Employee Benefit Plan Summary of Material Modifications

Benefits Summary: What's New for 2020

This document summarizes important changes to The Langdale Company Employee Benefit Plan. If you have any questions regarding the changes summarized in this Summary of Material Modifications ("SMM"), you should contact the Plan Administrator at the contact information provided below. You should keep a copy of this SMM with your Summary Plan Description for future reference.

The Langdale Company ("Langdale") sponsors The Langdale Company Employee Benefit Plan (the "Plan"). The Plan provides eligible Langdale employees with various health care benefit coverage options, as provided by the Plan's Summary Plan Description and Plan Documents.

If there is a conflict between this Benefit Summary and the Plan's Summary Plan Description (SPD), the SPD will control.

Summary of Changes:

The following is a description of changes made to the **Health Plan**:

1. Section 5. Schedule of Benefits. **Changes in Preventive/Wellness Adult benefits:**

   (1) Cervical cancer screening for age 21-65, this Plan now covers the following methods:
   - Pap smear every 3 years; or
   - High-Risk Human Papillomavirus (hrHPV) every 5 years, age 30-65 only; or
   - High-Risk Human Papillomavirus (hrHPV) in combination with Pap smear (cotesting) every 5 years, age 30-65 only

   (2) Generic Statin was added to Preventive Medicines

2. Section 5. Schedule of Benefits. **Change in Major Medical benefits:**

The following benefits were added to this Plan:

   (1) Hearing aids for children age 18 and under – limited to $2,500 per ear every 48 months, any amount over $2,500 is member's responsibility and will not apply towards the out-of-pocket

   (2) Marriage and/or family counseling is now covered, subject to $25 copayment per office visit

   (3) Orthospinology – new chiropractic care benefit is subject to $25 copayment per office visit, there is no annual limit on the number of visits

3. Section 5. Schedule of Benefits. **Change in Pharmacy Benefits:**

All references to 'Specialty Drugs' are removed from this section.

4. Section 5. Schedule of Benefits. **Change in SleepCharge Program Benefits:**

The benefit description is replaced in its entirety with the following:

Covered Persons may participate in the SleepCharge Program if they have been covered under the Plan for a minimum of six (6) months. This Program is voluntary and non-participation will not affect Covered Person's benefits or premium. SleepCharge utilizes telehealth to evaluate, diagnose, discuss, treat, and manage an array of sleep disorders and disruptors. Participation is subject to one-time Co-payment for the Calendar Year as described below. Covered Persons must average 70% compliance in order to qualify for annual renewal. If compliance is below 70% within 90 days of the renewal date, Covered Persons will be required to meet with a technician prior to the renewal being paid.

5. Section 8. Utilization Management Program. **Changes in Utilization Management:**
   (1) All references to Adhere2Care, Inc. are deleted and replaced with WiseThrive LLC, telephone number 1-800-485-0940

6. Section 9. Wellness Program. **Changes in Wellness Program benefits and requirements:**

Diabetes Management Program: the following requirement was deleted:

Monitor blood sugar before eating breakfast and two hours after supper. Patients with Type 1 diabetes may require readings up to 8 times daily. Physicians may have patients that have difficulty controlling their blood sugar test more frequently or at different times of the day. Provide your readings to Chancy Drugs. Patients participating in the Remote Monitoring program will have their blood sugar levels monitored by the remote glucose meters supplied by Adhere2Care through the Health Advocate.

7. Section 10. Defined Terms. **New definitions were added as follows:**

Employee Director means a person who receives a percentage of their W-2 wages from a covered participating employer and a percentage of their W-2 wages from an appointed or designated eligible 501(c)(3) organization. Employee Directors are eligible to participate in the Plan with the same benefits and rights as Employees.

Marriage and/or Family Counseling means psychotherapy that addresses the behaviors of all family members and the way these behaviors affect the individual family members and the family unit as a whole.

Orthospinology is a sub-specialty of the chiropractic profession, focusing on aligning the upper cervical spine. It is one of several upper cervical procedures utilizing radiographs (x-ray films) of the top two bones on the neck (C-1 vertebra "Atlas" and C-2 vertebra "Axis") and the base of the skull (the upper cervical spine) to determine a misalignment or subluxation that may create irritation of, and interference to, the functioning of the nervous system.

8. Section 11. Plan Exclusions. **The following exclusions were modified:**

Hearing Aids and Exams. Charges for services or supplies in connection with hearing aids or exams for their fitting unless required due to an accidental Injury to the ear. Hearing aids for children age 18 and under are covered – see the Schedule of Benefit for details.

The following exclusion was deleted:

Marriage Counseling. Marriage and/or family counseling is not covered. Expenses for treatment of an individual diagnosed with a Mental and Nervous disorder will be payable under Mental and Nervous Benefits as described in the Schedule of Benefits. Screening and counseling for interpersonal and domestic violence, when part of Preventive/Wellness exam, are covered under the Plan

9. Section 12. Prescription Drug Benefits. **Changes in Specialty Drug Benefit:**

SPECIALTY DRUGS

Specialty Drugs are excluded from coverage under this Plan. However, Specialty Concierge Services are offered to offset costs. Covered Persons are required to provide certain documentation to receive these services.

THE INTERNATIONAL DRUG PROGRAM

Your Plan has an International Drug Formulary for certain medications. Drugs obtained through this program are at no cost to the Participant. When these medications are obtained outside of the International Drug Program, the Participant is responsible for 50% of the Allowed Amount, non-applicable to your out-of-pocket.

10. Section 13. Claim Review and Audit. **Changes in Allowable Claim Limits:**

The *Allowable Claim Limits* section was replaced with the following language:

Allowable Claim Limits

"Allowable Claim Limits" means the charges for services and supplies, listed and included as covered medical expenses under the Plan, which are Medically Necessary for the care and treatment of illness or injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

1. Errors, Unbundled and/or Unsubstantiated Charges. Allowable Claim Limits will not include the following amounts:

a. Charges identified as improperly coded, duplicated, unbundled and/or for services not performed;
b. Charges for treating injuries sustained or illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator can be attributed to medical errors by the provider;
c. Charges that cannot be identified or understood; and
d. Charges that cannot be verified from audits of medical records.

2. Guidelines. The following guidelines will be used when determining Allowable Claim Limits:

a. Facilities. The Allowable Claim Limit for claims by a facility, including but not limited to, hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care facility, shall be the greater of (I) 112% of the facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. If insufficient information is available to identify either the facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

b. Ambulatory Health Care Centers. The Allowable Claim Limit for ambulatory health

care centers, including ambulatory surgery centers, which are independent facilities shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the outpatient or inpatient Medicare allowed amount for the service, plus an additional 20%.

c. Ambulance Providers. The Allowable Claim Limit for emergent and non-emergent ambulance services, including air and ground transport, shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%.

d. Directly Contracted Providers. The Allowable Claim Limits for Directly Contracted Providers shall be the negotiated rate as agreed under the Direct Agreement.

e. Insufficient Information to Determine Allowable Claim Limit. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above as may be applicable, the DDM may apply the following guidelines:

i. **General Medical and/or Surgical Services.** The Allowable Claim Limit for any covered services may be calculated based upon industry-standard resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that in the opinion of the Plan Administrator results in the determination of a reasonable expense under the Plan.

ii. **Pharmaceuticals.** The Allowable Claim Limit for pharmacy charges by a provider may be determined by applying the Average Wholesale Price (AWP) as defined by REDBOOK at the rate of 112% of AWP.

iii. **Medical and Surgical Supplies, Implants, Devices.** The Allowable Claim Limit for charges for medical and surgical supplies made by a provider may be based upon the invoice price (cost) to the provider, plus an additional 12%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator.

iv. **Facility Billed Physician, Medical and Surgical Care, Laboratory, X-ray, and Therapy.** The Allowable Claim Limit for these services may be determined based upon the 60th percentile of Fair Health (FH®) Allowed Benchmarks.

Comparable Services or Supplies. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above, Allowable Claim Limits will be determined considering the most comparable services or supplies based upon comparative severity and/or geographic area to determine the Allowable Claim Limit. The Plan Administrator reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

Notwithstanding any conflicting contracts or agreements, the Plan may consider the Allowable Claim Limits as the maximum amount of Covered Medical Expense that may be considered for reimbursement under the Plan, and may apply this determination in lieu of any PPO network provider hospitals' per diem, DRG rates or PPO discounted rates as the amount considered for reimbursement under the Plan. Additionally, in the event that a determination of an Allowable Claim Limit exceeds the actual charge billed for the service or supply, the Plan will consider for coverage the lesser of the actual billed charge or the Allowable Claim Limit determination.