

Collective Bargaining Exceptions. If you are covered by a collective bargaining agreement, you shall not be eligible to share in matching contributions unless participation in matching contributions is provided for in the relevant collective bargaining agreement. If you are covered by a collective bargaining agreement for the Elmira Local 529 union and joined the Plan prior to 1/1/2014, you are not eligible to share in the matching contribution for the Plan. Anyone hired for the Elmira Local 529 union after 1/1/2014 is not eligible for the Plan. Please see Appendix IV for a list of current unions that participate in the plan.

ARTICLE IV
COMPENSATION AND ACCOUNT BALANCE

Definition of Compensation. For the purposes of the Plan, compensation has a very specific definition. Compensation is generally defined as your total compensation subject to income tax withholding and paid to you by Airgas during the Plan Year. Compensation also includes any amount that would have been subject to income tax withholding except for your election to have that amount contributed on a pre-tax basis to the Plan, a cafeteria plan or certain other plans. Amounts paid to you before you are eligible for the Plan and after you terminate employment are generally not treated as compensation under the Plan.

In general, salary and commissions are included and bonuses are excluded for purposes of determining compensation under the Plan. Reimbursements or other expense allowances, fringe benefits, moving expenses, deferred compensation, and welfare benefits will be excluded.

In addition, income from the exercise of stock options, receipt or vesting or restricted stock grants, exercise of stock appreciation rights or similar equity-based compensation arrangements; severance pay; accrued vacation pay and accrued sick pay paid in one lump sum after termination of employment; or similar items will be excluded (even if includible in gross income).

The Plan, by law, cannot recognize annual compensation in excess of a certain dollar limit. The limit for the Plan Year beginning in 2015 is $265,000.The IRS dollar limit may increase for cost-of-living adjustments in future years.

Generally, the law imposes a maximum limit on the amount of contributions (excluding catch-up contributions) that may be made to your account and any other amounts allocated to any of your accounts during the Plan Year, excluding earnings. In 2015, this total cannot exceed the lesser of $53,000 or 100% of your annual compensation. The dollar limit may increase for cost-of-living adjustments in future years.

The Trustee of the Plan has been designated to hold the assets of the Plan for the benefit of Plan participants and their beneficiaries in accordance with the terms of this Plan. The trust fund established by the Plan's Trustee will be the funding medium used for the accumulation of assets from which Plan benefits will be distributed.

Participant Directed Investments. You direct the investment of your entire account in the Plan. Go to www.vanguard.com for detailed information on the investment choices available to you and to make investment elections. You can change your investment choices online at any time. Elections made after 4pm ET are effective the next business day. You should carefully review the information provided to you before you provide investment directions. If you do not select investment options, then your accounts will be invested in accordance with the Qualified Default Investment Alternative (QDIA) Fund established under the Plan. This default investment will be made in accordance with specific rules under which the fiduciaries of the Plan, including Airgas, the Trustee and the Plan Administrator, will be relieved of any legal liability for any losses resulting from the default investments. Participants may change investment elections at any time.

The Plan is intended to comply with Section 404(c) of ERISA (the Employee Retirement Income Security Act). If the Plan complies with this Section, then the fiduciaries of the Plan, including Airgas, the Trustee and the Administrator, will be relieved of any legal liability for any losses which may result from the investment directions that you give.

Earnings or Losses. When you direct investments, your accounts are segregated from all other participants for purposes of determining the earnings or losses on these investments. You should remember that the amount of your benefits under the Plan will depend upon your elected contributions and upon your choice of investments. Gains as well as losses can occur. Airgas, the Administrator, and the Trustee cannot provide investment advice or guarantee the performance of any investment you choose.

Expenses Allocated to All Accounts. The Plan permits the payment of Plan expenses to be made from the Plan's assets, and may be charged against your account in the Plan. Applicable expenses are detailed in the Plan's annual participant fee disclosures and on your quarterly account statement.

Terminated Employee. After you terminate employment, Airgas reserves the right to charge your account for your share of the Plan's administration expenses, regardless of whether Airgas pays some of these expenses on behalf of current employees.

Expenses Allocated to Individual Accounts. There are certain other expenses that may be paid just from your account. These are expenses that are specifically incurred by, or attributable to, you. Applicable expenses that may be charged against your account are detailed in the Plan's annual participant fee disclosures and on your quarterly account statement.

Airgas may, from time to time, change the manner in which expenses are allocated.

ARTICLE V
VESTING

100% Vested Contributions. You are always 100% vested (which means that you are entitled to all of the amounts) in your accounts attributable to the following contributions:

- Salary deferral contributions, including Roth after-tax 401(k) contributions and any catch-up contributions
- rollover contributions
- matching contributions

ARTICLE VI
DISTRIBUTIONS WHILE ACTIVELY EMPLOYED AND HARDSHIP DISTRIBUTIONS

In-service Distributions. You may be entitled to receive an in-service distribution. However, this distribution will reduce the value of the benefits you will receive at retirement. This distribution is made at your election and will be made only in accordance with the forms of distributions available under the Plan.

Conditions and Limitations. Generally you may receive a distribution from the Plan from certain accounts while actively employed provided you satisfy any of the following conditions:

- you have attained age 59 1/2
- you have attained age 55 and have an account attributable to transferred accounts from the Industrial Gas Products & Supply, Inc. Profit Sharing Plan.

You may take a distribution of your rollover account at any time; however you will be subject to tax and penalties as applicable.

The law restricts any in-service distributions from certain accounts which are maintained for you under the Plan before you reach age 59 1/2 subject to limited exceptions that are explained below.

If you remain employed past your Normal Retirement Date, you may generally defer the receipt of benefits until you actually terminate employment. In such event, benefit payments will begin as soon as feasible at your request, but generally not later than age 70 1/2.

If you were part of a retirement plan from an acquisition and had an accrued benefit at the time of the Plan merger, be sure to check with your Human Resources Manager, the Plan Administrator, or Vanguard Participant Services for any protected benefits.

This document is a summary of the Plan's benefits. If there is any discrepancy between this document and the Plan Document, the Plan Document will prevail.

Qualified Reservist Distributions. If you were/are: (i) a reservist or National Guardsman; (ii) called to active duty; and (iii) called to duty for at least 180 days or for an indefinite period, you may take a distribution of your elective contributions under the Plan while you are on active duty, regardless of your age. The 10% early distribution penalty tax, normally applicable to Plan distributions made before you reach age 59 1/2, will not apply to the distribution. While you cannot repay this distribution to the 401(k) Plan, you may repay the distribution to an IRA, without the normal IRA limits, provided you make the repayment within 2 years following your completion of active duty.

Annuity Waiver. Under limited circumstances, you may also receive distributions while you are still employed with Airgas. If you wish to receive an in-service distribution from the Plan in a single payment from your account, you (and your spouse, if you are married) must first waive the annuity form of payment. This is only applicable to participants who rolled over a balance from a prior Plan due to an acquisition. Contact Vanguard directly to determine your account balance from your prior Plan employer that is available for this type of distribution, if any.

Military Service. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the Employer. There may also be benefits for employees who die or become disabled while on active duty. Employees who receive wage continuation payments while in the military may benefit from law changes effective in 2009. If you think you may be affected by these rules, ask the Plan Administrator for further details.

Hardship Distributions. You may withdraw money from your account for financial hardship if you satisfy certain conditions listed below. A hardship distribution will reduce the value of the benefits you will receive at retirement.

Qualifying Expenses. A hardship distribution may be made to satisfy certain immediate and heavy financial needs that you have. A hardship distribution may only be made for payment of the following:

- Expenses for medical care (described in Section 213(d) of the Internal Revenue Code) previously incurred by you, your spouse or your dependents or necessary for you, your spouse or your dependents to obtain medical care.
- Costs directly related to the purchase of your principal residence (excluding mortgage payments).
- Tuition, related educational fees, and room and board expenses for the next twelve (12) months of post-secondary education for yourself, your spouse or your dependents.
- Amounts necessary to prevent your eviction from your principal residence or foreclosure on the mortgage of your principal residence.
- Payments for burial or funeral expenses for your deceased parent, spouse, children or other dependents.
- Expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under the Internal Revenue Code.

Conditions. If you have any of the above qualifying expenses, a hardship distribution can be made if you certify and agree that all of the following conditions are satisfied:

(a) The distribution is not in excess of the amount of your immediate and heavy financial need. The amount of your immediate and heavy financial need may include any amounts necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated to result from the distribution;

(b) You have obtained all distributions, other than hardship distributions, and all nontaxable loans currently available under all plans that Airgas maintains; and

(c) That you will not make any salary deferral contributions to this Plan for a period of six (6) months after your receipt of the hardship distribution. When the six months expire, your current salary deferral will automatically re-start unless you login to your account and make a different election.

Account Restrictions. You may request a hardship distribution only from the following accounts:

- Pre-tax 401(k) contribution accounts
- Roth after-tax 401(k) contribution accounts
- Accounts attributable to Employer profit sharing contributions
- Rollover accounts
- Transfer accounts from prior Plan acquisitions not subject to in-service distribution limitations.

Hardship distributions are not permitted from matching contributions made to this plan.

Generally, the only amounts that can be distributed to you on account of a hardship from these accounts are your salary contributions. The earnings on your salary contributions and special Employer contributions, if any, may not be distributed to you on account of a hardship. Ask the Administrator if you need further details.

Annuity waiver. If you wish to receive a hardship distribution from the Plan in a single payment from your

account, you (and your spouse, if you are married) must first waive the annuity form of payment. This is only applicable to participants who rolled over a balance from a prior Plan due to an acquisition. Contact Vanguard directly to determine if this applies to your account.

ARTICLE VII
BENEFITS AND DISTRIBUTIONS UPON TERMINATION OF EMPLOYMENT

You may receive a distribution of the vested portion of some or all of your accounts in the Plan for the following reasons:

- termination of employment for reasons other than death, disability or retirement
- normal retirement
- disability
- death

This Plan is designed to provide you with retirement benefits. However, distributions are permitted upon your death or if you become disabled. The rules under which you can receive a distribution are described below. The rules regarding the payment of death benefits to your beneficiary are described in "Benefits and Distributions Upon Death." If your employment terminates for reasons other than normal retirement, you will be entitled to receive your total account balance.

You may elect to have your account balance distributed to you as soon as administratively feasible following your termination of employment. However, if the value of your account balance does not exceed $5,000, then a distribution will be made to you regardless of whether you consent to receive it.

Normal Retirement Date. Your Normal Retirement Date is the date on which you attain your 65th birthday.

Payment of Benefits. The actual payment of benefits generally will not begin until you have terminated employment. In such event, a distribution will be made, at your election, as soon as administratively feasible.

Definition of Disability. Under the Plan, disability is defined as a physical or mental condition resulting from bodily injury, disease, or mental disorder which renders you incapable of continuing any gainful occupation and which has lasted or can be expected to last for a continuous period of at least twelve (12) months. Your disability must be determined by a licensed physician who confirms your current care and provides a letter (typed) on the physician's letterhead, dated and signed. However, if your condition constitutes total disability under the federal Social Security Act and you provide your Social Security disability award letter, then the Administrator may deem that you are disabled for purposes of the Plan.

Payment of Benefits. If you become disabled while an employee, you will be entitled to your account balance under the Plan. Payment of your disability benefits will be made to you as if you had retired. However, if the value of your account balance does not exceed $5,000, then a distribution of your account balance will be made to you, regardless of whether you consent to receive it.

Forms of Distribution. If your account balance does not exceed $5,000, then your account balance may only be distributed to you in a single lump-sum payment. In addition, if your account balance exceeds $5,000, you must consent to any distribution before it may be made. If your account balance exceeds $5,000, you may elect to receive a distribution of your account balance in:

- a single lump-sum payment
- partial withdrawals for disability purposes only
- partial withdrawals or installments but only with respect to minimum required distributions, over a period of not more than your assumed life expectancy (or you and your beneficiary's assumed life expectancies).

If any of your plan assets were a rollover from a previous Plan employer due to an acquisition, your distribution may be subject to Qualified Joint Survivor Annuity (QJSA) rules and spousal consent. Contact Vanguard to determine if this applies to your account.

Delaying Distributions. You may delay the distribution of your account balance unless a distribution is required to be made, as explained earlier, because your account balance does not exceed $5,000.

However, if you elect to delay the distribution of your account balance, there are rules that require that certain minimum distributions be made from the Plan at age 70 ½. You should see the Administrator if you think you may be affected by these rules.

ARTICLE VIII
BENEFITS AND DISTRIBUTIONS UPON DEATH

If you die while still employed by Airgas, then your account balance will provide your beneficiary with a death benefit.

Married Participant. As required by law, if you are married at the time of your death, your spouse will be the beneficiary of the entire death benefit unless you previously made an election to change the beneficiary.

IF YOU WISH TO DESIGNATE A BENEFICIARY OTHER THAN YOUR SPOUSE, YOUR SPOUSE MUST IRREVOCABLY CONSENT TO WAIVE ANY RIGHT TO THE DEATH BENEFIT. YOUR SPOUSE'S CONSENT MUST BE IN WRITING, BE WITNESSED BY A NOTARY OR A PLAN REPRESENTATIVE AND ACKNOWLEDGE THE SPECIFIC NONSPOUSE BENEFICIARY.

If you are married and you change your designation, then your spouse must again consent to the change. In addition, you may elect a beneficiary other than your spouse without your spouse's consent if your spouse cannot be located.

Unmarried Participant. If you are not married, you may designate a beneficiary on the website at Vanguard.com.

Divorce. If you have designated your spouse as your beneficiary for all or part of your death benefit, then upon your divorce, the designation is no longer valid. This means that if you do not select a new beneficiary after your divorce, then you are treated as not having a beneficiary for that portion of the death benefit (unless you have remarried).

No Beneficiary Designation. At the time of your death, if you have not designated a beneficiary or the individual named as your beneficiary is not alive, then the death benefit will be paid in the following order of priority to: the surviving spouse or domestic partner, but if no spouse or domestic partner, then to the estate. This hierarchy is effective July 1, 2014. For purposes of this provision, the term “domestic partner” means an individual (whether same-sex or opposite-sex) with whom the Participant has entered into a domestic partnership that has been registered with a state or local government domestic partnership registry.

The law generally restricts the ability of a retirement plan to be used as a method of retaining money for purposes of your death estate. Thus, there are rules that are designed to ensure that death benefits are distributable to beneficiaries within certain time periods. For additional information, contact Vanguard at 1-800-523-1188.

Since your spouse has certain rights to the death benefit, you should immediately report any change in your marital status to the Administrator.

ARTICLE IX
TAX TREATMENT OF DISTRIBUTIONS

Generally, you must include any Plan distribution in your taxable income in the year in which you receive the distribution. The tax treatment may also depend on your age when you receive the distribution. Certain distributions made to you when you are under age 59 1/2 are subject to an additional 10% early distribution penalty.

You will not be taxed on distributions of your Roth after-tax 401(k) contributions. In addition, a distribution of the earnings on the Roth after-tax 401(k) contributions will not be subject to tax if the distribution is a "qualified" distribution. A "qualified" distribution is one that is made after you have attained age 59 1/2 or is made on account of your death or disability. In addition, in order to be a "qualified" distribution, the distribution cannot be made prior to the expiration of a 5-year participation period. The 5-year participation period is the 5-year period beginning on the calendar year in which you first make a Roth after-tax 401(k) contribution to our Plan (or to another 401(k) plan or 403(b) plan if such amount was rolled over into our Plan) and ending on the last day of the calendar year that is 5 years later. For example, if you make your first Roth after-tax 401(k) contribution under this Plan on November 30, 2009, your participation period will end on December 31, 2014. It is not necessary that you make a Roth after-tax 401(k) contribution in each of the five years.

Qualified Reservist Distributions. if you were/are: (i) a reservist or National Guardsman; (ii) called to active duty; and (iii) called to duty for at least 180 days or for an indefinite period, you may take a distribution of your elective contributions under the Plan while you are on active duty, regardless of your age. The 10% early distribution penalty tax, normally applicable to Plan distributions made before you reach age 59 1/2, will not apply to the distribution. While you cannot repay this distribution to the 401(k) Plan, you may repay the distribution to an IRA without the normal IRA limits, provided you make the repayment within 2 years following your completion of active duty.

Rollover or Direct Transfer. You may reduce, or defer entirely, the tax due on your distribution through use of one of the following methods:

(a) 60-day Rollover. You may rollover all or a portion of an eligible rollover distribution to an Individual Retirement Account (IRA) or Annuity or another employer retirement plan willing to accept the rollover. A rollover will result in no tax being due until you begin withdrawing funds from the IRA or the qualified employer plan.

The rollover MUST be made within a strict time frame, which is usually 60 days from the date on the check. Any portion of a distribution that is not rolled over will generally be taxed.

(b) Direct Rollover. For most distributions, you may request a direct rollover of all or a portion of a distribution be made to either an Individual Retirement Account (IRA) or Annuity or another employer retirement plan willing to accept the rollover. A direct rollover will result in no tax being due until you withdraw funds from the IRA or other employer plan at a later date.

Automatic IRA Rollover. If a mandatory distribution is being made to you because you terminated employment, retired or are disabled and your account balance in the Plan does not exceed $5,000 but is over $1,000, then the Plan requires that your distribution be directly rolled over to an IRA if you do not make an affirmative election to either receive or rollover the account balance. The IRA provider selected by the Plan will invest the rollover funds in a type of investment designed to preserve principal and provide a reasonable rate of return and liquidity (e.g., an interest-bearing account, a certificate of deposit or a money market fund). The IRA provider will charge your account for any expenses associated with the establishment and maintenance of the IRA and with the IRA investments. You may transfer the IRA funds to any other IRA you choose. You will be provided with details regarding the IRA at the time you are entitled to a distribution. However, you may contact the Plan Administrator at the address and telephone number indicated in this SPD for further information regarding the Plan's automatic rollover provisions, the IRA provider, and the fees and expenses associated with the IRA.

Tax Notice. THE ADMINISTRATOR WILL DELIVER A DETAILED TAX NOTICE TO YOU AT THE TIME OF YOUR DISTRIBUTION. HOWEVER, AS THE RULES WHICH DETERMINE WHETHER YOU QUALIFY FOR FAVORABLE TAX TREATMENT ARE VERY COMPLEX WE RECOMMEND YOU CONSULT WITH QUALIFIED TAX COUNSEL OR A FINANCIAL ADVISOR BEFORE MAKING YOUR DISTRIBUTION DECISION.

ARTICLE X
LOANS

You may request a participant loan from your account by contacting Vanguard online at www.Vanguard.com or by calling Participant Services at 1-800-523-1188.

There are various rules and requirements that apply to any loan, which are outlined below. In addition, Airgas has established a written loan policy which explains these requirements in more detail. Generally, the rules for loans include the following:

- Loans are available to participants with a vested account balance on a reasonably equivalent basis.
- All loans must be adequately secured. You must sign a promissory note along with a loan pledge. Generally, you must use your interest in the Plan as security for the loan, provided the outstanding balance of all your loans does not exceed 50% of your interest in the Plan.
- You will be charged a commercially reasonable rate of interest. The Administrator will determine a reasonable rate of interest by reviewing the interest rates charged for similar types of loans by other lenders. The interest rate will be fixed for the duration of the loan.
- If approved, your loan will provide for level amortization with payments to be made by payroll deduction on an after-tax basis according to your regular pay schedule. Generally, the term of your loan may not exceed five (5) years. However, if the loan is for the purchase of your principal residence, the Administrator may permit a longer repayment term up to ten (10) years. Generally, the Administrator will require that you repay your loan by agreeing to payroll deduction. If you have an unpaid leave of absence or go on military leave while you have an outstanding loan, please contact the Administrator to find out your repayment options.
- All loans are considered a directed investment of your account under the Plan. All payments you make of principal and interest will be credited to your account.
- The loan amount you qualify for is limited by rules under the Internal Revenue Code. Any new loans, when added to the outstanding balance of all other loans from the Plan, will be limited to the lesser of:

(a) $50,000 reduced by the excess, if any, of your highest outstanding balance of loans from the Plan during the one-year period ending on the day before the date of the new loan over your current outstanding balance of loans as of the date of the new loan; or

(b) 1/2 of your interest in the Plan.

- No loan in an amount less than $1,000 will be made.
- Generally, the maximum number of Plan loans that you may have outstanding at any one time is one. However, you may have more than one outstanding loan if you were a participant in a plan that merged into this Plan and you had loans outstanding in your prior plan at the time of the merger. In such a case, you will be permitted to have the number of loans you had at the time your prior plan merged into the Plan until they are paid in full. As you pay off your outstanding loans,

the number of loans you are permitted to have outstanding will be reduced until you have one outstanding loan, at which point you will be permitted to only have one outstanding loan at a time.

- Your spouse generally must consent to any loan before it can be made if you use your vested interest as security for the loan.
- After a loan is paid off, there is a 30-day waiting period before you are eligible to take a new loan.
- If you fail to make payments when they are due under the terms of the loan, you will be considered to be "in default." The Administrator will consider your loan to be in default if any scheduled loan repayment is not made by the end of the calendar quarter following the calendar quarter in which the missed payment was due. The Plan must take all reasonable actions to collect the balance owed on the loan. Under certain circumstances, a loan that is in default may be considered a distribution from the Plan and could be considered taxable income to you. In any event, your failure to repay a loan will reduce the benefit you would otherwise be entitled to from the Plan at retirement or upon your termination, disability or death.

It is your responsibility to ensure your loan repayments are accurate. If you change payroll frequency because you transfer to a different Airgas business, you must notify your HR Manager immediately or your loan may be in jeopardy of defaulting.

Unpaid Leave of Absence. If you go on an approved leave of absence without pay, other than for military service as discussed below, the Plan allows you to temporarily suspend your repayments.

Suspension of Repayments. The suspension of loan payments will remain in effect until the earliest of the following:

- 12 months after the date your leave of absence begins. If you remain on leave, you will receive information to begin to pay your loan payments in order to avoid default.
- The end of the maximum loan term permitted for your loan type under the Plan. If the loan meets the maximum term while you are still on leave, you will receive information to begin to pay your loan payments in order to avoid default.
- The date you return from leave. Upon your return from leave, you must resume loan repayments. Vanguard will re-amortize your remaining balance plus interest without extending the payoff date, which will result in higher loan payments.

Military Leave of Absence. If your leave of absence is the result of military service in the uniformed services (as defined in chapter 43 of title 38, United States Code), the 12-month limit on the payment suspension does not apply. In addition, if your loan interest rate is higher than 6%, you have the option to reduce the applicable interest rate during your military leave to 6%, as permitted under the Service Members Civil Relief Act. Please contact your HR Manager if you wish to take advantage of this relief.

If you do not make up missed repayment(s), your loan will be in default, and the outstanding balance of your loan, including interest, will be treated as a deemed distribution. The amount of the deemed distribution will be reported as taxable income and may be subject to an additional 10% early distribution penalty.

The amount reported as a deemed distribution will continue to be treated as if it is an outstanding loan, and interest will continue to accrue on the balance. As a result, the deemed distribution will count against your available number of outstanding loans under the Plan and will reduce any available loan amounts. Even after default, you have the option to repay the outstanding amount at any time on an after-tax basis. If you choose not to repay the deemed distribution, there are no consequences beyond its impact on your ability to take any future loans from the Plan.

To repay the outstanding balance on a loan that has been deemed distributed, you must call Vanguard Participant Services to obtain the total amount due. You must repay the amount due in a single lump-sum payment. Because your loan has already been reported as taxable income, your repayment will establish an after- tax basis in the Plan.

If you terminate your employment with an outstanding loan balance, your loan becomes due in full. The outstanding balance must be paid in full as soon as possible, but at least within 90 days. If you fail to do so, your outstanding loan balance will become taxable at year-end following 90 days after your termination date.

Bankruptcy filings have no impact on 401(k) Plan loans. If you file for bankruptcy and have an outstanding loan in the Plan, your loan payments to the Plan will not be stopped due to your bankruptcy filing. This means that your loan will continue to be outstanding and that you will be required to continue to make payments according to the repayment schedule even if you have declared

bankruptcy. Payroll deductions will not be altered as a result of a bankruptcy filing.

In the event of your death, any outstanding loan balance becomes due and payable in full. The executor/administrator of your estate may repay the balance of your loan within 90 days. If your executor/administrator does not repay the loan balance within that time frame, the unpaid balance of your loan will be defaulted against your account balance, and your beneficiary will receive the net account balance as the death benefit. Your estate will be liable for any taxes attributable to the defaulted loan.

The Administrator may periodically revise the Plan's loan policy. To request a copy, contact your HR Manager.

ARTICLE XI
PROTECTED BENEFITS AND CLAIMS PROCEDURES

As a general rule, your account balance in the Plan may not be alienated. This means that your account may not be sold, used as collateral for a loan (other than for a Plan loan), given away or otherwise transferred. In addition, your creditors may not attach, garnish or otherwise interfere with your account.

There are exceptions to this general rule. The Administrator must honor a "qualified domestic relations order." A "qualified domestic relations order" is defined as a decree or order issued by a court that obligates you to pay child support or alimony, or otherwise allocates a portion of your assets in the Plan to your spouse, former spouse, children or other dependents. If a qualified domestic relations order is received by the Administrator, all or a portion of your benefits may be used to satisfy that obligation. The Administrator will determine the validity of any domestic relations order received. You and your beneficiaries can obtain, without charge, a copy of the Qualified Domestic Relations Order Procedure from the Administrator.

Also, the Federal government is able to use your interest in the Plan to enforce a Federal tax levy and to collect a judgment resulting from an unpaid tax assessment.

Benefits will be paid to you and your beneficiaries without the necessity for formal claims. However, if you think an error has been made in determining your benefits, then you or your beneficiaries may make a request for any Plan benefits to which you believe you are entitled. Any such request should be in writing and should be made to the Administrator.

If the Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

Your request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If your claim is wholly or partially denied, the Administrator will provide you with a written or electronic notification of the Plan's adverse determination. This written or electronic notification must be provided to you within a reasonable period of time, but not later than 90 days after the receipt of your claim by the Administrator, unless the Administrator determines that special circumstances require an extension of time for processing your claim. If the Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

In the case of a claim for disability benefits, if disability is determined by a physician (because a Social Security disability award letter cannot be obtained), then instead of the above, the Administrator will provide you with written or electronic notification of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any such extension, the notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days within which to provide the specified information.

The Administrator's written or electronic notification of any adverse benefit determination must contain the following information:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the determination is based.

(c) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

(d) Appropriate information as to the steps to be taken if you or your beneficiary wants to submit your claim for review, including a statement regarding your right to bring a civil action under ERISA following an adverse determination on review.

(e) In the case of disability benefits where disability is determined by a physician:

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

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.

If your claim has been denied, and you want to submit your claim for review, you must follow the

Claims Review Procedure as follows:

Upon the denial of your claim for benefits, you may file your claim for review, in writing, with the Administrator.

(a) YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 60 DAYS AFTER YOU HAVE RECEIVED WRITTEN NOTIFICATION OF THE DENIAL OF YOUR CLAIM FOR BENEFITS.

HOWEVER, IF YOUR CLAIM IS FOR DISABILITY BENEFITS AND DISABILITY IS DETERMINED BY A PHYSICIAN, THEN INSTEAD OF THE ABOVE, YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 180 DAYS FOLLOWING RECEIPT OF NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION.

(b) You may submit written comments, documents, records, and other information relating to your claim for benefits.

(c) You may review all pertinent documents relating to the denial of your claim and submit any issues and comments, in writing, to the Administrator.

(d) You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

(e) Your claim for review must be given a full and fair review. This review will take into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition to the Claims Review Procedure above, if your claim is for disability benefits and disability is determined by a physician, then the Claims Review Procedure provides that:

(a) Your claim will be reviewed without deference to the initial adverse benefit determination and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

(b) In deciding an appeal of any adverse benefit determination that is based in whole or part on medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

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

(d) The health care professional engaged for purposes of a consultation under (b) above will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Administrator will provide you with written or electronic notification of the Plan's benefit determination on review. The Administrator must provide you with notification of this denial within 60 days after the Administrator's receipt of your written claim for review, unless the Administrator determines that special circumstances require an extension of time for processing your claim.

If the Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 60-day period. In no event will such extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. However, if the claim relates to disability benefits and disability is determined by a physician, then 45 days will apply instead of 60 days in the preceding sentences. In the case of an adverse benefit determination, the notification will set forth:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the benefit determination is based.

(c) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

(d) A statement of your right to bring a civil action under ERISA.

(e) In the case of disability benefits where disability is determined by a physician:

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

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.

If you have a claim for benefits which is denied, then you may file suit in a state or Federal court. However, in order to do so, you must file the suit no later than 180 days after the Administrator makes a final determination to deny your claim.

Plan Participant's Rights As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

(a) Examine, without charge, at the Administrator's office and at other specified locations, all documents governing the Plan 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.

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

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

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

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. You and your beneficiaries can obtain, without charge, a copy of the qualified domestic relations order ("QDRO") procedures from the Administrator.

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

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

ARTICLE XII
GENERAL INFORMATION ABOUT THE PLAN

There is certain general information which you may need to know about the Plan. This information has been summarized for you in this Article.

Plan Name: The full name of the Plan is Airgas, Inc. 401(k) Plan.

Plan Number: Airgas has assigned Plan Number 002 to your Plan.

Plan Effective Dates:This Plan was originally effective on January 1, 1988. The amended and restated provisions of the Plan become effective on December 15, 2014. However, this restatement was made so the Plan conforms to new tax laws and some provisions may be retroactively effective.

Other Plan Information. Valuations of the Plan assets are generally made every business day. Certain distributions are based on the Anniversary Date of the Plan. This date is the last day of the Plan Year.

The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1st and ends on December 31st.

The Plan and Trust will be governed by the laws of Pennsylvania to the extent not governed by federal law.

Benefits provided by the Plan are NOT insured by the Pension Benefit Guaranty Corporation (PBGC) under Title IV of the Employee Retirement Income Security Act of 1974 because the insurance provisions under ERISA are not applicable to this type of Plan.

Service of legal process may be made upon Airgas. Service of legal process may also be made upon the Trustee or Administrator.

Airgas has the right to amend the Plan at any time. In no event, however, will any amendment authorize or permit any part of the Plan assets to be used for purposes other than the exclusive benefit of participants or their beneficiaries. Additionally, no amendment will cause any reduction in the amount credited to your account.

Although Airgas intends to maintain the Plan indefinitely, Airgas reserves the right to terminate the Plan at any time. Upon termination, no further contributions will be made to the Plan. Airgas will direct the distribution of your accounts in a manner permitted by the Plan as soon as practicable. You will be notified if the Plan is terminated.

Employer Information. Airgas's name, address and identification number are:

Airgas, Inc.
259 N. Radnor-Chester Rd., Suite 100
Radnor, Pennsylvania 19087
56-0732648

The Plan allows other employers to adopt its provisions. Other Employers who have adopted the provisions of the Plan are:

Airgas Carbonic, Inc.
2530 Sever Road, STE 300
Lawrenceville, Georgia 30043
770-717-2210
58-2298979

Airgas On-Site Safety Services, Inc.
3915 E. LaSalle Street
Phoenix, Arizona 85040
602-459-3031
26-2769558

Airgas-Refrigerants, Inc.
2530 Sever Road, Suite 300
Lawrenceville, Georgia 30043
770-717-2210
26-2708880

Employer Information (continued)

Airgas Safety, Inc.
2501 Green Lane
Levittown, Pennsylvania 19087
215-826-9000
23-2840701

Airgas Specialty Gases, Inc.
2530 Sever Road, Suite 300
Lawrenceville, Georgia 30043
770-717-2210
76-0182866

Airgas Specialty Products, Inc.
2530 Sever Road, Suite 300
Lawrenceville, Georgia 30043
770-717-2210
20-2529374

Airgas USA, LLC
259 N Radnor-Chester Rd., Suite 100
Radnor, Pennsylvania 19087
610-687-5253
45-3153734

Nitrous Oxide Corp.
STE 300
2530 Sever Road
Lawrenceville, Georgia 30043
770-717-2210
23-2359281

Red-D-Arc Inc.
7060 Mableton Parkway SE,
Mableton, Georgia 30126
678-460-0122
88-0259460

The Plan Administrator is responsible for the day-to-day administration and operation of the Plan. For example, the Administrator maintains the Plan records, including your account information, provides you with the forms you need to complete for Plan participation, and directs the payment of your account at the appropriate time. The Administrator will also allow you to review the formal Plan document and certain other materials related to the Plan. If you have any questions about the Plan or your participation, you should contact the Administrator. The Administrator may designate other parties to perform some duties of the Administrator.

The Administrator has the complete power, in its sole discretion, to determine all questions arising in connection with the administration, interpretation, and application of the Plan (and any related documents and underlying policies). Any such determination by the Administrator is conclusive and binding upon all persons.

The name, address and business telephone number of the Plan's Administrator are: Airgas, Inc.
259 N. Radnor-Chester Rd., Suite 100
Radnor, Pennsylvania 19087
610-687-5253

Plan Trustee Information and Plan Funding Account

All money that is contributed to the Plan is held in a trust fund. The Trustee is responsible for the safekeeping of the trust fund. The trust fund established by the Plan's Trustee(s) will be the fund used for the accumulation of assets from which benefits will be distributed. While all the Plan assets are held in a trust fund, the Administrator separately accounts for each Participant's account in the Plan.

The name and address of the Plan's Trustee is:
Vanguard Fiduciary Trust Company

100 Vanguard Blvd.

Malvern, Pennsylvania 19355

APPENDIX I
PLAN EXPENSE ALLOCATIONS

The Plan will assess against an individual participant's account the following Plan expenses which are incurred by, or are attributable to, a particular participant based on use of a particular Plan feature, listed by type and the amount charged. All fees are subject to change.

- ***Participant loan.*** Participant loan application fee (includes processing and document preparation) and annual maintenance fee.
  Amount of application fee (self- provisioned): $35
  Amount of application fee (non self- provisioned): $85
  Amount of annual maintenance fee: $20
- ***Annual Recordkeeping Fee*** - $24 per participant; deducted from participants' accounts quarterly
- ***QDRO Determination Service Fee*** - $700 per Domestic Relations Order; deducted from participant's account upon occurrence

APPENDIX II
ROLLOVERS FROM OTHER PLANS

The Plan will accept Participant Rollover Contributions and/or Direct Rollovers of distributions from the types of plans specified below:

- a qualified plan described in section 401(a) of the Internal Revenue Code (including a 401(k) plan, profit sharing plan, defined benefit plan, stock bonus plan and money purchase plan), including after-tax employee contributions.
- a qualified plan described in section 403(a) of the Internal Revenue Code (an annuity plan),***including*** after-tax employee contributions.
- an annuity contract described in section 403(b) of the Internal Revenue Code (a tax-sheltered annuity), **excluding** after-tax employee contributions.
- a plan described in section 457(b) of the Internal Revenue Code (eligible deferred compensation plan).
- a Roth elective contribution account under a qualified plan described in section 401(a) of the Internal Revenue Code (a 401(k) plan).

Participant Rollover Contributions from IRAs:

- The Plan will accept a participant rollover contribution of the portion of a distribution from a traditional IRA that is eligible to be rolled over and would otherwise be includible in gross income. Rollovers from Roth IRAs or a Coverdell Education Savings Accounts (formerly known as an Education IRA) are not permitted because they are not traditional IRAs. A rollover from a SIMPLE IRA is allowed only after the participant has been in the SIMPLE IRA for at least two years.

APPENDIX III
VANGUARD ADMINISTRATION SERVICES INFORMATION

CONNECT WITH VANGUARD®

Online. Log on to vanguard.com for 24-hour access to information about your account, your plan's funds, and Vanguard's financial planning and advice services.

By phone. Get 24-hour access to your account and information about your funds through the automated VOICE® Network at 800-523-1188.

With personal assistance. Vanguard Participant Services associates are available to assist you with transactions and answer your questions at 800-523-1188 Monday through Friday from 8:30 a.m. to 9 p.m., Eastern Time.

SELF DIRECTION OF INVESTMENTS All contributions made to the Plan on your behalf will be credited to one or more separate accounts established in your name. Plan contributions are held in trust by the Trustee for the exclusive benefit of participating employees and their beneficiaries.

Information About the Investment Options Available in the Plan When you are eligible to participate in the Plan, you will be provided with comprehensive information about the investment options available in the Plan, including an explanation of the investment objectives and policies, risk and return characteristics, past and current investment performance (net of expenses), operating expenses, and the type and diversification of assets that make up the portfolio of each fund.

You will also receive ongoing updates of this information in the form of prospectuses and shareholder reports for each of the investment options that you have selected for the investment of your Plan contributions. If you have any questions or require more detailed information concerning any investment option, you can contact Vanguard.

How to Change Investment Directions The general rule is that you may change your investment directions among the investment options available in your Plan with respect to your future Plan contributions and/or existing individual account balances at any time as long as you act in accordance with the investment fund's prospectus or investment guidelines.

You are permitted to redeem shares from one fund to purchase shares of another fund under the Plan. Although every effort is made to maintain this exchange privilege, investment companies reserve the right to revise or terminate this privilege, limit the amount of an exchange, or reject any exchange, at any time, without notice. Because excessive exchanges can potentially disrupt the management of a fund and increase its transaction costs, certain limitations are placed on participant exchange activity. Note also, that certain investment options, particularly funds made up of company stock or investment contracts, may be subject to unique restrictions. Please see the prospectuses or investment guidelines for the funds you have selected for more details.

The transfer of existing balances will generally be made the same day if your transaction is received in complete and good order before the close of the New York Stock Exchange, (generally 4 p.m., Eastern time), or the earliest cut-off time of the funds involved. Vanguard will send a confirmation of your change to the address on file for you with Vanguard.

Responsibility for Investment Results The Plan is intended to comply with Section 404(c) of ERISA (the Employee Retirement Income Security Act of 1974). Because your Plan allows and encourages you to direct your investments and to have access to all pertinent information concerning your investments, the fiduciaries of the plan will be relieved of liability for the results of your investment decisions, as provided under Section 404(c) of ERISA.

When you direct investments, your accounts are segregated for purposes of determining the gains, earnings, or losses on these investments. Your account does not share in the investment performance for other Participants who have directed their own investments.

You should remember that the amount of your benefits under the Plan will depend in part upon your choice of investments. Gains as well as losses can occur. There are no guarantees of performance, and neither the Employer, the Administrator, the Trustee, nor any of their representatives provide investment advice or insure or otherwise guarantee the value or performance of any investment you choose. You will be responsible for any expenses and losses resulting from your choice of investments.

Keeping Track of Your Individual Accounts in the Plan Quarterly statements will be mailed to your home address or posted on Vanguard.com showing the total amounts credited to your individual accounts under the Plan as of the end of each calendar quarter.

These statements will reflect all Plan activities including contributions, earnings, investment exchanges, and distributions occurring within your individual accounts during the most recent calendar quarter. You can view account information at any time by logging onto vanguard.com

Rules Regarding Voting Rights in the Plan – Mutual Funds In the event of a mutual fund proxy, shares of mutual funds held in your individual accounts under the Plan will be voted by the Trustee on your behalf as directed by the Employer. In making voting decisions on the fund shares, the Employer will direct the Trustee to vote the mutual fund shares in the long-term, economic best interests of Plan Participants.

Rules Regarding Voting Rights in the Plan – Airgas stock As a Participant, you will be given the right to instruct the Trustee how to vote, and generally exercise all other rights which a shareholder of record has, for any shares of the Airgas, Inc. Common Stock held in your individual accounts. In the event of a proxy, if you fail to give the Trustee specific instructions, the Trustee will treat you as having directed the Trustee to vote your shares in the same proportion as the shares for which the Trustee has received voting instructions from other Participants in the Plan

As a responsible Participant, you should exercise your rights or vote your shares. The instructions that you provide to the Trustee for the shares of Airgas, Inc. Common Stock are held in the strictest confidence.

APPENDIX IV
BARGAINING UNITS

Division	Region	Union Type	Local	City, State	EV4 Union Code	Airgas 401(k)
West	West	Teamsters	Local 542	El Centro, CA	T542	YES
North	Northeast	Teamsters	Local 25	Hingham, MA	T25	YES
North	East	Teamsters	Local 701	Piscataway, NJ	T701	YES
North	East	Teamsters	Local 639	Bladensburg, MD	639	YES
North	East	Teamsters	Local 463	Bellmawr, NJ	463	YES
North	Great Lakes	USW	Local 2-0240	Murrysville, PA	2240	YES
North	Great Lakes	Teamsters	Local 397	Erie, PA	T397	YES
North	Northeast	Teamsters	Local 317	Syracuse, NY	T317	YES
North	East	Teamsters	Local 764	White Deer, PA	T764	YES
North	Great Lakes	Teamsters	Local 20 - OTR Drivers	Ottawa Lake, MI	20OR	YES
West	South	Teamsters	Local 385 - Cylinder Fillers & Handlers	Orlando, FL	T385	YES
West	South	Teamsters	Local 385 - Cylinder Route Drivers	Orlando, FL	385D	YES
South	Mid-America	Teamsters	Local 627	Peoria, IL	T627	YES
South	Mid-America	Teamsters	Local 279	Decatur, IL	T279	YES
North	Northeast	Teamsters	Local 633	Salem, NH	T633	YES
West	N CA Nevada	Teamsters	Local 665 (was 624)	Santa Rosa, CA	T665	YES
North	Great Lakes	USW	#9445	Creighton, PA	9445	YES
North	East	Teamsters	Local 355	Frederick, MD	T355	YES
West	West	Teamsters	Local 36	San Diego, CA	T36	YES

APPENDIX IV
BARGAINING UNITS (CONTINUED)

Division	Region	Union Type	Local	City, State	EV4 Union Code	Airgas 401(k)
	Merchant Gases	Paper, Allied-Industrial Chemical and Energy Workers International Union	Local 5-450	Canton, OH	5450	YES
North	Great Lakes	Teamsters	Local 406 - PLANT Lansing (was 486)	Lansing, MI	406L (was 486L)	YES
North	Great Lakes	Teamsters	Local 406 - DRIVERS - Lansing (WAS 486)	Lansing, MI	406D (was 486D)	YES
North	Northeast	Teamsters	Local 529	Elmira, NY	T529	NO to new hires after 1/1/14-NO MATCHING FUNDS
North	East	Teamsters	Local 773	Allentown, PA	773A	YES
North	Northeast	Teamsters	Local 25	Billerica, MA	T25B	YES
South	Mid-America	Teamsters	Local 175	Charleston, WV	TBD	YES
North	Great Lakes	USW	Local 240	Jannette, PA	TBD	YES
South	Mid-America	Teamsters	Local 26	Bloomington, IL	TBD	YES
South	Mid-America	Teamsters	Local 705 - South Chicago Heights	South Chicago Heights, IL	TBD	YES
North	East	Teamsters	Local 701	Lincoln Park, NJ	701L	YES
North	Great Lakes	Teamsters	Local 283	Wayne, MI	283W	YES
North	Northeast	Teamsters	Local 251	East Greenwich, RI	T251	YES

Airgas, Inc. 401(K) Plan
Disclousure Document

Airgas

401(K) PLAN DISCLOSURE DOCUMENT
This document is dated December 1, 2015

This disclosure document constitutes part of a prospectus covering securities that have been registered under the Securities Act of 1933. Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved the stock of Airgas, Inc. to be offered and issued under the prospectus or determined if the prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

Introduction

Airgas, Inc. currently maintains a 401(k) Plan that is designed to encourage long-term savings by Airgas employees for retirement or other purposes. This Disclosure Document, along with the Summary Plan Description, which is incorporated herein by reference and is also, provided to you, sets forth a description of the Airgas, Inc. 401(k) Plan and of the rights and benefits of participants under the Plan. It is not meant to interpret or change the provisions of the Plan. If any discrepancies exist between this Disclosure Document, including the Summary Plan Description, and the actual provisions of the Plan, the Plan will govern. Airgas urges each employee to read this Disclosure Document and the Summary Plan Description (also provided to you) carefully in its entirety before deciding whether, or how, to participate in the Plan. Employees should recognize that we cannot and do not provide any assurance that interests in the Plan, and any shares of Airgas Common Stock acquired under the Plan, will at any particular time be worth more or less than their purchase price.

Summary Plan Description Matters

Please refer to the Summary Plan Description for information on the following matters:

- General plan information, including the general nature, purpose and duration of the Plan; provisions for its modification, termination or extension; information on the Plan's tax qualification; application of the Employee Retirement Income Security Act of 1974 ("ERISA") to the Plan; and information on Plan administration.
- Eligibility requirements; employee and employer contribution amounts and limitations; certain information regarding investment options; and certain fees and charges.
- Withdrawal and distributions from the Plan; Plan loans; and tax consequences to the employee and the employer. Subject to any applicable limitations of Internal Revenue Code 404, Airgas, Inc. is entitled to a deduction on its corporate tax return for any matching contributions it makes to the Plan.

Investment Options

There are a variety of investment options available under the Plan. You may elect to invest your contributions in any combination of these alternatives (for example, 10% in one, 20% in another, and 70% in a third). Airgas contributions made on your behalf will be invested in the same investment options you select for your own contributions.

Upon entry into the Plan, you elect the investment option or options in which your contributions and Airgas' contributions made on your behalf are to be invested.

The following is a brief description of the investment options available under the Plan. The value of investments made under these options will fluctuate, up or down, depending on the market value of the particular security or securities in which the investment option is invested.

Option A. Vanguard Explorer Fund (Stock Fund). The fund seeks to provide long-term capital appreciation.

Option B. Vanguard International Growth Fund (International Stock Fund). The fund seeks to provide long-term capital appreciation.

Option C. Vanguard U.S. Growth Fund (Stock Fund). The fund seeks to provide long-term capital appreciation.

Option D. Vanguard Morgan Growth Fund (Stock Fund). The fund seeks to provide long-term capital appreciation.

Option E. Vanguard Windsor II Fund (Stock Fund). The fund seeks to provide long-term capital appreciation and income.

Option F. Vanguard 500 Index Fund (Stock Fund). The fund seeks to track the performance of a benchmark index that measures the investment return of large capitalization stocks.

Option G. Vanguard/Wellington Fund (Balanced Fund). The fund seeks to provide long-term capital appreciation and reasonable current income.

Option H. Vanguard LifeStrategy Growth Fund (LifeStrategy Balanced Fund). The fund seeks to provide capital appreciation and some current income.

Option I. Vanguard LifeStrategy Moderate Growth Fund (LifeStrategy Balanced Fund). The fund seeks to provide capital appreciation and a low to moderate level of current income.

Option J. Vanguard LifeStrategy Conservative Growth Fund (LifeStrategy Balanced Fund). The fund seeks to provide current income and low to moderate capital appreciation.

Option K. Vanguard LifeStrategy Income Fund (LifeStrategy Balanced Fund). The fund seeks to provide current income and some capital appreciation.

Option L. Vanguard Total Bond Market Index Fund (Income Fund). The fund seeks to track the performance of a broad, market-weighted bond index.

Option M. Vanguard Retirement Savings Trust (Income Fund). The trust seeks stability of principal and a high level of current income consistent with a 2-3 year average maturity. The trust is a tax-exempt collective trust invested primarily in investment contracts issued by insurance companies and commercial banks, and similar types of fixed-principal investments. The trust intends to maintain a constant net asset value of $1.00 per share. Investments in Vanguard Retirement Savings Trust are limited to participant directed defined contribution plans and, with Vanguard's approval, other qualified pension plans.

Option N. Airgas, Inc. Common Stock Fund (Stock Fund). Invests in Airgas, Inc. Common Stock to provide the possibility of long-term growth through increases in the value of the stock. This fund invests in shares of Airgas, Inc. Common Stock, although a portion of the fund may be invested in cash or cash equivalents to maintain liquidity and avoid excessive turnover of Airgas, Inc. Common Stock held in the fund. Any dividends are paid to the Trustee and allocated proportionately to the accounts of participants on the basis of each participant's investment in the fund and are used to purchase additional shares of Airgas Common Stock. The value of the fund and the value of each participant's interest will fluctuate with the market value of Airgas Common Stock.

Prior to the annual stockholders' meeting, each participant invested in the Airgas, Inc. Common Stock Fund will be sent proxy materials and proxy cards that may be used to instruct the Trustee on how to vote the participant's allocable portion of Airgas common stock held in the fund. The Trustee will vote fractional shares and shares for which it receives no instructions in the same proportions as the voting instructions received from participants who give them.

Participants invested in the Airgas, Inc. Common Stock Fund may also direct the Trustee on how to respond if a tender or exchange offer is ever made for Airgas Common Stock. Each participant may direct the Trustee to either sell or not to sell the participant's allocable portion of Airgas Common Stock held in the fund. A participant who fails to direct the Trustee will be considered to have given a direction not to sell and the Trustee will not tender the shares, except if the Trustee determines that the failure to tender would be inconsistent with Title I of ERISA.

Past Performance

The following table presents total returns for each of the investment options for the periods indicated, assuming the reinvestment of all dividends. This total return information represents past performance and is no guarantee of future return.

Total Returns for Period Ended March 31, 2015

	Fund Name	Expense Ratio	Average 1 Year Return as of March 31,2015	Average 3 Year Return as of March 31,2015	Average 5 Year Return as of March 31,2015	Average 10 Year Return as of March 31,2015
A	Explorer Fund Investor	0.36%	9.74%	17.27%	16.30%	9.42%
B	International Growth Inv	0.34%	0.43%	8.98%	7.56%	6.97%
C	U.S. Growth Fund Investor	0.30%	17.49%	17.19%	15.45%	8.99%
D	Morgan Growth Fund Inv	0.26%	15.11%	15.51%	14.79%	8.97%
E	Windsor II Fund Inv	0.28%	8.04%	14.76%	12.77%	7.25%
F	500 Index Fund Inv	0.04%	12.71%	16.08%	14.44%	8.01%
G	Wellington Fund Inv	0.18%	8.27%	11.61%	10.72%	8.22%
H	LifeStrategy Growth Fund	0.17%	7.80%	11.36%	10.34%	6.63%
I	LifeStrategy Mod Growth	0.16%	7.47%	9.38%	9.01%	6.31%
J	LifeStrategy Consrv Grwth	0.15%	7.13%	7.37%	7.31%	5.64%
K	LifeStrategy Income Fund	0.14%	6.66%	5.32%	5.77%	5.03%
L	Total Bond Mkt Index Inv	0.07%	5.63%	3.06%	4.37%	4.93%
M	Retirement Savings Trust	0.38%	2.02%	2.06%	2.46%	3.30%
N	Airgas Common Stk Fd	0.15%	1.39%	7.79%	12.43%	17.43%

You should understand that investing in the Airgas, Inc. Common Stock Fund may or may not be appropriate for you, depending on your investment goals, risk tolerance, total financial resources (in and outside of the Plan), your age, retirement plans and other factors. Airgas makes no recommendation with respect to this investment option or any other investment option.

Airgas reserves the right at any time to modify or terminate any investment option offered under the Plan.

Option O. Vanguard Institutional Target Retirement Funds (2010 – 2060). The fund seeks to provide diversification and is designed to keep assets invested appropriately for employees up to and including retirement.

Total Returns for Period Ended September 30, 2015

Attribute	Inst Target Ret 2010 Fund	Inst Target Ret 2015 Fund	Inst Target Ret 2020 Fund	Inst Target Ret 2025 Fund	Inst Target Ret 2030 Fund	Inst Target Ret 2035 Fund	Inst Target Ret 2040 Fund	Inst Target Ret 2045 Fund	Inst Target Ret 2050 Fund	Inst Target Ret 2055 Fund	Inst Target Ret 2060 Fund	Inst Target Ret Inc Fund
Total Return - Cumulative 3 Month	-2.56%	-3.93%	-4.85%	-5.62%	-6.44%	-7.16%	-7.94%	-7.99%	-7.99%	-7.94%	-7.99%	-2.15%
Total Return - Cumulative Since Inception	-3.00%	-4.70%	-5.80%	-6.75%	-7.75%	-8.65%	-9.60%	-9.65%	-9.65%	-9.60%	-9.65%	-2.44%

Questions

If you have questions concerning any of the investment options, you should contact The Vanguard Group, Inc. They will then attempt to answer your questions or to direct you to a source which may be able to answer your questions. However, no advice on how to invest contributions will be given by Airgas or its representatives. Airgas offers the Vanguard Financial Planning Service for participants age 55 and over.

Resale Restrictions

If you are an executive officer of Airgas you may be deemed to be an "affiliate" of Airgas as that term is defined under the Securities Act of 1933, and therefore subject to special restrictions on resale imposed by the Securities Act. If you are an affiliate and you invest in the Airgas, Inc. Common Stock Fund under the Plan, the shares may be reoffered or resold only pursuant to an effective registration statement (other than the registration statement filed with the Securities and Exchange Commission with respect to the shares that are the subject of this Prospectus), or under Rule 144 of the Securities Act, or under another exemption from the registration requirements of the Securities Act. Among other requirements, Rule 144 imposes volume limitations on resales. Because the Airgas Common Stock to be issued under the Plan has been registered under the Securities Act, the six-month holding period imposed by Rule 144 for resales of restricted stock is not applicable to the resale of shares acquired under the Plan.

Section 16 Insider

If you are an executive officer of Airgas, you are subject to Section 16 of the Securities Exchange Act of 1934. If you make a contribution to, or withdrawal from, the Airgas Common Stock Fund, the transaction will be exempt from short-swing liability under Section 16(b), unless the transaction involves a "discretionary transaction." A discretionary transaction is a voluntary intra-plan transfer in the Airgas Common Stock Fund, a cash distribution funded by a voluntary disposition of the Airgas Common Stock, or a loan funded by the disposition of Airgas Common Stock, unless the transfer or distribution is in connection with your death, disability, retirement or termination of employment, or as required by the Internal Revenue Code.
Discretionary transactions are only exempt from matching with other discretionary transactions

(which could result in short-swing liability) if there is an interval of at least six months between the date of your election to engage in the transaction and the date of your most recent "opposite-way" election under the Plan. That is, an election to effect such a transaction must be at least six months after the date of your prior election that effected an "opposite way" transaction. The initial discretionary transaction election during the six-month period is exempt.

For example, if you elect to transfer one-half of your account balance under the Plan from the Airgas, Inc. Common Stock Fund to one of the other funds, and four months later elect to transfer your account balance from one of the other funds to the Airgas, Inc. Common Stock Fund, the transaction resulting from the second election would be a non-exempt purchase and would be matched against any subsequent transfer of funds from the Airgas, Inc. Common Stock Fund to one of the other funds within the next six months. Alternatively, the second non-exempt purchase could be matched against any other non-exempt sale (such as a sale of shares acquired upon exercise of stock options) within the next six months. However, a voluntary withdrawal in-kind of Airgas, Inc. Common Stock from the Airgas, Inc. Common Stock Fund would not be a discretionary transaction because it does not involve an intra-plan transfer or a cash withdrawal. But a plan loan which is funded by a disposition of Airgas Common Stock would be a discretionary transaction. An open market sale or purchase of directly owned shares is not a discretionary transaction and does not affect the discretionary transaction exemption. You must report discretionary transactions on Form 4, whether or not they are exempt. It is suggested that you contact the Plan Administrator if you are contemplating electing to make a discretionary transaction.

Insider Trading Policy

Any intra-fund transfer involving the Airgas, Inc. Common Stock Fund is considered a purchase or sale of Airgas stock under the federal securities laws and is subject to Airgas' insider trading policy which prohibits trading or tipping others who may trade, when you are in possession of material non-public information. You must comply with this policy in making intra-fund transfers involving the Airgas, Inc. Common Stock Fund. Directors, executive officers and others who are subject to the trading "black-out" requirements of Airgas' insider trading policy should also take care to ensure that any intra-fund transfers involving the Airgas, Inc. Common Stock Fund are made in compliance with those requirements.

Incorporation by Reference

Incorporation of Documents by Reference in this Disclosure Document includes:

1. Airgas' latest Annual Report on Form 10-K filed pursuant to Section 13(a) or 15(d) of the Exchange Act.
2. The description of Common Stock contained in Airgas' Registration Statement on Form 8-A filed pursuant to Section 12(g) of the Exchange Act on December 19, 1986.
3. All other reports filed pursuant to Section 13(a) or 15(d) of the Exchange Act since the end of Airgas' last fiscal year.
4. The Plan's latest Annual Report on Form 11-K filed pursuant to Section 15(d) of the Exchange Act.

Airgas will deliver or cause to be delivered with this document a copy of its Annual Report on Form 10-K referred to in (1) above or Airgas' Annual Report to Stockholders for the last fiscal year, provided that if Airgas has previously sent or given a participant a copy of such report, it

will furnish such report, without charge, to such participant upon written or oral request. Airgas will furnish, without charge, to each person to whom information is required to be delivered, upon such person's writ- ten or oral request, a copy of the foregoing information that has been incorporated by reference into this prospectus (not including exhibits to the information that is incorporated by reference unless such exhibits are specifically incorporated by reference into the information that this document incorporates). Airgas will also furnish to all participants who do not otherwise receive such material, copies of all reports, proxy statements and other communications distributed to its security holders generally, no later than the time that it is sent to security holders.

Severance Pay Plan
Summary Plan Description

Airgas

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INTRODUCTION

We originally adopted the Airgas, Inc. Severance Pay Plan ("Plan") effective August 1, 2003. This document describes the provisions of the Plan effective as of January 1, 2010. The purpose of the Plan is to provide salary continuation benefits to those employees whose employment we terminate due to certain economic conditions or restructuring of our business. This document describes the most important features of the Plan

This document is only a summary of the most important features of the Plan and of the rights of an eligible employee. It is not part of the official Plan document. If there is a conflict between the official Plan document and this document, the Plan document controls.

As explained in this document, we have the right to change or end this Plan at any time. If we do, the Plan change or termination will apply both to active employees and former employees, even if they were receiving Plan benefits before the change or termination, unless we expressly state otherwise.

ELIGIBILITY

General Information

This Plan provides benefits to employees who meet certain eligibility requirements and have a "Qualifying Severance" if, but only if, the employee agrees in writing: (i) to release us from any claims he or she may have against us; and (ii) (to the extent permitted by law) not to engage in certain competitive activities including using our confidential information, soliciting our customers and employees and competing with us.

Eligible Group

To be eligible to receive benefits, an employee must satisfy certain employment conditions. These are explained below.

First, the employee must be our "employee" or the employee of a business in which we own at least 80% of ownership interests that is located in the United States. A list of those businesses is included at the end of this document. We may own non-U.S. businesses and smaller interests in several other businesses. Employees of those businesses are not eligible.

A person is an "employee" if we withhold federal income tax or federal payroll tax, such as social security tax, from their regular pay check. This Plan does not provide benefits to persons that we treat as independent business people, such as consultants and contractors, or to persons who are the employees of some other business that provides services to us.

Second, the employee must be regularly scheduled to work at least 30 hours per week on an annual basis.

Third, the employee must have completed his or her initial probationary period of employment.

Fourth, the employee must not have been hired on a temporary basis, regardless of the number of hours he or she works in any week.

Fifth, the employee's terms and conditions of employment are not covered by a current collective bargaining agreement unless eligibility is granted in the bargaining agreement or by negotiation between us and the union representing the employee.

Sixth, the employee must not have any other opportunity to receive payments of any kind from us in connection with his or her employment termination, unless specifically provided to the contrary in the agreement, plan, or program governing such payments. For example, if the employee may receive employment termination payments from us based on an individual employment agreement or individual severance agreement or a plan or program that makes payments to a class or group of employees who continue employment through a specified date or event (often known as a "stay-put" bonus or plan), the employee is not in this Plan's eligible group regardless if he or she fails to satisfy the conditions of the individual employment or severance agreement or "stay-put" plan.

Qualifying Severance

We intended the Plan to provide benefits to eligible employees whose employment with us terminates for either of two reasons. Each reason is called a "Qualifying Severance".

If you are in the eligible group and we terminate your employment solely because of a lack of work for you, a reorganization of our business, the closing of all or a portion of your principal work place or economic conditions, you will have a Qualifying Severance unless:

- We offer you another position at a location not more than 50 miles from your current work place with us that gives you the possibility to earn an amount similar to what you earn in your current job. This exception applies even if you do not accept the job that we offer you. or

- Your job is eliminated because we transferred the work you do to a business that is not related to us and that business offers you a job. This exception applies even if you do not accept the job that is offered to you or it provides less wages or benefits than the job you had with us.

If you are in the eligible group and we terminate your employment solely because we sell all or any part of one of our businesses to another party in which we do not have any ownership interest, then you will have a "Qualifying Severance" unless the purchaser of the business offers you employment or continues your employment. This exception applies even if you do not accept the job that is offered to you or it provides a different position or less wages or benefits than the job you had with us.

Terminations that are not a Qualifying Severance.

No other reason for termination of your employment is a Qualifying Severance. The employment termination reasons listed below are some examples of circumstances that are **not** Qualifying Severances.

- We reduce the number of hours you are regularly scheduled to work.
- We reduce your hourly pay rate or salary level.
- You were hired on a temporary basis and the project or assignment for which you were hired is completed.
- You become an independent business person who provides services to us.
- You voluntarily terminate your employment with us.
- You terminate your employment with us before the employment termination date we set for you in your termination notice.
- You accept employment with another Airgas company after you receive your notice of employment termination but before your employment termination date
- We terminate your employment for performance related reasons, for misconduct or for any reason whatsoever, other than either of the reasons listed as a Qualifying Severance.
- Your employment terminates because of your disability or death.

Release and Restrictions

As a condition to receiving any severance benefits, the Plan requires you to sign an agreement in which you release or give up any claim you may have against us for any reason, including, but not limited to, your termination of employment. In addition, the agreement will require, where permitted by law, that you do not engage in acts or conduct that may be harmful to us, such as engaging in competition with us as an employee of another business or as a business owner, or soliciting or calling on our clients or customers or potential clients or customers or encouraging any of our employees to terminate employment with us.

We will give you a copy of the required agreement with your employment termination notice. At that time, we will also explain to you the time limits for returning the agreement. You should review the agreement with your attorney or legal adviser before signing it since you will be obligated to follow its terms.

We will not pay severance benefits until you return a properly signed and dated agreement. After you return the agreement and any revocation period in your agreement has passed, we will begin your severance payments.

BENEFITS

Amount.

The amount of your benefit depends on your weekly base pay on the date your employment terminates.

If you are an hourly paid employee, your weekly base pay is your regular straight time hourly rate of pay multiplied by the number of hours you are regularly scheduled to work in a week, but not more than 40 hours. For example, if your regular straight time hourly rate is $18 per hour on your employment termination date and you are regularly scheduled to work 40 hours per week, then your gross weekly benefit, before any deductions, is $720 per week (40 x $18= $720).

If you are paid on a salaried basis, your weekly base pay is your weekly salary on the date your employment terminates.

If you are paid partly by weekly salary and partly by commission, your weekly base pay is your weekly salary rate on the date your employment terminates plus the average weekly commission you were paid over the 52 weeks immediately preceding your employment termination date (or weekly average commissions for your entire period of employment if you were an employee for less than 52 weeks.)

Payment Period

The length of time your severance benefit will be paid depends on your full years of employment prior to your termination date. The Plan does not credit partial years.

Length of Service	Weeks of Benefits
Two full years or less	Two
Three full years	Three
Four full years	Four
Each additional full year	One additional week
Twenty-four full years or more	Twenty-four weeks

Generally, your length of service is measured from your date of hire with us. If you were an employee of a business that we purchased on the date we purchased it, then your length of service will also include your service with the business we purchased.

In general, if your employment with us terminates for any reason and you are rehired, you will be treated as a new employee (and therefore will receive no credit for your prior period of service) unless you had at least two years of service before your prior employment terminated and the period between the date your prior employment terminated and the date your current employment began is less than one year. Your period of absence will not be counted as service. Any prior service credit shall be reduced to the extent severance benefits under the Plan with respect to such credit were previously received by you

Notice Period

In addition to benefits payable under the Plan, we will give you at least two weeks' notice prior to your employment termination date due to a Qualifying Severance or pay you at least two additional weeks of base pay instead of giving you notice. Any such additional payment amount shall be separate and apart from Plan benefits, and shall be determined in accordance with Company policy.

Group Health Plans

Under our group health plans, you are permitted to continue the coverage you had in effect on your termination date for you and your eligible dependents by paying the cost for that coverage as well as an administrative fee. This continuation of coverage is referred to as COBRA, the federal law that requires employers to offer continuation coverage under certain circumstances.

You will receive information about continuation coverage and continuation coverage election forms. Effective June 1, 2010, if you elect continuation coverage, we will pay the same employer portion of the cost that we were paying on the date your employment terminated for the lesser of the period that you are receiving severance benefits or three (3) months. In addition, you will not be required to pay the administrative fee for that period. For example, if you are eligible for 10 weeks of severance benefits, we will pay the employer share of the group health plan cost for 10 weeks (plus the notice period if applicable). Thereafter, you must pay the full cost plus administrative fee if you desire to keep your continuation coverage in effect.

If the employee cost changes during the period that we are paying for a portion of your coverage, then your share of the cost will change just as it would for an active employee.

Payment Terms and Conditions

Generally, Plan benefits are paid on your regular payroll period dates. However, as explained before, your benefit payments will not start until the next regularly scheduled payroll cycle that follows the date your agreement to release any claims and restrict your activities becomes final. We will make up all prior payments you were due in one lump payment as soon as possible. All remaining payments owed to you shall continue in accordance with the normal payroll schedule.

Your benefit payments are subject to income and payroll taxes. Therefore, we will withhold all amounts that we are required to withhold to satisfy applicable federal, state and local laws.

Other Deductions

If you are receiving worker's compensation or disability payments under a disability plan sponsored by an Airgas company after your employment termination date, then we will reduce your severance payments by the amount of those payments if we are legally permitted to do so. In addition, if you owe us money for any reason, such as overpayment of wages, loans, damage to or failure to return property or the like, then we will reduce your severance payments by the amount you owe us if we are legally permitted to do so.

New Airgas Employment
If we rehire you after you begin to receive benefit payments but before the end of the period for which you are eligible to receive them, your benefit payments will terminate. This termination applies even if your new job with us is in a different position or provides less wages or benefits than the prior job you had with us.

Violation of Agreement
If you violate the terms of your written severance agreement, your benefit payments will terminate. This termination is in addition to other rights and remedies we may have.

ADMINISTRATION

Plan Operations
Airgas, Inc. is the "Plan Administrator" for purposes of satisfying legal requirements that deal with filing reports with the government and delivering information about the Plan to you. We have the authority to name an officer or a committee to manage this Plan and make all decisions necessary or desirable to operate it. We have named our Senior Vice President for Human Resources (or senior human resources executive) as the officer responsible for the Plan's operation. He has the authority to name other officers or employees to act for him in connection with the Plan. In addition, he has complete discretion to interpret the Plan and determine whether a person qualifies for benefits and, if so, the amount of benefit and length of time it will be paid.

Amendment and Termination
Our Senior Vice President for Human Resources has the authority to amend or change the Plan's terms at any time or to terminate the Plan completely. If the Plan is amended or terminated, the change will apply to all persons including those whose employment has already terminated and are receiving benefits (unless the amendment or termination provides otherwise). This Plan does not provide any "vested" or nonforfeitable right to benefits.

Source of Benefits
We pay all benefits from our general assets. We have not established any trust fund or separate account as a source of benefits.

Claims
If we believe your termination of employment is a Qualifying Severance, we will provide you with a package of information that includes the amount of your benefit, the number of weeks it will be paid, the agreement that includes your release and restrictions and other relevant information. If you do not agree with the information in this package or if you believe your termination of employment is a Qualifying Severance even though we did not regard it as such, you may submit a written claim for benefits. The claim should be delivered to your Human Resources representative who will then forward it to the Senior Vice President for Human Resources for action.

The Senior Vice President for Human Resources or the person or persons he names to rule on your claim will advise you of the decision within 90 days. If your claim is denied, you will be advised of the specific reason for the denial, the reference to the Plan provision on which the denial is based, a description of any information that is necessary to support your claim and the reason that information is needed as well as a description of the appeals process.

You may appeal from a denial of your claim by notifying the Senior Vice President for Human Resources within 60 days of the date you receive notification of the claim denial. You (or your attorney or other authorized representative) may submit relevant documents, issues and comments for consideration. You will receive a written decision on the appeal within 60 days unless special circumstances require a delay. In that case, you will be notified. The delay may not exceed an additional 60 days.

Employment Status
Our adoption of this Plan does not create any employment rights and does not alter or change the "at-will" nature of your employment relationship with us.

ERISA RIGHTS

Exclusions

As a participant in the Airgas, Inc. Severance Pay Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites, all documents governing the plan, including 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.
- Obtain, upon request to the Plan Administrator, copies of all documents governing the operation of the plan, including copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries.

No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from the plan, or from exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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

If you have any questions about the plan, you should contact the Senior Vice President for Human Resources through your Human Resources representative. If you any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ADDITIONAL ADMINISTRATIVE INFORMATION

- Name of Plan and Plan Number:
  Airgas, Inc. Severance Pay Plan
  Plan # 502
- Name, address, telephone number and employer identification number of Plan Sponsor and Plan Administrator:

  Airgas, Inc.
  259 North Radnor-Chester Road
  Radnor, PA 19087-5240
  610-687-5253
  Employer identification number: 56-0732648
- List of Airgas, Inc. subsidiaries that participate in the Plan.
  See Appendix A
- Designated Agent for service of legal process and the address at which legal process may be served.

  Senior Vice President, General Counsel and Secretary
  Airgas, Inc.
  259 North Radnor-Chester Road
  Radnor, PA 19087-5240

Legal process may also be served on Airgas, Inc. in its capacity as plan administrator.

- The Plan is a severance pay plan. As such, it is an "employee welfare benefit plan" covered by ERISA.
- The sponsoring employer administers the Plan.
- Plan Year: January 1 to December 31
- Plan's Original Effective Date: August 1, 2003. Effective date of amended and restated Plan is January 1, 2010.

APPENDIX A

Airgas, Inc.

Airgas USA, LLC

Red-D-Arc US

Nitrous Oxide Corp.

Airgas Specialty Gases, Inc.

Airgas Carbonic, Inc.

Airgas Specialty Products, Inc.

Airgas Merchant Gases LLC

Airgas Refrigerants, Inc.

Airgas Safety, Inc.

Airgas On-Site Safety, Inc.

Airgas Priority Nitrogen, LLC

Note: This Appendix A is current as of October 1, 2015. Please contact the Plan Administrator should you have any questions about participating subsidiaries after this date.

APPENDIX B

Effective May 1, 2011, severance benefits under the Plan are enhanced for an employee whose termination of employment is determined to be a result of a consolidation in the Company's business operations involving two or more Participating Companies, also known as a Restructuring Event, in which: (1) affected employees are relocated or work functions reorganized; and (2) at least 100 positions are either eliminated or relocated.

Each employee who qualifies as eligible for enhanced benefits, know as an Enhancement Eligible Employee, is entitled to 12 weeks of severance pay in addition to what is otherwise provided for under the Plan.

Each Enhancement Eligible Employee is entitled to continue his or her group health coverage for 6 months or the total severance period (including the 12 weeks of enhanced severance payments), whichever period is shorter, as long as the employee elects and pays for such coverage during the period described in the Group Health Plans section of this document.

An Enhancement Eligible Employee is an employee who meets all of the following requirements:

- The employee otherwise meets all of the requirements for benefits under the Plan without regard to the Plan's enhanced benefit provisions;
- The employee's Qualifying Severance is a direct result of changes in the Company's business operations through a Restructuring Event, as determined by the Plan Administrator;
- The employee is sent and receives notice from the Plan Administrator expressly stating that the employee's termination of employment is in connection with the changes in the Company's business operations through a Restructuring Event. Such notice will also contain other requirements for eligibility for enhanced benefits, such as a requirement to remain employed through a specified date and to perform satisfactorily through such date.

Only those employees who are expressly designated as eligible for enhanced severance will be eligible. No employee who has not been notified of eligibility for enhanced severance benefits will be entitled to such benefits, regardless of the facts and circumstances surrounding the employee's termination of employment. All determinations regarding eligibility for enhanced severance will be made by the Plan Administrator, in its sole and absolute discretion.

Airgas

Airgas, Inc.
259 N. Chester-Radnor Road
Radnor, PA 19087-5240