SUMMARY PLAN DESCRIPTION/ PLAN DOCUMENT

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1. INTRODUCTION

In this document, capitalized terms have a special meaning. You should refer to the Defined Terms section for the definitions of any capitalized terms.

The Langdale Company is the Plan Sponsor of the Langdale Company Employee Benefit Plan (the Plan). The Plan is a self-funded plan, meaning that The Langdale Company pays claims with its own funds from its general assets.

The Plan provides medical and prescription drug benefits to eligible Employees and their dependents. The Plan is a welfare benefit plan, as defined under the Employee Retirement Income Security Act of 1974 (ERISA).

How to Use This Document

The Plan Sponsor is pleased to provide you with this Summary Plan Description/Plan Document (SPD), which describes the benefits available under the Plan. The SPD includes information regarding:

- who is eligible;
- services that are covered;
- services that are not covered;
- 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 under federal law. Please take the time to read and understand how the benefits of the Plan affect you. As you read this document, please keep in mind that the written terms will govern whatever benefits you receive under the Plan. No oral modifications or interpretations can change this Plan.

If you have questions regarding the Plan, please contact the Plan Administrator: TLC Benefit Solutions, Inc., P.O. Box 947, Valdosta, GA 31603. Phone: (229) 249-0940, Toll-free: (877) 949-0940.

Not an Employment Contract

The Plan shall not be deemed to constitute an employment contract with any Participating Employer. Participation in the Plan does not guarantee employment or continued employment with a Participating Employer.

Important Updates Regarding COVID-19 Relief – Tolling of Certain Plan Deadlines

In accordance with 85 FR 26351, “Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak,” notwithstanding any existing Plan language to the contrary, the Plan will disregard the

period from March 1, 2020 until sixty (60) days after (1) the end of the National Emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 5121 *et seq.* or (2) such other date announced by the Departments of Treasury and/or Labor, for purposes of determining the following periods and dates:

1) The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Internal Revenue Code section 9801(f);
2) The 60-day election period for COBRA continuation coverage under ERISA section 605 and Internal Revenue Code section 4980B(f)(5);
3) The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Internal Revenue Code section 4980B(f)(2)(B)(iii) and (C);
4) The date for individuals to notify the Plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Internal Revenue Code section 4980B(f)(6)(C);
5) The date within which individuals may file a benefit claim under the Plan's claims procedure pursuant to 29 CFR 2560.503-1;
6) The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedure pursuant to 29 CFR 2560.503-1(h);
7) The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or Final Internal Adverse Benefit Determination pursuant to 29 CFR 2590.715-2719(d)(2)(i) and 26 CFR 54.9815-2719(d)(2)(i); and
8) The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29 CFR 2590.715-2719(d)(2)(ii) and 26 CFR 54.9815-2719(d)(2)(ii).

This period may also be disregarded in determining the applicable date for the Plan's duty to provide a COBRA election notice under ERISA section 606(c) and Internal Revenue Code section 4980B(f)(6)(D), however, note that the Plan intends to continue to follow all established COBRA parameters.

In no instance will the duration of an extension granted under this section exceed one calendar year.

The disregarded period (one calendar year) for an individual to elect COBRA continuation coverage and the disregarded period (one calendar year) for the individual to make initial and subsequent COBRA premium payments will generally run concurrently.

2. ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS

A. ELIGIBILITY

Eligible Class of Covered Persons. All Full-Time Active Permanent Employees of a Participating Employer are eligible to participate in the Plan. Full-Time Active Permanent refers to an Employee who is regularly scheduled to work at least 30 hours per week. Seasonal Employees, part-time Employees, volunteers, and independent contractors are excluded.

Individuals who are shareholders of The Langdale Company and its subsidiaries are eligible to participate in the Plan.

The following employees may be eligible to participate in the Plan after completion of a look-back measurement period:

- Variable Hour
- Seasonal

These employees will have their hours tracked and may qualify for eligibility to participate in the Plan based on hours worked over a twelve-month period of time called a “measurement period”. Employees’ hours during the measurement period will determine the employee’s eligibility to participate and obtain coverage under the Plan.

If the employee is determined to have worked, on average, 30 or more hours per week during the entire measurement period, then that employee will be offered coverage under the Plan for the next plan year called a “stability period”. If instead, the employee is determined to have not worked, on average, 30 or more hours per week during the entire measurement period, then that employee will not be eligible for coverage during the stability period.

Variable Hour and Seasonal employees’ hours will be tracked each year, and these employees’ eligibility to participate in the Plan will be based on each year’s measurement period. This means that a Variable Hour or Seasonal employee may be covered under the Plan in one year’s stability period, but not the next year’s stability period if that employee did not work, on average, at least 30 hours or more hours per week during last year’s measurement period.

Please note that newly hired Variable Hour or Seasonal employees will not be eligible for Plan coverage during their first year of employment, due to the application of the measurement period to determine eligibility.

If the employee is determined to be eligible for coverage during the stability period, the employee will be notified of their eligibility for Plan coverage after their measurement period and will have some time to elect to enroll in the Plan called an "administrative period".

Variable Hour and Seasonal Reference:

Periods and Definitions	**Duration**
Measurement Period – the period of time during which hours are tracked to determine Variable Hour and Seasonal employees' eligibility in the Plan.	12 months
Stability Period – the period of time in which coverage is offered or not offered due to the results of the measurement period.	12 months
Administrative Period - the period of time in which Variable Hour and Seasonal employees who are offered enrollment in the Plan can review and make elections.	Up to 90 days

Eligibility Requirements for Employee Coverage. An Employee is initially eligible for Plan coverage from the first day that he or she meets all of the following requirements:

(1) Is in an Eligible Class of Employees;

(2) Completes the employment Waiting Period of 60 days as a member of an Eligible Class of Employees. Langboard, Inc. hourly Employees must complete a Waiting Period of 90 days.

Eligible Classes of Dependents. An eligible Dependent is any one of the following persons:

(1) A covered Employee's Spouse who is not eligible for employer-sponsored health coverage through the Spouse's own Employer. (For purposes of this section, a Spouse is not eligible if the Spouse's employer-sponsored health coverage is "affordable" and/or meets "minimum value", as such terms are defined by The Patient Protection and Affordable Care Act (PPACA)).

(2) A covered Employee's Child or covered Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption, a foster child, or a child for who you or your Spouse are the legal guardian; or

(3) An unmarried Child age 26 or over who is or becomes Totally Disabled and dependent upon you. The Plan Administrator may require at reasonable intervals during the two years following the Child's reaching the limiting age, subsequent proof of Total Disability and continuing to meet the definition of

Child and other terms of this coverage. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Child examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of Total Disability.

(4) A child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order. Please see the Qualified Medical Child Support Order (QMCSO) section for more details.

Excluded from Eligible Classes of Dependents. A person who does not fall within any of the four Eligible Classes of Dependents is excluded from the Eligible Classes of Dependents. Additionally, the following persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any Child born to a Dependent Child; an Employee's Spouse who is a resident of another country outside the United States; or any person who is covered under the Plan as an Employee.

An Employee's Spouse must meet the following requirements:

1. Employee and Spouse shall not have been engaged in a trial separation for more than 12 consecutive months upon the date a Clean Claim for Covered Expense(s) provided to Spouse are received by the Plan.

2. Employee and Spouse shall have been cohabitating at the same residence for the majority of the applicable Plan Year. When an Employee or Spouse is traveling or residing elsewhere as part of their profession, to care for a family member (due, for instance, to Sickness or Injury), and/or is residing elsewhere due to their own Sickness or Injury, for more than half of the applicable Plan Year (and thus residing with each other for less than the majority of the applicable Plan Year), but the primary residence of the Employee is also the Spouse's primary residence for all legal, regulatory, and statutory purposes, this constitutes cohabitation as required by this provision.

The Plan Administrator has discretionary authority to interpret these terms, and determine spousal status as defined herein, to the extent allowed by law.

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

If both husband and wife are Employees, their Children will be covered as Dependents of the husband or wife, but not of both.

Eligibility Requirements for Dependent Coverage. An eligible Dependent of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the eligible Dependent satisfies all requirements for Dependent coverage. As for Spouses, see the Section below: "Additional Requirements for Spousal Eligibility".

Additional Requirements for Spousal Eligibility. A Spouse who is eligible for his or her own employer's group health plan is encouraged to become covered under that plan. If such coverage is available to the Spouse, and the coverage is "affordable" and/or meets "minimum value", as such terms are defined by The Patient Protection and Affordable Care Act (PPACA), the Spouse is not eligible for coverage under this Plan.

Employees must advise the Plan Administrator of his or her Spouse's work status and whether the Spouse has group health plan coverage available through the Spouse's employer. An Employee must attest to Spouse's Medical Eligibility status at the time of hire, upon change in enrollment due to HIPAA Special Enrollment Events, during an Open Enrollment period, or upon request. If at a later date, group health plan coverage becomes available to or ceases to become available to the Spouse, the Plan Administrator must be notified within 31 days.

If notice of a change in availability of a Spouse's group health plan coverage is not timely given, the Employee will be required to reimburse the Plan Administrator for any payments for a Spouse's claims that were incurred in the period of the Spouse's ineligibility. If fraud or intentional misrepresentation occurred, the Plan Administrator may retroactively terminate the coverage of the Employee and his or her Dependents.

B. ENROLLMENT

Enrollment Requirements. An eligible Employee must timely enroll for coverage when initially eligible. Enrollment will be "timely" if the completed enrollment application is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage. If an eligible Employee elects to cover eligible Dependents, those Dependents are also required to be timely enrolled at that time.

The Plan does not allow for late enrollment. This means that if an eligible Employee or Dependent does not timely enroll when initially eligible, there will be no coverage in the Plan unless enrollment is later allowed due to a HIPAA Enrollment Event, as described below, or the Employee elects coverage during an Open Enrollment period.

Enrollment Rules if Spouse is Also Employed by a Participating Employer. If your spouse is also an employee of a Participating Employer of this Plan, you may each have single coverage or one of you may elect to have family coverage, which will cover your spouse and any eligible dependents. You may not have one single coverage and one family coverage or two-family coverages.

If you and your spouse are each enrolled for single coverage, you may change one of the single coverages to a family coverage at any time without restriction, but only those Dependents who were timely enrolled will be covered. The other single coverage will be canceled. If you have family coverage that covers your spouse and any eligible dependents, you may transfer the family coverage to your spouse at any time.

If, at the time of marriage, the employees each have family coverage or one has family coverage and the other has single coverage, coverage must be changed to one of the options listed above within 31 days of marriage. Failure to comply with this requirement may result in denial of claims for eligible Dependents.

If two Employees (husband and wife) are covered under the Plan and the employment of the Employee who is covering a Dependent Child terminates, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee must be timely enrolled in this Plan (i.e., within 31 days after birth) in order to receive coverage. This applies whether the Employee has single coverage or family coverage. Charges for covered nursery care and routine Physician care will be applied toward the Plan of the newborn child. If a newborn child is not enrolled in the Plan on a timely basis, there will be no payment of any kind from the Plan related to the newborn, regardless of whether the baby is well or sick. If the child is not timely enrolled, the Plan will not pay or be responsible for any costs; and the newborn child will not be eligible for mid-year enrollment unless a HIPAA Enrollment Event applies, as described below.

HIPAA Special Enrollment Events. Enrollment is typically permitted only during specified times following initial eligibility and at Open Enrollment; however, the Plan will allow Eligible Employees and Dependents, who previously declined Plan coverage, to enroll in the Plan upon experiencing one of the following special enrollment events listed below. Enrollment is requested by filling out, signing, and returning the enrollment application to the Plan Administrator.

1. **Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program).** If you declined enrollment for yourself or for an eligible Dependent while other health insurance or group health plan coverage was in effect, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Loss of other coverage due to failure to pay premiums or for cause (such as making a fraudulent claim) does not qualify for special enrollment rights. Coverage will become effective as of the 1st day following the loss of other coverage.

2. **New Dependent by Marriage Birth, Legal Guardianship, A Foster Child Being Placed With an Employee, Adoption, or Placement for Adoption.** If you have a new Dependent as a result of marriage, birth, legal guardianship, a foster child being placed with an Employee, adoption or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within 31 days after the marriage, birth, legal guardianship, having a foster child, adoption or placement for adoption. If enrollment is timely requested, coverage will become retroactively effective as of the date of the marriage, birth, legal guardianship, having a foster child, adoption, or placement for adoption (as applicable).

3. **Loss of Coverage for Medicaid or a State Children's Health Insurance Program.** If you declined enrollment for yourself or for an eligible Dependent while Medicaid coverage or coverage under a state children's health insurance program was in effect, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your Dependents' coverage ends under Medicaid or a state children's health insurance program. Coverage will become effective as of the 1st day following the loss of other coverage.

4. **Eligibility for Medicaid or a State Children's Health Insurance Program.** If you or your Dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan, you may be able to enroll yourself and your Dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. Coverage will become effective as of the day you or your Dependents become eligible for the state premium assistance.

Open Enrollment. Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Covered Persons who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Coverage for Covered Persons enrolling during an Open Enrollment Period will become effective on January 1st, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Covered Persons enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility Requirements for Employee Coverage".

The terms of the Open Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an Open Enrollment Period.

"Open Enrollment Period" shall mean the time frame specified by the Plan Administrator.

Change of Election Under Flexible Benefits Plan. If a situation occurs that would allow an election change under The Langdale Company Flexible Benefits Plan to begin coverage under a health plan, then this Plan will allow a special enrollment period attributable to and consistent with that authorized change of election, provided all requirements of the Flexible Benefits Plan and this Plan are met. For a copy of the Flexible Benefits Plan, please contact the Plan Administrator.

Special enrollment periods and election changes under this Plan must be timely requested within 31 days of the authorized Flexible Benefits Plan event by filling out, signing, and returning an enrollment application to the Plan Administrator. If such changes are timely requested, coverage will become effective under this Plan as of the day a qualifying event under Flexible Benefits Plan occurs, unless otherwise provided by law.

C. EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the date that the Employee satisfies the Eligibility requirements and the Enrollment requirements of the Plan. If an Employee enrolls due to a HIPAA Special Enrollment Event, coverage will become effective as explained above in that Section.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility and Enrollment requirements are met, and the Employee is covered under the Plan. If a Dependent enrolls due to a HIPAA Special Enrollment Event, coverage will become effective as explained above in that Section.

D. TERMINATION OF COVERAGE

Generally, when your coverage ends, the Plan Administrator will still pay claims for covered services received before coverage ended. However, once coverage ends, claims will not be paid for health services received after coverage ended, even if the underlying medical condition occurred before coverage ended.

Employee Coverage will end on the earliest of:

- the date employment with a Participating Employer ends;
- the date the Plan is terminated;
- the last day of the month for which the required Employee contribution has been paid if the charge for the next period is not paid when due;
- the day an Employee is no longer eligible;
- the last day of the month the Plan Administrator receives notice from a Participating Employer to end coverage, or the date requested in the notice, if later; or
- the date following the end of the stability period for Variable Hour employees, if the employee failed to qualify during the previous measurement period.

Coverage for an Employee's eligible Dependents will end on the earliest of:

- the date the Plan is terminated;
- the date Employee coverage ends for any reason;
- the last day of the month for which the required contribution has been paid if the charge for the next period is not paid when due;
- the last day of the month the Plan Administrator receives notice from a Participating Employer to end Dependent coverage or the date requested in the notice, if later;
- the day the Dependent, other than a Dependent Child, no longer qualifies as a Dependent under this Plan; or
- the end of the month in which the Dependent Child turns 26 years old.

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 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.

Continuing Coverage Through COBRA. If an Employee and/or Dependents lose Plan coverage, health coverage continuation options may be available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please see the COBRA Continuation Options section of the SPD.

Employees on Military Leave. 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 Covered Person and the Covered Person's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). Please see the Other Federal Laws That Apply section of this SPD or ask your Plan Administrator for details.

Continuation During Employer-Approved Leaves of Absence (Non-FMLA). Notwithstanding the above termination date, a covered Employee may remain eligible for a limited time if coverage would otherwise terminate, but the Employee is on an Employer-approved leave of absence and employment has not terminated.

The limited time of continuation is up to 12 weeks provided that the Employee remains on an Employer-approved leave of absence. For coverage to continue, any contribution required of the Employee must continue to be made during this period. It is intended that this limited continuation will run concurrently with any continuation of medical benefits that may be required under the Family and Medical Leave Act. If coverage would terminate earlier than 12 weeks under any other provision of this Plan, then the earlier termination provision of the Plan will take precedence. While coverage is continued, the coverage provided would be the same that was in force on the last day the Employee was actively at work. However, any changes that may be made to the Plan during the period of limited continuation, including any change in the required Employee contribution, will also apply to those who are receiving limited continuation.

Continuation During Family and Medical Leave. This Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor, notwithstanding anything to the contrary in the Plan. If the Participating Employer is covered by the FMLA, then during any leave taken under the FMLA, the Employee will be eligible to maintain coverage under this Plan on the same conditions as coverage would have been available if the covered Employee had been actively employed during the FMLA leave period. It is intended that where appropriate, the period of medical coverage required by the FMLA will run concurrently with the limited continuation provided in the preceding section.

If Plan coverage terminated during the period of the FMLA leave (e.g. for Employee's failure to pay premiums while on FMLA leave), coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her covered Dependents when Plan coverage terminated.

It is intended that this section regarding the FMLA shall be interpreted in accordance with the FMLA and not be construed as an expansion or restriction of any of the Employer's or Employee's obligations or rights thereunder.

Reinstatement of Coverage. If employment is terminated and the Employee returns to active employment within 13 weeks from the date of termination, the Waiting Period will be waived and coverage will take effect on the first day the Employee returns to active employment.

All coverage reinstatements will be subject to other terms of the Plan.

3. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

Pursuant to Section 609(a) of the Employee Retirement Income Security Act of 1974 (ERISA), this Plan will honor the terms of a Qualified Medical Child Support Order (QMCSO) to the extent required by law.

A 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 a child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it is "qualified" – i.e., whether it meets the requirements for a QMCSO. If the Plan determines that a medical child support order is qualified, the child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Plan benefits as directed by the QMCSO. A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

You may obtain, without charge, a copy of the procedures governing QMCSOs, including how to submit a medical child support order to the Plan, from the Plan Administrator by submitting a written request.

4. PRIMARY CARE PROVIDER (PCP)

A Primary Care Provider (PCP) is a health care professional (usually a Physician) who is responsible for monitoring, supervising, and coordinating an individual's overall health care needs, referring the individual for specialist care when necessary.

Plan Benefits Relating to Certain PCP-Provided Services
To encourage Covered Persons to use a Primary Care Provider (PCP) for primary care and treatment, the Plan provides additional incentives for those who receive services from a PCP rather than a specialty physician.

The Plan offers incentives for treatment rendered by a PCP on an outpatient basis. The Plan includes a co-payment by the Covered Person of $25 per visit for office visit only on the same day.

Eligible Routine Care, as described in the Schedule of Benefits, must be provided by the PCP to be a covered expense under this Plan. Each Calendar Year, one routine gynecological examination is covered under Preventive/Wellness benefits, whether the PCP or OB/GYN provides such examination.

All Plan benefits are subject to the Schedule of Benefits, Limitations, and Exclusions of this Plan. Care and treatment by your PCP must be Medically Necessary.

This Plan has a Preferred Laboratory.

Selection of a Primary Care Provider
This Plan generally allows the designation of a Primary Care Provider (PCP). You have the right to designate a PCP who participates in the PPO network and who is available to accept you or your family members. A PCP can be selected from practitioners in Family/General Practice, Internal Medicine, or Pediatrics (for children).

For information on how to select a PCP, and for a list of the participating PCPs, contact the Plan Administrator at (229) 249-0940 or toll free (877) 949-0940, or go to TLC's website: www.tlcbenefitsolutions.net.

Direct Access to Obstetricians and Gynecologists
You do not need prior authorization from the Plan or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a PPO participating health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including but not limited to obtaining prior authorization for certain services. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator at (229) 249-0940 or toll free (877) 949-0940, or go to TLC's website: www.tlcbenefitsolutions.net.

5. SCHEDULE OF BENEFITS

Except as otherwise specified in this Plan, determinations for Non-Network facility and professional providers will be made under the Plan's Claim Review and Audit Program, and covered expenses will be the amount of Allowable Claim Limits subject to the Network Provider Deductibles, Co-payments, coinsurance percentage and maximums limits.

DEDUCTIBLES		
	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Calendar Year Deductible		
Per Covered Person	$800	$2,500
Per Family Unit	$2000	No Limit
Additional Deductibles/Penalties		
Impairment Related Injury	$5000	$5000
Child Safety Seat	$1000	$1000
Safety Helmet	$1000	$1000
Seat Belt	$1000	$1000
Failure to Obtain Pre-Authorization*	$1000	$1000

*If Covered Person does not receive pre-authorization as explained in *Section 8: Utilization Management Program*, the allowable expense will be denied until authorization is obtained. Upon receipt of the retroactive authorization, $1,000 penalty will apply towards the allowable expense.

PLAN MAXIMUMS
Calendar Year Maximum . . . . . unlimited
Lifetime Maximum . . . . . unlimited
Calendar Year Maximum and Lifetime Maximum apply to Essential Health Benefits, as determined by the Secretary of Health and Human Services (HHS). There are other Maximums on non-Essential Health Benefits as noted under “Benefits”.

MAXIMUM OUT-OF-POCKET LIMIT PER CALENDAR YEAR			
	NETWORK PROVIDERS		NON-NETWORK PROVIDERS*
	Medical	Pharmacy	
Per Covered Person	$5,775	$1,325	No Limit**
Per Covered Family Unit	$11,550	$2,650	No Limit**

The Plan will pay the percentage of covered charges designated below until the maximum Out-of-Pocket payments are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the Calendar Year unless stated otherwise. When calculating the family out-of-pocket maximum, each family member may contribute up to the individual out-of-pocket maximum amount, after which the Plan will pay 100% of the Maximum Allowable Charge for that family member’s covered services for the remainder of the Calendar Year.

Expenses incurred for the following are included in the Out-of-Pocket Maximum:
1. Deductible(s)
2. Co-Payment(s)
3. Coinsurance

Expenses incurred for the following are not included in the Out-of-Pocket Maximum:
1. Additional Deductibles/Penalties

*Medical Provider Only. All Pharmacies participate in Preferred or Non-Preferred Networks.
**Claims subject to Section 13. Claim Review and Audit comply with Network Benefits and Maximums.

BENEFITS
Preventive/Wellness Adult – One Wellness Exam Allowed Per Calendar Year with no cost-sharing for the patient.
The Plan provides benefits for a comprehensive range of preventive care services for adults age 19 and over, including the preventive services recommended under the Patient Protection and Affordable Care Act (the Affordable Care Act). Preventive/Wellness Care includes the following routine services:

Adult Female Wellness	***Adult Male Wellness***
Complete physical exam w/Breast and Pelvic Exam *Height *Weight *Pulse *Blood Pressure *Respirations	Complete physical exam w/Prostate Screening *Height *Weight *Pulse *Blood Pressure *Respirations
Urinalysis, Cervical cancer screening	Urinalysis, PSA
Cervical cancer screening – age 21–65, using any of 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 (cotesting) every 5 years, age 30–65 only	
Cholesterol, FBS, TSH	Cholesterol, FBS, TSH
Chemistry Panel, Complete Blood Count with Differential	Chemistry Panel, Complete Blood Count with Differential
COVID-19 (2019 Novel Coronavirus) Testing (covered at 100% both Network and Non-Network Providers) The Plan will: • Cover the costs of OTC COVID-19 tests for participants either directly (referred to in the as “direct coverage”) or by requiring participants to pay for the tests upfront and then submit a claim for reimbursement. starting Jan. 15 without the need for a health care provider's order. • Make tests available for upfront coverage through preferred pharmacies or retailers and provides direct coverage of OTC COVID-19 tests both through its pharmacy network and a direct-to-consumer shipping program, it may limit reimbursement for OTC COVID-19 tests from nonpreferred pharmacies or other retailers to the lesser of $12 per test or the actual cost of the test. • Set limits on the number of OTC COVID-19 tests covered without cost-sharing but must allow up to eight tests per plan enrollee per 30 days (or calendar month). A family of four, all on the same plan, would be able to get up to 32 of these tests covered by their health plan per 30- day period (or calendar month).	COVID-19 (2019 Novel Coronavirus) Testing (covered at 100% both Network and Non-Network Providers) The Plan will: • Cover the costs of OTC COVID-19 tests for participants either directly (referred to in the as “direct coverage”) or by requiring participants to pay for the tests upfront and then submit a claim for reimbursement. starting Jan. 15 without the need for a health care provider's order. • Make tests available for upfront coverage through preferred pharmacies or retailers and provides direct coverage of OTC COVID-19 tests both through its pharmacy network and a direct-to-consumer shipping program, it may limit reimbursement for OTC COVID-19 tests from nonpreferred pharmacies or other retailers to the lesser of $12 per test or the actual cost of the test. • Set limits on the number of OTC COVID-19 tests covered without cost-sharing but must allow up to eight tests per plan enrollee per 30 days (or calendar month). A family of four, all on the same plan, would be able to get up to 32 of these tests covered by their health plan per 30- day period (or calendar month).

Adult Female Wellness	*Adult Male Wellness*
• May take reasonable steps—such as requiring a written attestation—to ensure that each OTC COVID-19 test for which you seek coverage under the Plan was purchased for personal use, not for employment purposes; has not been (and will not be) reimbursed by another source; and is not for resale. • Require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of an OTC COVID-19 test. • May not set limits on the number of covered tests if these are ordered by a health care provider following a clinical assessment.	• May take reasonable steps—such as requiring a written attestation—to ensure that each OTC COVID-19 test for which you seek coverage under the Plan was purchased for personal use, not for employment purposes; has not been (and will not be) reimbursed by another source; and is not for resale. • Require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of an OTC COVID-19 test. • May not set limits on the number of covered tests if these are ordered by a health care provider following a clinical assessment.
COVID-19 (2019 Novel Coronavirus) Vaccination	COVID-19 (2019 Novel Coronavirus) Vaccination
Digital Rectal Exam	Digital Rectal Exam
Colorectal cancer screening – age 45–75, using any of the following methods: • Fecal occult blood testing (FOBT)/fecal immunochemical test (FIT) annually; or • Sigmoidoscopy every five years; or • Colonoscopy every 10 years; or • Computed tomographic colonography (virtual colonoscopy) every five years; or • Double contrast barium enema (DCBE) every five years • Stool-based deoxyribonucleic acid (DNA) (i.e., Cologuard) every one to three years Effective for plan years on or after May 31, 2022, the Plan must cover, without cost-sharing, a colonoscopy conducted after a positive noninvasive stool-based screening test or direct visualization screening test for colorectal cancer for adults ages 45-75.	Colorectal cancer screening – age 45–75, using any of the following methods: • Fecal occult blood testing (FOBT)/fecal immunochemical test (FIT) annually; or • Sigmoidoscopy every five years; or • Colonoscopy every 10 years; or • Computed tomographic colonography (virtual colonoscopy) every five years; or • Double contrast barium enema (DCBE) every five years • Stool-based deoxyribonucleic acid (DNA) (i.e., Cologuard) every one to three years Effective for plan years on or after May 31, 2022, the Plan must cover, without cost-sharing, a colonoscopy conducted after a positive noninvasive stool-based screening test or direct visualization screening test for colorectal cancer for adults ages 45-75.
Bone Density – every 2 years, age 65 and older, younger women with risk factors	
EKG	EKG
Chest X-Ray	Chest X-Ray
Screening Mammogram *(one baseline age 35-40, one per year age 40 and over)**	Abdominal aortic aneurysm screening – one-time ultrasound, ages 65-75
Alcohol misuse screening and counseling	Alcohol misuse screening and counseling
Aspirin use to prevent cardiovascular disease and colorectal cancer – ages 50-69	Aspirin use to prevent cardiovascular disease and colorectal cancer – ages 50-69
BRCA counseling about genetic testing and BRCA test – women at higher risk	
Breast cancer preventive medication counseling	
Depression screening	Depression screening

Adult Female Wellness	*Adult Male Wellness*
Prediabetes and Type 2 Diabetes Screening – in adults aged 35 to 70 years who are overweight or obese	Prediabetes and Type 2 Diabetes Screening – in adults aged 35 to 70 years who are overweight or obese
Falls prevention – exercise and physical therapy, and vitamin D supplementation, age 65 and older	Falls prevention – exercise and physical therapy, and vitamin D supplementation, age 65 and older
Healthy diet counseling for patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease when billed by a covered provider such as a Physician, nurse, nurse practitioner, licensed certified nurse practitioner, licensed certified nurse midwife, dietician or nutritionist, who bills independently for nutritional counseling services	Healthy diet counseling for patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease when billed by a covered provider such as a Physician, nurse, nurse practitioner, licensed certified nurse practitioner, licensed certified nurse midwife, dietician or nutritionist, who bills independently for nutritional counseling services
Human Immunodeficiency virus (HIV) counseling	Human Immunodeficiency virus (HIV) counseling
Human papillomavirus DNA testing – age 30 and older, every 5 years	
Intimate partner violence screening – women of childbearing age	
Obesity screening and counseling	Obesity screening and counseling
Osteoporosis screening – age 65 and older, younger women at risk, and postmenopausal women younger than 65 years at increased risk of osteoporosis	
Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. This benefit is in effect as of September 17, 2021, and includes: • FDA-Approved Medication – Descovy and Truvada • Kidney function testing (creatinine) • Serologic testing for hepatitis B and C virus • Testing for other STIs • Pregnancy testing when appropriate • Ongoing follow-up and monitoring including HIV testing every 3 months	Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. This benefit is in effect as of September 17, 2021, and includes: • FDA-Approved Medication – Descovy and Truvada • Kidney function testing (creatinine) • Serologic testing for hepatitis B and C virus • Testing for other STIs • Pregnancy testing when appropriate • Ongoing follow-up and monitoring including HIV testing every 3 months
Screening and counseling for interpersonal and domestic violence	
Sexually transmitted infections counseling	Sexually transmitted infections counseling
Skin cancer behavioral counseling – ages 18-24	Skin cancer behavioral counseling – ages 18-24
Statin preventive medication – age 40-75, and meets following criteria: 1) no history of CVD; 2) 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking and 3) calculated 10-year CVD event risk of 10% or greater	Statin preventive medication – age 40-75, and meets following criteria: 1) no history of CVD; 2) 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking and 3) calculated 10-year CVD event risk of 10% or greater
Tobacco use counseling and tobacco cessation interventions**	Tobacco use counseling and tobacco cessation interventions**

Adult Female Wellness	***Adult Male Wellness***
Screenings for: • Chlamydial infection (nonpregnant and pregnant women) – age 24 and younger, an older women at increased risk • Gonorrhea infection (nonpregnant and pregnant women) • Human Immunodeficiency virus (HIV) infection • Hepatitis C virus (HCV) infection – adults born between 1945 and 1965 and those at high risk for infection • Syphilis infection (nonpregnant and pregnant women) • Thyroid • Hepatitis B virus (HBV) infection – adults at high risk of infection	Screenings for: • Chlamydial infection • Gonorrhea infection • Human Immunodeficiency virus (HIV) infection • Hepatitis C virus (HCV) infection – adults born between 1945 and 1965 and those at high risk for infection • Syphilis infection • Thyroid • Hepatitis B virus (HBV) infection – adults at high risk
Immunizations***: Hepatitis (Type A and B) for patients with increased risk or family history Herpes Zoster (shingles) – age 50 and older Human Papillomavirus (HPV) Influenza (flu) Influenza (flu) high dose – age 65 and older Measles, Mumps, Rubella (MMR) – if born in 1957 or later Meningococcal Pneumococcal (pneumonia) Tetanus, Diphtheria, Pertussis booster – 10 years Varicella (chickenpox) Coronavirus (COVID-19)	Immunizations***: Hepatitis (Type A and B) for patients with increased risk or family history Herpes Zoster (shingles) – age 50 and older Human Papillomavirus (HPV) Influenza (flu) Influenza (flu) high dose – age 65 and older Measles, Mumps, Rubella (MMR) – if born in 1957 or later Meningococcal Pneumococcal (pneumonia) Tetanus, Diphtheria, Pertussis booster –10 years Varicella (chickenpox) Coronavirus (COVID-19)

Pregnancy-related Wellness	
Anemia screening, iron deficiency – pregnant women	Gestational diabetes – pregnant women at first prenatal visit for those at risk; all pregnant women at 24 weeks or later
Bacteriuria screening with urine culture – pregnant women at 12-16 weeks gestation or at the first prenatal visit, if later	Hepatitis B screening – pregnant women
	Perinatal depression – counseling and intervention
Breastfeeding support, supplies, and Counseling****	Rh incompatibility screening – 1st pregnancy visit and 24-28 weeks' gestation
Contraceptive methods and counseling The Plan will cover all FDA-approved, cleared, or granted contraceptive products that are determined by an individual's medical provider to be medically appropriate to such individual without cost-sharing, whether or not specifically identified in the current FDA Birth Control Guide. The Plan may need to cover a newer contraceptive product–such as a mobile app for contraception based on fertility awareness—if it is deemed medically appropriate.	
Tobacco use counseling – pregnant women	
Folic acid supplementation – 0.4 to 0.8 mg daily, women planning or capable of pregnancy	Low-dose aspirin (81 mg/d) after 12 weeks of gestation in women who are at high risk for preeclampsia
Preeclampsia screening	Human Immunodeficiency virus (HIV) screening

Benefits apply only when the Covered Person's PCP or Gynecologist provides services. Please be aware that "SICK" office visits and "WELLNESS" office visits on the same day by the same provider are not payable. Only one office visit will be paid.

Preventive Medicines, limited to: Aspirin, generic Statin, Folic acid supplements, Vitamin D, Available OTC, and FDA-approved Female Contraceptive Methods available OTC (such as contraceptive sponges and spermicides) are covered without cost sharing only when prescribed by a Network Provider and purchased at a Network Pharmacy.

*Additional mammograms may be allowable under major medical if determined to be necessary by a Physician and approved by the Plan Administrator.

**The Plan covers the following tobacco cessation products at no cost up to six (6) months in a Calendar Year when prescribed by a Network Provider and purchased at a Network Pharmacy:

- Bupropion SR 150mg (generic/prescription)
- Chantix Tabs (brand/prescription)
- Nicotine Replacement Therapy (NTR), limited to:
  - Nicotine Patches (generic/over-the-counter)
  - Lozenges (generic/over-the-counter)
  - Gum (generic/over-the-counter)
  - Inhaler(generic/prescription)
  - Nasal Spray (generic/prescription)

***Immunizations are covered through the Medical Plan and through the Pharmacy Plan when provided by Network retail Pharmacy and administered in compliance with applicable state law and pharmacy certification requirements.

****(1) Comprehensive lactation support and counseling, by a Physician, physician assistant, nurse midwife, nurse practitioner/clinical specialist, or registered nurse certified lactation consultant during pregnancy and/or in the postpartum period.

****(2) Breast pump kit, limited to one of the two kits and conditions listed below, for women who are pregnant and/or nursing:

- Double Electric pump kit, one time only
- Manual pump kit, one per subsequent pregnancy

Note: Benefits for the breast pump kit are **only** available when you contact TLC Benefit Solutions Inc. by calling (877) 949-0940.

*****FDA-approved, generic (or step therapy brand) contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. **Hysterectomies and Vasectomies are not considered part of the women's preventive care benefit covered at 100%.**

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Office Visit	$0 Co-Payment	50% After Deductible
Deductible	Waived	$2,500
Maximum Benefit Per Calendar Year	Unlimited	Does Not Apply

Preventive/Wellness Pediatric
The Plan provides benefits for a comprehensive range of preventive care services for covered dependents up to age 19, including the preventive services recommended under the Patient Protection and Affordable Care Act (the Affordable Care Act). Preventive/Wellness Pediatric Care includes the following routine services:
Complete Physical Exam with age appropriate lab
Hearing and Vision Screenings
Developmental screening and Developmental surveillance
Anticipated Guidance
Routine Immunizations
Alcohol and drug use assessment – adolescents
Autism screening
Cholesterol screening (dyslipidemia) – children at risk due to known family history, when family history is unknown, or with personal risk factors such as obesity, high blood pressure or diabetes, after age two but by age 10
COVID-19 (2019 Novel Coronavirus) Testing (covered at 100% both Network and Non-Network Providers) The Plan will: • Cover the costs of OTC COVID-19 tests for participants either directly (referred to in the as “direct coverage”) or by requiring participants to pay for the tests upfront and then submit a claim for reimbursement. starting Jan. 15 without the need for a health care provider's order. • Make tests available for upfront coverage through preferred pharmacies or retailers and provides direct coverage of OTC COVID-19 tests both through its pharmacy network and a direct-to-consumer shipping program, it may limit reimbursement for OTC COVID-19 tests from nonpreferred pharmacies or other retailers to the lesser of $12 per test or the actual cost of the test. • Set limits on the number of OTC COVID-19 tests covered without cost-sharing but must allow up to eight tests per plan enrollee per 30 days (or calendar month). A family of four, all on the same plan, would be able to get up to 32 of these tests covered by their health plan per 30- day period (or calendar month). • May take reasonable steps—such as requiring a written attestation—to ensure that each OTC COVID-19 test for which you seek coverage under the Plan was purchased for personal use, not for employment purposes; has not been (and will not be) reimbursed by another source; and is not for resale. • Require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of an OTC COVID-19 test. • May not set limits on the number of covered tests if these are ordered by a health care provider following a clinical assessment.
COVID-19 (2019 Novel Coronavirus) Vaccination
Dental caries prevention – oral fluoride supplementation, ages 6 months to preschool
Depression screening – ages 12 to 18
Gonorrhea prophylactic medication – newborns

Hearing loss screening - newborns
Hemoglobinopathies screening – newborns
Hypothyroidism screening – newborns
Iron supplementation in children – ages 6 to 12 months
Lead screening – children at risk for lead exposure
Obesity screening and counseling – age 6 and older
Ocular topical medication – newborns
Nutritional counseling
Phenylketonuria screening – newborns
Psychosocial/behavioral assessment
Sexually transmitted infections counseling and screening* - adolescents
Skin cancer behavioral counseling – ages 6 months to 24 years
Tuberculin testing – children and adolescents at high risk
Visual acuity screening – once between the ages of 3 and 5 years

*Benefits for sexually transmitted infection (STI) screening tests are limited to one test per STI per year.

The Plan follows Immunization Schedules and other recommendations of:
The Advisor Committee for Immunization Practices (ACIP), and
The American Academy of Pediatrics (AAP) Bright Futures periodicity schedule

Preventive Medicines, limited to: Iron supplements, Ocular topical medication and Oral fluoride supplements, available OTC are covered without cost-sharing only when prescribed by a Network Provider and purchased at a Network Pharmacy.

Benefits apply only when the Covered Person's PCP or Pediatrician provides services. Please be aware that "SICK" office visits and "WELLNESS" office visits on the same day by the same provider are not payable. Only one office visit will be paid.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Office Visit	$0 Co-Payment	50% After Deductible
Deductible	Waived	$2,500
Maximum Benefit Per Calendar Year	Unlimited	Does Not Apply

BENEFITS Continued

Primary Care

You are eligible for Primary Care benefits only when services are provided by a PCP*. Please be aware that "SICK" office visits and "WELLNESS" office visits on the same day by the same provider are not payable. Only one office visit will be paid.

Your PCP is your personal doctor. He or she will provide your routine medical care and refer you to a specialist or Hospital if he or she determines you need additional care. Whether you are sick, need a checkup or have a medical question, you should call your PCP first.

*A Primary Care Provider (PCP) can be selected from practitioners in Family/General Practice, Internal Medicine, or Pediatrics (for children). Please see *Section 4: Primary Care Provider (PCP)* for details.

Primary Care Adult

The PCP Co-Payment applies to the office visit only. Laboratory services and tests associated with the visit will be paid under major medical with Deductible applied and balance paid within Plan limits. There is no benefit for Routine Venipuncture, Lab Handling Fees with Syringe and Needle Fees when provided during a Primary Care Visit. This will be considered a Non-Covered Service.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Office Visit	$25 Co-Payment	50% After Deductible
Deductible	Waived	$2,500
Maximum Visits Per Day	1 Visit	1 Visit

Primary Care Pediatric

The Pediatric Care Co-Payment applies to the office visit only. Laboratory services and tests associated with non-wellness visit will be paid under major medical with Deductible applied and balance paid within Plan limits. There is no benefit for Routine Venipuncture, Lab Handling Fees and Syringe with Needle Fees when provided during a Primary Care Visit. This will be considered a Non-Covered Service.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Office Visit	$25 Co-Payment	50% After Deductible
Deductible	Waived	$2,500
Maximum Visits Per Day	1 Visit	1 Visit

BENEFITS Continued		
Major Medical		
	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Benefit Percentages Payable After Satisfaction of the Deductible. Deductible and Coinsurance Do Not Apply When Co-Payment is Listed.		
Emergency Room Treatment Non-Network emergency services accrue towards the Network Deductible and Maximum Out-of-Pocket Limit.	$200 Co-Payment	$200 Co-Payment
Ambulance Service Non-Network air ambulance services accrue towards the Network Deductible and Maximum Out-of-Pocket Limit.	80%	80%
Physician Services Inpatient Outpatient Surgical Specialty Physician Office Visit	 80% 80% 80% $50 Co-Payment	 50% 50% 50% 50%
There is no benefit for Routine Venipuncture, Lab Handling Fees and Syringe with Needle Fees when provided during an Office Visit.		
Second and/or Third Surgical Opinion	100%	100%
Hospital Care Services Inpatient Outpatient	 80% 80%	 80% 80%
Hospital Room and Board	80%	80%
Intensive Care Unit	80%	80%
Outpatient (Ambulatory) Surgery	80%	80%
Pregnancy Benefits* Covered Employee or Covered Spouse Office Visits Other services (testing, ultrasounds, screenings)	 $25 Co-Payment 80%	 50% 50%
*Note: This benefit is separate from the pregnancy benefits that are included under the preventive care benefit, which apply to all plan participants.		
Hospice Care Inpatient Care *Maximum Days Per Benefit Period* Inpatient Respite Care *Maximum Days Per Benefit Period* Home Care	 100% 30 Days 100% 5 Days 100%	 50% 30 Days 50% 5 Days 50%

Spinal Manipulation/Chiropractic Services Maximum Visits Per Year	$50 Co-Payment 20 Visits	50% 20 Visits
Orthospinology Maximum Visits Per Year	$25 Co-Payment N/A	50% N/A
Acupuncture Maximum Visits Per Year	80% 10 Visits	50% 10 Visits
Temporomandibular Joint Dysfunction	80%	50%
Hearing aids** for Children age 18 and under	Limited to $2,500 per ear Every 48 months	Limited to $2,500 per ear Every 48 months
**Amounts over $2500 are Covered Person's responsibility and will not apply towards Out-of-Pocket		
Skilled Nursing Facility Maximum Days Per Year	80% 120 Days	80% 120 Days
Home Health Care Maximum Visits Per Day Maximum Days Per Year	80% 1 Visit 120 Days	50% 1 Visit 120 Days
Marriage and/or Family Counseling	$25 Co-Payment	50%
Telehealth office visit*** (outside of the Telehealth Mobile Clinic) Office Visits Deductible	 $15 Co-Payment Waived	 50%
***Applicable to primary care providers (PCP) and behavioral health/substance use disorders counseling		
Telehealth Mobile Clinic (Includes telehealth office visit, lab tests, radiology, and medication.)	No Cost to Employees	N/A
Mental Disorders and Substance Abuse		
	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Inpatient and Partial Hospitalizations	80%	80%
Office Visits Deductible Maximum Visits Per Day	$25 Co-Payment Waived 1 Visit	50% $2,500 1 Visit
Outpatient Care	80%	80%
Benefit available only when service is provided by MD, PhD, LCSW, LMFT, LPC or APRN. APRN and Clinical Nurse Specialist (CNS) must be supervised by a Physician who approves the treatment plan and therapy. The Deductible and Out-of-Pocket Limit for Mental Health Disorders and Substance Abuse Disorders benefits are COMBINED with the Deductible and Out-of-Pocket limit for Medical/Surgical benefits. The above financial requirements are NOT combined for Network and Non-Network Providers. Pre-Authorization Requirements and Medical Management apply to Mental Health Disorders and Substance Abuse Disorders to the same extent, and no more stringent, as they apply to Medical/Surgical benefits in a classification of benefits. Medical necessity determination disclosure and claims denial disclosure are available upon request.		

BENEFITS Continued			
PHARMACY BENEFITS			
Preferred Network 34 Day Supply		**Non-Preferred Network 34 Day Supply**	
	Co-payment		Co-payment
Tier 1 – Generics*	**$15**	**Tier 1** – Generics*	**$25**
Tier 2 – Preferred Brands (Formulary Brands)	**$40 or 20%** (Greater Amount)	**Tier 2** – Preferred Brands (Formulary Brands)	**$50 or 20%** (Greater Amount)
Tier 3 – Non-Preferred Brands (Non-Formulary Brands)	**$75 or 30%** (Greater Amount)	**Tier 3** – Non-Preferred Brands (Non-Formulary Brands)	**$90 or 30%** (Greater Amount)
Compound Drugs**	**$25**	**Compound Drugs**	Not Covered
Preferred Network 90 Day Supply		**Non-Preferred Network 90 Day Supply**	
Tier 1 – Generics	**$45**	**Tier 1** – Generics	Not Covered
Tier 2 – Preferred Brands (Formulary Brands)	**$120 or 20%** (Greater Amount)	**Tier 2** – Preferred Brands (Formulary Brands)	Not Covered
Tier 3 – Non-Preferred Brands (Non-Formulary Brands)	**$225 or 30%** (Greater Amount)	**Tier 3** – Non-Preferred Brands (Non-Formulary Brands)	Not Covered
**All Generics exceeding $400 in drug cost will adjudicate at 20% coinsurance, not to exceed $250.* ***Not to exceed $250 in drug cost. Must be filled at Chancy Drugs pharmacy stores.*			

BENEFITS Continued			
DISEASE MANAGEMENT PHARMACY BENEFITS			
The following benefits apply to medications that treat the following conditions: Hypertension (high blood pressure), Hyperlipidemia (high cholesterol), Asthma, and Cardiovascular Disease; and you are not Diabetic.			
Preferred Network 34 Day Supply		**Non-Preferred Network 34 Day Supply**	
	Co-Payment		Co-Payment
Tier 1 – Generics*	**$10**	**Tier 1** – Generics*	**$25**
Tier 2 – Preferred Brands (Formulary Brands)	**$30 or 20%** (Greater Amount)	**Tier 2** – Preferred Brands (Formulary Brands)	**$50 or 20%** (Greater Amount)
Tier 3 – Non-Preferred Brands (Non-Formulary Brands)	**$75 or 30%** (Greater Amount)	**Tier 3** – Non-Preferred Brands (Non-Formulary Brands)	**$90 or 30%** (Greater Amount)
Compound Drugs**	**$25**	**Compound Drugs**	Not Covered
Preferred Network 90 Day Supply		**Non-Preferred Network 90 Day Supply**	
Tier 1 – Generics	**$30**	**Tier 1** – Generics	Not Covered
Tier 2 – Preferred Brands (Formulary Brands)	**$90 or 20%** (Greater Amount)	**Tier 2** – Preferred Brands (Formulary Brands)	Not Covered
Tier 3 – Non-Preferred Brands (Non-Formulary Brands)	**$225 or 30%** (Greater Amount)	**Tier 3** – Non-Preferred Brands (Non-Formulary Brands)	Not Covered
**All Generics exceeding $400 in drug cost will adjudicate at 20% coinsurance, not to exceed $250.* ***Not to exceed $250 in drug cost. Must be filled at Chancy Drugs pharmacy stores.*			

BENEFITS Continued			
DIABETES MANAGEMENT PHARMACY BENEFITS			
The following benefits apply to medications that treat the following conditions: Diabetes, Hypertension (high blood pressure), Hyperlipidemia (high cholesterol), Asthma, and Cardiovascular Disease; and you are a Diabetic.			
Preferred Network* 34 Day Supply or 90 Day Supply		**Non-Preferred Network 34 Day Supply or 90 Day Supply**	
	Co-Payment		Co-Payment
Tier 1 – Generics	**$0**	**Tier 1** – Generics	Not Covered
Tier 2 – Preferred Brands (Formulary Brands)	**$0**	**Tier 2** – Preferred Brands (Formulary Brands)	Not Covered
Tier 3 – Non-Preferred Brands (Non-Formulary Brands)	**$0**	**Tier 3** – Non-Preferred Brands (Non-Formulary Brands)	Not Covered
Compound Drugs**	**$25**	**Compound Drugs**	Not Covered
**Members have to participate in the Diabetes Management Program to qualify for these benefits.* ***Not to exceed $250 in drug cost. Must be filled at Chancy Drugs pharmacy stores.*			

Human Organ and Tissue Transplant Coverage Limits

The Langdale Company Employee Benefit Plan (the "Plan") includes a special carve-out program for human organ and tissue transplant benefits, which are fully-insured by HCC Life Insurance Company (the "Transplant Policy"). Please refer to *Section 7: Transplant Program* for additional details and applicable coverage limits.

SleepCharge Program Benefits

Covered Persons can participate in the SleepCharge Program if they have been covered under the Plan for at least 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 your renewal date Covered Persons will be required to meet with a technician prior to the renewal being paid.

Services	**Your Co-Payment Year 1**	**Your Co-Payment Year 2**
Newly Diagnosed Member	**$200**	**$100**
Transfer of Care	**$150**	**$100**

6. ADDITIONAL COVERAGE DETAILS

This section supplements *Section 5: Schedule of Benefits*. These descriptions include any additional limitations that may apply. Services that are not covered are described in *Section 11: Plan Exclusions*.

DEDUCTIBLE

Deductible Amount. This is the amount that must be paid before any benefits are payable by the Plan. Before benefits can be paid in a Calendar Year a Covered Person must meet the Deductibles shown in the Schedule of Benefits. Amounts paid to satisfy any applicable Deductibles will accrue toward the maximum Out-of-Pocket payment. For some services, the Deductible is waived.

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

Child Seat Deductible. An additional Deductible will apply to covered charges before any Plan benefits are paid for injuries sustained by a child who was not properly restrained in a child seat as required by State law.

Impairment-Related Injury Deductible. An additional Deductible will apply to covered charges if impairment due to alcohol and/or controlled substance was a contributing cause of the Covered Person's injuries unless impairment due to a medical condition.

Safety Helmet Deductible. An additional Deductible will apply before any benefits are paid if a Covered Person or covered dependent is injured while operating a motorcycle or a two-wheeled vehicle, three-wheeled, or four-wheeled all terrain motor vehicle without a safety helmet.

Seatbelt Deductible. An additional Deductible will apply before any benefits are paid if the Covered Person is injured in an automobile accident while not wearing a seatbelt according to State law.

BALANCE BILLING

In the event that a claim submitted by a Network or non-Network Provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any provider's actions, including balance billing.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Covered Person is responsible for any applicable payment of co-insurances, Deductibles, and Out-of-Pocket maximums and may be billed for any or all of these.

BENEFIT PAYMENT

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

CALENDAR YEAR AND LIFETIME MAXIMUM AMOUNTS

The Calendar Year and Lifetime Maximum Benefit amounts are shown in the Schedule of Benefits. In general, the Plan has unlimited Calendar Year and Lifetime Maximum Benefit amounts. Certain non-essential health benefits have specific Calendar Year and Lifetime Maximum Benefit amounts as shown in the Schedule of Benefits. Limitations other than Calendar Year and Lifetime Maximum Benefit amounts may be applied to some benefits, as well.

CLAIMS AUDIT

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

NETWORK EXCEPTION

If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular provider is a Network provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's coinsurance, Co-Payment, Deductible, and Out-of-Pocket maximum will be calculated as if the provider had been in-Network despite that information proving inaccurate.

CONTINUITY OF CARE

In the event a Covered Person is a continuing care patient receiving a course of treatment from a provider which is in-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the provider's failure to meet applicable quality standards or for fraud, the Covered Person shall have the following rights to continuation of care.

The Plan shall notify the Covered Person in a timely manner, but in no event later than 10 calendar days after termination that the provider's contractual relationship with the Plan has terminated, and that the Covered Person has rights to elect continued transitional care from the provider. If the Covered Person elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Covered Person ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

- is undergoing a course of treatment for a serious and complex condition from a specific provider,
- is undergoing a course of institutional or inpatient care from a specific provider,
- is scheduled to undergo non-elective surgery from a specific provider, including receipt of postoperative care with respect to the surgery,
- is pregnant and undergoing a course of treatment for the Pregnancy from a specific provider, or
- is or was determined to be terminally ill and is receiving treatment for such illness from a specific provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the provider may be free to pursue the Covered Person for any amounts above the Plan's benefit amount.

NO SURPRISES ACT – EMERGENCY SERVICES AND SURPRISE BILLS

For Non-Network claims subject to the No Surprises Act ("NSA"), Covered Person cost-sharing will be the same amount as would be applied if the claim was provided by a Network provider and will be calculated as if the Plan's Covered Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The

NSA prohibits providers from pursuing Covered Persons for the difference between the Maximum Allowable Charge and the provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

COVERED CHARGES

The Plan pays benefits for the covered charges listed below. Covered charges are the Maximum Allowable Charge that is Incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

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

In the absence of a PPO agreement, Multiple Surgical Procedures performed outpatient will be determined based on 100% of the allowable amount for the most expensive procedure and 50% of the allowable amount for all subsequent procedures. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedure.

(2) **Skilled Nursing/Extended Care Facility Care.** The room and board and nursing care furnished by a Skilled Nursing/Extended Care Facility will be payable if and when:

(a) The patient is confined as a bed patient in the facility;
(b) The attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
(c) The attending Physician completes a treatment Plan that includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing/Extended Care Facility.

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

(a) Charges for multiple **Surgical Procedures** will be a covered charge subject to the following provisions, except when prohibited by contract:

(i) If bilateral or multiple Surgical Procedures are performed during a single surgery session, benefits will be determined based on 100% of the Allowable Amount for the most expensive procedure and 50% of the Allowable Amount for additional procedures performed during the same surgery session. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedure;

(ii) If multiple unrelated Surgical Procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Allowable Amount for Procedure for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowable Amount for that Procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the Allowable Amount for Procedure.

(b) Charges for anesthesiology benefits will be determined based on the Allowable Amount for Procedures of a licensed anesthesiologist for services rendered in connection with a surgical operation. The benefit payable shall be based upon unit value plus time, according to the current American Society of Anesthesiologist Relative Value Guide and special modifiers (updates). Certified Registered Nurse Anesthesiologist (CRNA) will be reimbursed at 50% of the allowable if an anesthesiologist is also involved in the case. Anesthesiologist Assistant (AA) will be reimbursed at 25% of the allowable.

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

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

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial Care in nature. The only charges covered for

outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour shift basis is not covered.

(5) **Gastric Sleeve Surgery**. Helps obese patients lose weight by making them feel full more quickly, which reduces the intake of food. In gastric sleeve surgery, 80 percent of the patient's stomach is removed, and what remains resembles a "sleeve," hence the name. The procedure and the weight loss program associated with the procedure must be approved in advance by the Utilization Management. Patient adherence with recommended pre-surgery diet and lifestyle changes for a minimum of three (3) months is essential to the approval process. The Plan requires patients have scheduled consultations with a dietician, an exercise therapist, or the surgeon at least once a month for a minimum of three (3) consecutive months prior to the procedure.

You may be a candidate for weight loss surgery if you meet the following criteria:

(a) BMI of 40 or greater with or without coexisting medical problems,
(b) BMI of 35 or greater with one or more obesity-related co-morbidities, including type II diabetes, hypertension, obstructive sleep apnea (OSA), and hyperlipidemia,
(c) Inability to achieve sustainable weight loss with prior weight loss efforts.

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

Benefit payment for nursing and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.
A home health care visit will be considered a periodic visit by either a nurse or a therapist, as the case may be, for four hours of services.

(7) **Home Health Aides.** Charges for Home Health Aides are covered only when aides are state-certified or licensed, if the state requires it, and provided by the home hospice agency with prior authorization by the Plan.

(8) **Hospice Care Services.** Charges for Hospice Care Services are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal with a projected life expectancy of six (6) months or less and placed the person under a Hospice Care Plan.

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

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

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

(b) Emergency repair due to Injury to sound natural teeth.

(c) Excision of benign bony growths of the jaw and hard palate.

(d) External incision and drainage of cellulitis.

(e) Incision of sensory sinuses, salivary glands or ducts.

(10) **Panniculectomy** is a surgical procedure used to remove a panniculus, which is an apron of fat and skin that hangs from the front of the abdomen. In certain circumstances, the panniculus can be associated with skin irritation and infection due to interference with proper hygiene and constant skin-on-skin contact in the folds underneath the panniculus. The presence of a panniculus may also interfere with daily activities. The Plan will provide coverage for Panniculectomy when it is determined to be medically necessary.

A panniculectomy may be considered medically necessary when all of the following criteria are met:

(a) The pannus hangs at or below the level of the pubic symphysis; AND
(b) The pannus causes cellulitis, skin ulcerations or persistent dermatitis that has failed to respond to at least 3 months of non-surgical treatment (such as antibiotics, antifungals, good hygiene or dressing changes); OR
(c) There is a documented functional impairment and the panniculectomy is expected to improve the impairment. Functional impairment is defined as complete or partial loss of function of a body part.

In addition to the criteria listed above, a panniculectomy may be considered medically necessary after weight loss under the following circumstances:

(a) If individual has not had bariatric surgery, the member must have maintained a stable weight for a minimum of 6 months; OR
(b) If individual has had bariatric surgery and experienced significant weight loss, a panniculectomy should not be performed until at least 18 months after surgery and only after weight has been stable for the most recent 6 months.

(11) **Treatment of Mental Disorders.** Covered charges for care, supplies and treatment of Mental Disorders will be limited as follows:

(a) All treatment is subject to the maximum benefits shown in the Schedule of Benefits.

(b) Psychiatrists (M.D.), psychologists (Ph.D.), licensed clinical social workers (LCSW), licensed professional counselor (LPC) and licensed marriage and family therapists (LMFT) (with the exception of counseling for marriage and family therapy) may bill the Plan directly. Advanced Practice Registered Nurse (APRN) and Clinical Nurse Specialist (CNS) may bill if supervised by a physician who approves the treatment plan and therapy.

(c) Partial Hospitalizations (also known as day treatment programs) are defined as a program consisting of at least 6 hours of treatment programming or therapy per day in an approved facility. Benefits will be processed according to the Hospital Inpatient Benefits as stated in the Schedule of Benefits.

(12) **Treatment of Substance Abuse.** Benefits under this provision concerning Substance Abuse will be payable only upon the diagnosis or recommendation of a Physician and only for expenses for treatment recognized by the medical profession as appropriate methods of Effective Treatment of Substance Abuse. Benefits will cease for treatment of Substance Abuse if the program is terminated by the Covered Person receiving treatment before the program is complete.
Effective treatment of Substance Abuse means a program of Substance Abuse therapy that meets all of the following:

(a) It is prescribed and supervised by a Physician; and

(b) The Physician certifies that a follow-up program has been established which includes therapy by a Physician, or group therapy under a Physician's direction, at least once per month.

Treatment solely for detoxification when not medically warranted or primarily for maintenance care or residential treatment will not be covered under the Plan. Detoxification is care aimed primarily at overcoming the aftereffects of a specific drinking or drug episode. Maintenance care consists of providing an alcohol-free or drug-free environment. Detoxification may be allowed if a person's life is at risk without medically supervised detoxification. Precertification will be required.

Covered charges for care, supplies and treatment of Substance Abuse will be limited as follows:

(c) All treatment is subject to the maximum benefits shown in the Schedule of Benefits.

(d) If the conditions for Effective Treatment are met, benefits are payable for Substance Abuse as follows:

(i) If a Covered Person is confined as an inpatient in a Hospital solely for treatment of complications of Substance Abuse (cirrhosis of the liver or delirium tremens) or if such Covered Person is confined, for the Effective Treatment of Substance Abuse, as an inpatient in a Hospital that does not have a section which is a Substance Abuse treatment facility, Hospital expenses incurred during any such confinement will be considered covered charges as if for any other Sickness.

(ii) If a Covered Person is confined as a full-time inpatient in a Substance Abuse treatment facility for the Effective Treatment of Substance Abuse, room and board charges and charges for miscellaneous services will be considered covered charges as if incurred in a Hospital, up to the maximums shown in the Schedule of Benefits.

(iii) If a Covered Person is not confined in a Hospital or treatment facility, charges for the outpatient treatment of Substance Abuse are covered under Medical Benefits for Substance Abuse treatments as shown in the Schedule of Benefits.

(e) Psychiatrists (M.D.), psychologists (Ph.D.) or counselors (Ph.D.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(f) Inpatient and Partial Hospitalization treatment must be provided in an accredited Substance Abuse treatment facility/hospital.

(13) **Human Organ and Tissue Transplant Coverage Limits.** The Langdale Company Employee Benefit Plan (the "Plan") includes a special carve-out program for human organ and tissue transplant benefits, which are fully insured by HCC Life Insurance Company (the "Transplant Policy"). Please refer to *Section 7: Transplant Program* for additional details and applicable coverage limits.

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

(a) Charges for Routine Nursery Care. Routine well newborn nursery care is room, board and other normal care for which a Hospital makes a charge. The benefit is limited to Allowable Amount for Procedures for nursery care for the first 4 days after birth while the newborn Child is Hospital confined as a result of the Child's birth and charges related to circumcision. Charges for covered routine nursery care will be applied toward the Plan of the covered newborn child. (See *Section 2: Eligibility, Enrollment Effective Date, and Termination Provisions*).

(b) Charges for Routine Physician Care. The benefit is limited to the Allowable Amount for Procedures made by a Physician for routine pediatric care for the first 4 days after birth while the newborn Child is Hospital confined. Charges for covered routine Physician care will be applied toward the Plan of the covered newborn Child.

(15) **Coverage of Pregnancy.** The Allowable Amount for Procedures for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse. There is no coverage of Pregnancy for a dependent Child, unless the services are pregnancy-related wellness and/or are covered under the "Routine Preventive Care" benefit.

(16) **Routine Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Routine Preventive Care includes care by a Primary Care Physician or Gynecologist that is not for an Injury or Sickness for Covered Persons. Preventive Care includes one pap smear, mammogram (as detailed in *Section 5: Schedule of Benefits*), one prostrate screening, one gynecological exam, and one physical examination per Calendar Year. Eligible charges also include immunizations, x-rays and laboratory tests.

"Preventive Care" shall mean certain Preventive Care services.

To comply with the Affordable Care Act (ACA), and in accordance with the recommendations and guidelines, plans shall provide Network coverage for all of the following:

a. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
b. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
c. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
d. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
https://www.hrsa.gov/womensguidelines/.

For more information, Covered Persons may contact the Plan Administrator / Employer.

(17) **Pediatric Care.** Pediatric Care includes routine pediatric care and immunizations by a Physician that is not for an Injury or Sickness for Covered Persons until the end of the month in which they turn 19.

Pediatric Care includes a history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with recommendations for preventative pediatric health care of the American Academy of Pediatrics.

(18) **Routine Patient Care Costs in Approved Clinical Trials.** An approved clinical trial includes 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 is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

Routine patient care costs of a clinical trial include all items and services that are otherwise generally available to Covered Persons who are not enrolled in a clinical trial.

Routine patient care costs exclude:

- The actual clinical trial or the investigational item, service or device itself;
- Items and services that are provided solely for data collection and analysis and that are not used in the direct clinical management of the patient; and
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Utilization Management and other Plan limitations apply.

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

(a) **Ambulance Service**, Medically Necessary – professional land or air. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing/Extended Care Facility where necessary treatment can be provided, but in any event, no more than 50 miles from the place of pick-up, unless the Plan Administrator finds a longer trip was Medically Necessary.

(b) **Anesthetic, oxygen, blood and blood derivatives** that are not donated or replaced, **intravenous injections** and **solutions**. Administration of these items is inclusive to the service and supply.

(c) **B-12 Therapy**, intramuscular or subcutaneous vitamin B-12 injections are considered medically necessary only for current or previously documented B-12 deficiency and any of the following diagnoses and conditions: Anemia; Gastrointestinal disorders; Neuropathy; Dementia secondary to vitamin B-12 deficiency; Homocystinuria; Patients receiving methotrexate or pralatrexate (Folotyn); Patients receiving pemetrexed (Alimta); Patients with vitamin B-12 deficiency due to use of metformin that is not corrected by oral vitamin B-12; Methylmalonic aciduria, and; Retrobulbar neuritis associated with heavy smoking, also known as tobacco amblyopia.

B-12 Therapy is considered experimental and investigational, and therefore non-covered service under this Plan for all other indications, including use for treatment of autism, chronic fatigue syndrome (myalgic encephalomyelitis), delayed sleep-wake phase disorder, non-24-hour sleep-wake rhythm disorder, depression, elevated homocysteine in persons not diagnosed with homocysteinuria, fibromyalgia, impaired cognitive function (except for dementia secondary to vitamin B-12 deficiency), for the prevention of osteoporotic fracture, for the reduction of cardiovascular risks, for the prevention of stroke, and as adjunctive therapy for weight loss because there is insufficient evidence in the peer-reviewed literature to support the use of B-12 injections for these indications.

(d) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered

(i) Under the supervision of a Physician;

(ii) In connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery;

(iii) Initiated within 12 weeks after other treatment for the medical condition ends; and

(iv) In a Medical Care Facility as defined by this Plan.

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

(f) **Cataract surgery** with initial contact lenses or initial glasses. Special implant lenses are not covered.

(g) **Contraceptive management** services or supplies including but not limited to the insertion or removal of devices.

(h) **Diabetes Self-Management Training** is allowed for patients that have an eligible diabetes diagnosis, is ordered by the physician treating the patient's diabetes and is furnished by a qualified practitioner, as defined in the Plan. One hour of individual training is allowed and up to nine hours in a group setting. The initial training should not exceed 10 hours.

(i) **Durable Medical or Surgical Equipment Rental** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Sponsor.

(j) **Injectables** not otherwise included under Prescription Drug Benefits, if deemed medically necessary by the Plan.

(k) **Laboratory studies**.

(l) **Mastectomy supplies** including and limited to 4 bras per year, 1 silicone form every 2 years, a foam form every 6 months and 1 camisole post surgery.

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

(n) **Orthotic appliances** – initial purchase, fitting, repair and replacement of such as braces, splints or other appliances that are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(o) **Ostomy supplies** include the wafer, pouch, stoma paste, powders, skin preps, adhesive removers and one irrigation sleeve per year.

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

(q) **Prescription Drugs** as defined. See *Section 10: Defined Terms* and *Section 12: Prescription Drug Benefits* for more information.

(r) **Prosthetic devices** – the initial purchase, fitting, repair and replacement of prosthetic device that replace body parts.

(s) **Speech therapy** by a licensed speech therapist. Therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve speech function.

(t) **Spinal Manipulation/Chiropractic Services** by a licensed M.D., D.O. or D.C. When treatment becomes maintenance care, benefits shall cease. Maintenance care consists of expenses incurred for other than analysis and adjustment of spinal subluxations by manipulation, and electrical stimulation.

(u) **Sterilization** procedures as defined. See *Section 10: Defined Terms*.

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

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

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

(y) **COVID-19 (2019 Novel Coronavirus).** Covered Expenses associated with testing for COVID-19 include the following:

- *Diagnostic Tests.* The following items are covered at 100%, deductible waived, as provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise-applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require Pre-Authorization. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the provider's website, or such other amount as may be negotiated by the provider and Plan. If the cash price is not posted, reimbursement will be made in accordance with the current Plan terms.
    - In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy **one** of the following conditions:
        - that are approved, cleared, or authorized by the FDA;
        - for which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;

        - that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
        - that are deemed appropriate by the Secretary of Health and Human Services.
    - Items and services furnished during an office visit (including both in-person and telehealth), urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.
- *Qualifying Coronavirus Preventive Services.* The following items are covered at 100%, deductible waived, and do not require Pre-Authorization.
    - An item, service, or immunization that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and
    - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- *Telehealth and Other Communication-Based Technology Services*. Covered Persons can communicate with their doctors or certain other practitioners without going to the doctor's office in person. This is recommended if a Covered Person believes he or she has COVID-19 symptoms.
- *Requests for Prescription Refills*. When considering whether to cover a greater-than-30-day-supply of drugs, the Plan and its Prescription Drug Plan Administrator will, on a case-by-case, basis, consider each request and make decisions based on the circumstances of the patient.

The above benefits are specific to diagnosis COVID-19. Covered Persons who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

CATASTROPHIC CLAIMS

Claims for Catastrophic Diagnosis must be submitted no later than 30 days after Covered Person is diagnosed or treated for any catastrophic claims diagnosis regardless of payment status or the level of expense anticipated. For the definition of Catastrophic Diagnosis, please see Section 10: Defined Terms.

CENTERS OF EXCELLENCE

Selected Specialty Hospitals are reimbursed at a higher rate of 90% lowering Covered Person's coinsurance to 10%. Contact Plan Administrator for more information.

7. TRANSPLANT PROGRAM

The Langdale Company Employee Benefit Plan (the "Plan") includes a special carve-out program for human organ and tissue transplant benefits, which are fully-insured by HCC Life Insurance Company (the "Transplant Policy"). Contributions for the Transplant Policy are 100% paid by Participating Employers.

All eligible Employees and their dependents requiring human organ and tissue transplant services will have transplant-related charges covered under this separate Transplant Policy, subject to its terms and conditions, from the time of the Transplant Evaluation through 365 days following a Covered Transplant Procedure ("transplant benefit period").

After the transplant benefit period has elapsed, all transplant-related medical benefits will revert to the terms and conditions of health coverage under the Plan and this SPD.

Eligibility for Transplant Policy Benefits
Employees and dependents are eligible for benefits under the Transplant Policy if:

(1) The Employee and dependent(s) are eligible and enrolled for medical benefits under The Langdale Company Employee Benefit Plan;

(2) The Employee and dependent(s) meet all the terms and conditions outlined in the Transplant Policy plan documents.

(3) Pre-notification is made by the Covered Person or his/her Physician as soon as the Covered Person is identified as a potential transplant candidate. Pre-notification must be made to the Plan Administrator, TLC Benefit Solutions, 229-249-0940.

Pre-Authorization of Transplant Services
Pre-authorization of transplant services is required prior to seeing a transplant provider for a consult and/or evaluation. Failure to do so could result in reduced benefits.

Transplant Network
In order to obtain 100% in-network benefits, you must use providers in a transplant network approved by and accessed through Tokio Marine HCC's Transplant Unit. Expenses billed by the transplant network provider that are not covered by the TMHCC policy are subject to this Plan's benefits and the payment terms and conditions of the transplant network provider's contracted rates.

Claims and Appeals Under the Transplant Policy
Claims and appeals for benefits under the Transplant Policy are governed by the terms of the Transplant Policy plan documents, and administered by HCC Life Insurance Company.

For more information, please request a copy of the Transplant Policy plan documents from the Plan Administrator.

8. UTILIZATION MANAGEMENT PROGRAM

The Plan Administrator has delegated the administration of the Plan's Utilization Management ("UM") program to WiseThrive LLC.

When you choose to receive certain covered health services, you are responsible for notifying WiseThrive LLC and/or obtaining Prior Authorization before you receive those covered health services. In many cases, your benefits will be reduced or denied if WiseThrive LLC is not notified, and/or Prior Authorization is not obtained. **Please see the end of this Section 8 for a list of services requiring notification and/or Prior Authorization.**

NOTE: Notification and/or Prior Authorization is not an assurance of eligibility and/or benefits.

This UM program may include, but is not limited to the following:

(1) Hospital Admissions Authorization. A Covered Person's physician must obtain hospital admission Prior Authorization from WiseThrive LLC, as appropriate, before a scheduled hospital admission. If an Emergency results in a hospital admission, Covered Persons must notify WiseThrive LLC of continued treatment for services to be covered after the Emergency Medical Condition is Stabilized. If the Covered Person's Medical Condition is determined not to be an Emergency, Covered Persons must notify WiseThrive LLC of the post-screening services they receive for services to be covered. Notification should take place as soon as reasonably practical, given the Covered Person's Medical Condition. If notification is not received, the services may not be covered. For Emergency inpatient and outpatient admissions, notification must be received within 2 business days of admission, or claims will be denied. **PRIOR AUTHORIZATION SERVICES WILL NOT HAVE THE 2-DAY WINDOW.**

(2) **Length of Stay.** WiseThrive LLC will assign the initial covered hospital length of stay. This will be based on the diagnosis and other clinical data provided by the Physician. Facilities will receive written notice of the number of covered days that are approved.

(3) **Continuation of Hospital Stay.** WiseThrive LLC will determine whether a covered hospital length of stay can be continued. This will be after review of the Covered Person's hospital record or any other clinical data provided by the Physician.

(4) **Non-Authorization.** Non-Authorization is a determination by WiseThrive LLC that an admission, availability of care, continued stay, or other health care service has been reviewed. Based upon information provided by the Physician, the above-mentioned service(s) does not meet WiseThrive LLC requirements for medical necessity, appropriateness, health care setting, and/or level of care or effectiveness. The

requested service is therefore denied, reduced, or terminated. A Non-Authorization is not a decision rendered solely on the basis that the Plan does not provide benefits for the health care service in question if the exclusion of the specific service requested is clearly stated in the Summary Plan Description.

(5) **Prior Authorization.** The notification of and prior approval by WiseThrive LLC to the Covered Person and the provider of an admission, availability of care, continued stay or other service has been reviewed and based on the information provided, satisfies our requirements for Medically Necessary services and supplies, appropriateness, health care setting, level of care and effectiveness.

(6) **Retroactive Authorizations.** For Emergency inpatient and outpatient admissions, notification must be received within 2 business days of admission, or claims will be denied. For inpatient and outpatient services obtained without prior authorization, claims will be denied. Retroactive Authorizations may be requested within 180 days from the date services denied and will be subject to medical necessity approval and benefit reduction.

Covered Person's Rights With Respect to Utilization Management.

(1) The right to a UM decision within two business days of receipt of all necessary information.

(2) The right to have the clinical appropriateness of a Non-Authorization evaluated by a medical doctor before such Non-Authorization is issued.

(3) The right to have the Covered Person's attending physician speak with the WiseThrive LLC Medical Director before the decision to non-authorize or disapprove a request for service is made.

(4) A Covered Person or his or her representative or provider has the right to appeal any Non-Authorization. The Plan Administrator determines appeals from Covered Persons and their representatives. WiseThrive LLC determines appeals submitted by healthcare providers.

WiseThrive LLC Responsibilities with Respect to Utilization Management.

WiseThrive LLC is responsible for the following:

(1) Obtaining all information required to make the UM decision, including patient clinical information;

(2) Providing Covered Persons and providers with telephone access 1-800-485-0941 to UM staff at least 40 hours per week Monday-Friday during normal business hours;

(3) Limiting the information requested from the Covered Person to that which is necessary to authorize that service in question;

(4) Providing notification of UM decisions within two business days of receipt of all necessary information;

(5) WiseThrive LLC will notify providers of Authorizations; and

(6) WiseThrive LLC will notify Covered Persons and providers of Non-Authorizations with written or electronic confirmation.

Noncompliance

Noncompliance by a Covered Person or any provider with the above UM process, or with any other UM process, including the failure or inability of the provider or Covered Person to provide the necessary information, may result in the Covered Person becoming financially responsible for certain health care services received, regardless of medical necessity.

Covered Person Audit Bonus

A Covered Person may be paid a cash bonus of 50% of any demonstrated reduction in a Hospital bill due to the audit or checking of such bill by the Covered Person. The minimum and the maximum amounts of savings will be limited to $100 and $1,000, respectively.

Second and/or Third Surgical Opinion Program

Certain Surgical Procedures are performed either inappropriately or unnecessarily. In some cases, Surgery is only one of several treatment options. In other cases, Surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the Second and/or Third Surgical Opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for and are payable as stated on the Schedule of Benefits for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective Surgical Procedure. An elective Surgical Procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty. While any surgical treatment is allowed a second opinion, the following procedures are ones for which Surgery is often performed when other treatments are available.

Appendectomy	Hernia Surgery	Spinal Surgery
Cataract Surgery	Hysterectomy	Surgery to knee, Shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy Surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose Surgery)	Prostate Surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein litigation

Case Management

When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting-even to his or her home.

Case Management is a program whereby a case manager monitors these patients and other patients who may not have catastrophic conditions, but may require alternate services than those covered under the Plan, explores, discusses and recommends coordinated and/or alternate types of appropriate medical care. Case Management services are administered by WiseThrive LLC.

The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care. This plan of care may include some or all of the following:

- Personal support to the patient;
- Contacting the family to offer assistance and support;
- Monitoring Hospital or Skilled Nursing/Extended Care Facility care or home health care;
- Determining alternative care options;
- Assisting in obtaining any necessary equipment and services; and
- Assisting in coordination of specialty program care, including obtaining specialty drugs and medicines, and related services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan.

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

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Alternate Course of Treatment

Certain types of conditions, such as spinal cord injuries, cancer, AIDS or premature births, may require long term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable lifetime benefit set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. A more expensive course of treatment, selected by the Covered Person and/or their attending Physician may not be deemed to be Medically Necessary or within Maximum Allowable Charge limitations, as those terms are defined by the Plan. The Plan may provide coverage in such circumstances by providing benefits equivalent to those available had the Medically Necessary and otherwise covered course of treatment, subject to the Maximum Allowable Charge, been pursued.

Pre-Admission Testing

If a Covered Person is to be admitted to a Hospital for non-Emergency Surgery or treatment, one set of laboratory tests and x-ray examinations performed on an outpatient basis within seven days prior to such Hospital admission will be paid, with Deductible and coinsurance, provided that the following conditions are met:

(1) The tests are related to the performance of the scheduled Surgery or treatment.

(2) The tests have been ordered by a Physician after a condition requiring Surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital.

(3) The Covered Person is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary.

(4) The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

WISETHRIVE LLC
Telephone 1-800-485-0941
Fax 1-800-783-6182

PRE-AUTHORIZATION REQUIREMENTS

BENEFITS & SERVICES UM REQUIREMENTS (When medically necessary)	Plan
INPATIENT ADMISSIONS (Non-emergency) ***Includes Medical, Mental Health, Chemical Dependency and Rehabilitation**	**Prior Authorization Required** (If not obtained, benefits will be denied per SPD pending medical necessity approval.)
INPATIENT ADMISSIONS (Emergency) ***Includes Medical, Mental Health and Chemical Dependency**	**Notification Required within 2 business days of admission.** (If not notified, benefits will be denied per SPD pending medical necessity approval.)
SURGERY-OUTPATIENT **(performed outside of the provider's office – including ambulatory surgery centers)**	**Prior Authorization Required** (If not obtained, benefits will be denied per SPD pending medical necessity approval.)
SKILLED NURSING FACILITY CARE	**Prior Authorization Required** (If not obtained within the first 48 hours of admission, benefits will be denied per SPD pending medical necessity approval.)
PRIVATE DUTY NURSING	**Prior Authorization Required** (If not obtained within the first 48 hours, benefits will be denied per SPD pending medical necessity approval.)
TRANSPLANTS	**Prior Authorization Required**
OTHER SERVICES: **Genetic Testing** **Home Health, Hospice** **Home Infusion Therapy** **IV Chemotherapy** **Physical Therapy (after initial evaluation)** **Procedures for treatment of varicose veins in the office or surgical suite** **Occupational Therapy (after initial evaluation)** **Speech Therapy (after initial evaluation)** **Cardiac Rehab (after initial evaluation)** **Pulmonary Rehab (after initial evaluation)** **Adult MRI's (age 17 and older)** **PET Scan Sonorex/OssaTron/ESWT Therapy** **Reconstructive/Plastic Surgery** **Oral Surgery/Medical Dental** **Durable Medical Equipment (DME)*** **Orthotics & Prosthetics***	**Prior Authorization Required** (If not obtained, benefits will be denied per SPD) pending medical necessity approval.) ***DME/Medical Supplies/Orthotics & Prosthetics:** Pre-certification is required for all rentals. Purchases greater than $1,000 will also require pre-certification. **Note: During the Outbreak Period of COVID-19, this Plan waives the pre-authorization requirement for oxygen and supplies.** ****Please note – Nebulizers, Diabetic Supplies (except for Insulin Pump) and CPAP and CPAP supplies do not require pre-certification.**

Please contact WiseThrive LLC's Medical Management Office at 1-800-485-0941 for questions regarding pre-authorization requirements. Claims requiring Prior Authorization will not be paid unless and until Prior Authorization is obtained.

9. WELLNESS PROGRAM

INTRODUCTION

Establishment of Program

The Langdale Company (the Employer) hereby establishes The Langdale Company Wellness Program (the Wellness Program) effective January 1, 2016 (the Effective Date). Capitalized terms used in this Wellness Program that are not otherwise defined shall have the meanings set forth in Section: *Definitions*.

This Wellness Program is intended to provide nontaxable wellness benefits to Eligible Employees and Dependents who participate in The Langdale Company Employee Benefit Plan (the Plan). This Wellness Program is a component of, and is incorporated by reference into, the Plan. In the event that this Wellness Program conflicts with the Plan, this Wellness Program provision shall govern, as this program may provide a greater benefit to encourage participation.

Legal Status

This Wellness Program is intended to provide nontaxable employer-provided health coverage under Code §§ 105 and 106 and the regulations issued thereunder, and shall be interpreted to accomplish that objective. The Benefits provided under the Wellness Program are intended to be eligible for exclusion from Covered Persons' gross income under Code §105 (b).

DEFINITIONS

"Administrator" means The Langdale Company. The contact person is the Human Resources Manager for The Langdale Company, who has the full authority to act on behalf of the Administrator, except with respect to appeals, for which the Compliance Officer has the full authority to act on behalf of the Administrator, as described in Section: *Appeals Procedure*.

"Benefits" means the wellness benefits described under Section: *Benefits Offered and Method of Funding*.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Dependent" means (a) a dependent as defined in Code §152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof; (b) any child (as defined in Code §152(f)(1) of the Covered Person who as of the end of the taxable year has not attained age 27 and subject to limitations of the Plan; and (c) any child of the Covered Person to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of

the calendar year). Notwithstanding the foregoing, the Wellness Program will provide Benefits that are health benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent".

"Effective Date" of this Wellness Program has the meaning described in Section: *Introduction*.

"Eligible Employee" means an Employee eligible to participate in this Wellness Program, as provided in Section: *Eligibility and Participation*.

"Employee" means an individual whom the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code §414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or other to be a common-law employee of the Employer; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation, including those deemed to be more than 2% shareholders by virtue of the Code §318 ownership attribution rules. The term "Employee" does not include "former Employees" except for the limited purpose of allowing continued eligibility for benefits in accordance with Section: *General Provisions* (i.e., COBRA coverage).

"Employer" means The Langdale Company, Affiliates and any Related Employer that adopts this Wellness Program with the approval of The Langdale Company. Related Employers that have adopted this Wellness Program are listed in Appendix A to this Wellness Program. However, for purposes of Article VII and Section: *General Provisions*, "Employer" means only The Langdale Company and Affiliates.

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

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Highly Compensated Individual" means an individual defined under Code §105(h), as amended, as a "highly compensated individual".

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996 as amended.

"Plan" means the plan that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance policy or policies.

"Plan Year" means the calendar year (i.e., the 12-month period commencing January 1 and ending on December 31), except in the case of a short plan year representing the

initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

"QMCSO" means a Qualified Medical Child Support Order, as defined in ERISA §609(a).

"Related Employer" means any employer affiliated with The Langdale Company that, under Code §414(b), (c), or (m), is treated as a single employer with The Langdale Company for purposes of Code §105.

"Spouse" means an individual who is legally married to a Covered Person as determined under applicable state law (and who is treated as a spouse under the Code).

"Tobacco User" means a Covered Person who has used tobacco or tobacco products (including, but not limited to cigarettes, snuff, chewing tobacco, cigars, pipe tobacco and other similar products in any quantity) during the last twelve (12) months.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Wellness Program" means The Langdale Company Wellness Program as set forth herein and as amended from time to time.

ELIGIBILITY AND PARTICIPATION

Eligibility to Participate

An individual may participate in this Wellness Program if the individual is a Covered Person on the Plan. An individual will become eligible to be a Covered Person in this Wellness Program on the same day that he or she becomes a Covered Person in the Plan.

Termination of Participation

A Covered Person will cease to be a Covered Person in this Wellness Program upon the earliest to occur of:

- the date this Wellness Program terminates
- the date the Plan terminates;
- the date that the Covered Person ceases to be a participant under the Plan; or
- the date on which the Covered Person ceases to be an Eligible Employee (because of retirement, termination of employment, layoff, reduction in hours, or any other reason), provided that eligibility under this Wellness Program may continue beyond such date for purposes of COBRA coverage, as may be permitted by the Administrator on a uniform and consistent basis under Section: *General Provisions*.

FMLA and USERRA Leaves of Absence

Notwithstanding any provision to the contrary in this Wellness Program, if a Covered Person goes on qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the

Covered Person's Benefits on the same terms and conditions as if the Covered Person were still an active Eligible Employee.

Non-FMLA and Non-USERRA Leaves of Absence

If a Covered Person goes on a leave of absence that is not subject to the FMLA or USERRA, the Covered Person will be treated as having terminated participation, as described above under *Termination of Participation*.

METHOD AND TIMING OF ENROLLMENT

Enrollment When First Eligible

Participation in the Program is voluntary, but if certain health factors are present the refusal to participate may result in surcharges, each of which is described in Article V. Covered Persons must elect to enroll in the various components of the wellness benefit programs as follows:

(a) *Tobacco Cessation Program.* Tobacco Users may elect to participate in the Tobacco Cessation Program by attending the tobacco cessation classes any time throughout the year. For more information about the time and location of the tobacco cessation classes, Covered Persons may contact Human Resources at (229) 219-2336.

(b) *Health Risk Assessment Program & Biometric Screening.* Covered Persons may elect to participate in the HRA program by attending the HRA event. For more information about the time and location of the HRA event, Covered Persons may contact Human Resources (229) 219-2336.

(c) *Disease Management Program.* Covered Persons who are diagnosed with a chronic condition other than diabetes are automatically enrolled in the Disease Management Program; however, Covered Persons can elect to opt-out of the Disease Management Program at any time with no applicable surcharge.

(d) *Diabetes Management Program.* Covered Persons who are diagnosed with diabetes are eligible to elect participating in the Diabetes Management Program. Upon notification of the diagnosis, TLC Benefit Solutions will mail an enrollment form to the Covered Person's home address. To elect participation in this program, the Covered Person must return the completed enrollment form within 14 days after receipt of the enrollment forms.

BENEFITS OFFERED AND METHOD OF FUNDING

Benefits Offered

When an Eligible Employee becomes a Covered Person in accordance with Articles III and IV, such Covered Person and his or her Spouse and Dependents enrolled in the Plan will be eligible to receive Benefits under any of the wellness benefit programs described below:

(a) Tobacco Cessation Program. This voluntary program is available to Tobacco Users and provides tobacco cessation aids to willing participants (and their Spouses and Dependents) for one (1) year at no cost. Those who decide to participate in the tobacco cessation program will be required to attend tobacco cessation classes. An $80 monthly surcharge will be added to Employee's medical premium if the Employee, Spouse, or Dependent who is a Covered Person and Tobacco User chooses not to participate in the tobacco cessation program. In addition to attending a tobacco cessation class, Covered Persons will need to submit a certificate of completion to the Human Resources office in order to have the surcharge removed from their health premium for a period of twelve (12) months.

(b) Health Risk Assessment Program & Biometric Screening. This voluntary program provides basic screenings to willing Employees for blood pressure, pulse, cholesterol, body mass index, blood sugar, tobacco use, weight, neck circumference and waist measurement. A $40 monthly surcharge will be added to any Employee's medical premium who chooses not to participate in the Health Risk Assessment Program & Biometric Screening.

(c) Disease Management Program. This voluntary opt-out disease management (DM) care program provides case managers to Covered Persons (and their Spouses and Dependents) who have, or who are at risk for developing the following chronic diseases: hypertension (high blood pressure), hyperlipidemia (high cholesterol), asthma, and cardiovascular disease. The case managers/health advocate will help monitor compliance with medication protocols and schedule appointments with health care providers. No premium surcharge will be added for employees who opt-out of the Disease Management Program; however, Covered Persons who opt-out of the program will not receive the reduced DM medication copay as outlined in the Plan document.

(d) Diabetes Management Program. This voluntary program is for Employees, Spouses, and Dependents who have been diagnosed with diabetes and may, in addition, have an associated chronic disease: (hypertension (high blood pressure), hyperlipidemia (high cholesterol), asthma, and cardiovascular disease). Covered Persons will meet with a Health Advocate and/or pharmacist to help manage their condition. All information exchanged with your Health Advocate and/or pharmacist is confidential and Covered Person privacy is a priority.

Benefits of the program include:

- Diabetic medications and testing supplies as well as medications to treat associated chronic diseases, which include: hypertension (high blood pressure), hyperlipidemia (high cholesterol), asthma, and cardiovascular diseases, at no cost to participants
- Glucose meters will be provided free of charge, one per year

- Regular A1C screenings free of charge
- A comprehensive medical review of program participant's medications will be performed
- Educational opportunities free of charge
- One-on-one meetings with the Health Advocate in a private and secure environment to assess participant's progress and opportunities for improvement

Requirements of the program are as follows:

- All participant medications must be filled through the FiveStar Telehealth Clinic
- Participate in one educational event per quarter covering nutrition, general diabetes, exercise, blood sugar readings and impaired healing. The following education events are approved for this program:
  - Chancy Drugs' educational classes
  - Training at a local hospital – Certification of Completion required
  - Education Session with the Health Advocate
  - Education courses through Health Portal – limited to one per year

  (Contact TLC Benefit Solutions for the schedule of events or how to access quizzes modules online)
- Take A1C test as required (8 or higher = update every 3 months; less than 8 = update every 6 months)

A $40 monthly premium surcharge will be added when eligible Employees and/or their Dependents who have been diagnosed with diabetes choose not to participate in the Diabetes Management Program.

Employer and Covered Person Contributions

(a) *Employer Contributions.* The Employer funds the full amount necessary to provide Benefits under this Wellness Program.
(b) *Covered Person Contributions.* There are no Covered Person contributions for Benefits under this Wellness Program.

Funding This Wellness Program

Any insured Benefits provided under this Wellness Program shall be provided through Insurance Contracts, the premiums for which are paid solely from the Employer's general assets. Any self-insured Benefits provided under this Wellness Program shall be provided solely from the Employer's general assets. Nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of any Covered Person, and no Covered Person or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any Benefit under this Wellness Program may be provided. There is no trust or other fund from which Benefits are paid.

Rewards for Participating in Wellness Program

The Employer shall have the option to provide rewards for participation in this program. A reward can relate to one or more of the Benefits. Any reward will be in the form and amount selected by the Employer. The form of reward can include, but is not limited to, gift cards, health plan premium discounts, reductions in a deductible or co-payment under the Plan, cash payments or contributions to another arrangement (such as a health reimbursement arrangement or health flexible spending account sponsored by the Employer). The form and amount of any available reward shall be as set forth from time to time in communications to Covered Persons. The Employer may take all necessary actions to address the taxation of a reward, including but not limited to treating the amounts as taxable income on reports and, to the extent consistent with other applicable laws, withholding amounts from an employee's wages to pay for taxes owed by the employee with respect to the rewards. The Employer may withhold or modify rewards, alter the requirements for obtaining a reward, and take whatever other steps it deems reasonably necessary to ensure that the rewards are provided in accordance with all applicable laws.

APPEALS PROCEDURE

Procedure If Benefits Are Denied Under This Wellness Program

If a claim for Benefits under this Wellness Program is wholly or partially denied, claims shall be administered in accordance with the claims procedure set forth in the Plan documents.

RECORDKEEPING AND ADMINISTRATION

Administrator

The administration of this Wellness Program shall be under the supervision of the Administrator. It shall be the principal duty of the Administrator to see that this Wellness Program is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Wellness Program without discrimination among them.

Powers of the Administrator

The Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Wellness Program and to decide all matters hereunder, and all determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority:

(a) to construe and interpret this Wellness Program, including all possible ambiguities, inconsistencies, and omissions in the Wellness Program and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Wellness Program (provided that, notwithstanding the

first paragraph in this Section: *Recordkeeping and Administration*, the Administrator shall exercise such exclusive power with respect to an appeal of a claim under Section: *Appeals Procedure*);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Covered Persons to enroll in and submit claims pursuant to this Wellness Program;

(c) to prepare and distribute information explaining this Wellness Program and the Benefits under this Wellness Program in such manner as the Administrator determines to be appropriate;

(d) to request and receive from all Employees and Covered Persons such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Wellness Program;

(e) to furnish each Employee and Covered Person with such reports with respect to the administration of this Wellness Program as the Administrator determines to be reasonable and appropriate;

(f) to receive, review, and keep on file such reports and information concerning the Benefits covered by this Wellness Program as the Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Wellness Program as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Wellness Program, or to designate an individual or individuals to sign documents for the purposes of administering this Wellness Program;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Wellness Program and to meet any applicable disclosure and reporting requirements.

Reliance on Covered Person, Tables, etc.

The Administrator may rely upon the information submitted by a Covered Person as being proper under the Wellness Program and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Covered Person. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

Provisions for Third-Party Plan Service Providers

The Administrator, subject to the approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Wellness Program. Unless otherwise provided in the service agreement, obligations under this Wellness Program shall remain the obligations of the Employer.

Fiduciary Liability

To the extent permitted by law, the Administrator shall not incur any liability for any acts or for failure to act except for the Administrator's own willful misconduct or willful breach of this Wellness Program.

Compensation of Administrator

Unless otherwise determined by the Employer and permitted by law, any Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of the Administrator's duties shall be paid by the Employer.

Bonding

The Administrator shall be bonded to the extent required by ERISA.

Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Wellness Program; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Wellness Program but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

Inability to Locate Payee

If the Administrator is unable to make payment to any Covered Person or other person to whom a payment is due under the Wellness Program because it cannot ascertain the identity or whereabouts of such Covered Person or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Covered Person or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee or the amount of Benefits paid or to be paid to a Covered Person or other person, the Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code §105, the regulations issued thereunder, or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Covered Person or other person the Benefits to which he or she is properly entitled under the Wellness Program. Such action by the Administrator may include the withholding of any amounts due to the Wellness Program or the Employer from compensation paid to the Covered Person by the Employer.

GENERAL PROVISIONS

Expenses

All reasonable expenses incurred in administering the Wellness Program are currently paid by the Employer.

No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

Amendment and Termination

This Wellness Program has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Wellness Program at any time for any reason by resolution of The Langdale Company, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Wellness Program.

Governing Law

This Wellness Program shall be construed, administered, and enforced according to the laws of the State of Georgia, to the extent not superseded by the Code, ERISA, or any other federal law.

Named Fiduciary; Compliance With the Code, ERISA, COBRA, HIPAA, etc.

The Langdale Company is the named fiduciary for the Wellness Program for purposes of ERISA §402(a).

It is intended that this Wellness Program meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This Wellness Program shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Wellness Program and the Code or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Wellness Program shall be deemed superseded to the extent of the conflict.
Benefits shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws.

No Guarantee of Tax Consequences

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Covered Person under this Wellness Program will be excludable from the Covered Person's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Covered Person to determine whether each payment under this Wellness Program is excludable from the Covered Person's

gross income for federal, state, and local income tax purposes and to notify the Administrator if the Covered Person has any reason to believe that such payment is not so excludable.

Indemnification of Employer

If any Covered Person receives one or more payments or reimbursements under this Wellness Program on a tax-free basis and such payments or reimbursements do not qualify for such treatment under the Code, such Covered Person shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

Non-Assignability of Rights

The right of any Covered Person to receive any payment or reimbursement under this Wellness Program shall not be alienable by the Covered Person by assignment or any other method and shall not be subject to claims by the Covered Person's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

Headings

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Wellness Program or as indicating or controlling the meaning or construction of any provisions.

Program Provisions Controlling

In the event that the terms or provisions of any summary or descriptions of this Wellness Program are in any construction interpreted as being in conflict with the provisions of this Wellness Program as set forth in this document, the provisions of this Wellness Program shall be controlling.

Severability

Should any part of this Wellness Program subsequently be invalidated by a court of competent jurisdiction, the remainder of this Wellness Program shall be given effect to the maximum extent possible.

10. DEFINED TERMS

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

Acute shall mean the sudden onset of symptoms that are short duration.

Adjudication shall mean defined as processing claims according to the Plan.

AHA shall mean the American Hospital Association.

Allowable Claim Limits shall mean 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 permitted by the Plan. See *Section 13: Claim Review and Audit* for a more thorough definition of Allowable Claim Limits.

Allowable Expense(s) shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some "Other Plan" pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

AMA shall mean the American Medical Association.

Ambulance Service shall mean defined as a professional Ambulance Service.

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

Ancillary Services shall mean defined as supplemental services including lab, x-ray, physical therapy and inhalation therapy that are provided in conjunction to medical or hospital care.

Appeal shall mean a formal review process requested after a claim for benefits is partially or completely denied.

Approved Clinical Trial shall mean a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services ("CMS"), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

The Affordable Care Act requires that if a "qualified individual: is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Covered Person provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out of network benefits are otherwise provided under the Plan.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Biosimilar Drug shall mean a biological medical product that is similar but not identical to the original product manufactured by another company. Biosimilars are approved versions of original innovator products that can be produced when the original patent expires.

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

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

Brand Name Drugs shall mean a drug that is manufactured and marketed under a trademark or name by a specific drug manufacturer.

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

Catastrophic Diagnosis shall mean a diagnosis for any of the medical conditions including, but not limited to:

- Bone Marrow/Stem Cell Transplants
- Cancers/Neoplasm
- Cardiac Disease, Congestive Heart Failure, Cardiomyopathy
- Cerebral Vascular Accident/Stroke
- Chronic Lung Disease/Respiratory Failure/COPD
- Cryptococcal Meningitis
- Head or Spinal Injury
- Hepatitis, Cirrhosis, Liver Disease
- HIV/AIDS
- High Risk Pregnancy
- Multiple Trauma due to Accident
- Premature Infant with or without Congenital Anomalies
- Renal Failure
- Solid Organ Transplants

Claims for Catastrophic Diagnosis must be submitted no later than 30 days after Covered Person is diagnosed or treated for any catastrophic claims diagnosis regardless of payment status or the level of expense anticipated.

Certified IDR Entity shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Child(ren) shall mean a covered Employee's or covered Spouse's natural child, stepchild, a legally adopted child, a child placed for adoption, a foster child, a child for whom the covered Employee or covered Spouse is the legal guardian, or a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order.

Adult Children shall mean Children 19 years old through the limiting age of 26. The children and spouses of covered Adult Children are not eligible for coverage with the Plan.

Clean Claim shall mean a claim that can be processed in accordance with the terms of this document without obtaining additional information from the service provider or third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document,

from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

Complications of Pregnancy shall mean a condition or conditions with a diagnosis distinct from Pregnancy, but which may be caused by or adversely affected by Pregnancy. Complications include but are not limited to:

(1) Nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; and
(2) Cesarean section, termination of ectopic Pregnancy and spontaneous termination of Pregnancy occurring during a period of gestation in which a viable birth is not possible.

Co-Payment shall mean a cost-sharing arrangement in which the Covered Person pays a specified flat amount for a specific service. It does not vary with the cost of the service.

Cosmetic Dentistry shall mean dentally unnecessary Surgical Procedures, usually but not limited to, plastic Surgery directed toward enhancing dental attractiveness.

Cosmetic or **Cosmetic Surgery** shall mean any Surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

Covered Expense(s) shall mean a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective, than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Schedule of Benefits and as set forth elsewhere in this document.

Covered Person shall mean an Employee or dependent who is covered by this Plan. A Covered Employee may also be referred to as a participant. A covered dependent may also be referred to as a beneficiary.

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

Deductible shall mean the amount a Covered Person must pay each calendar year under the Plan, before benefits become payable. 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.

Dentist shall mean a person who is properly trained and licensed to practice Dentistry and who is practicing within the scope of such license.

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

Emergency shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

Emergency Medical Condition shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman

or her unborn child), in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

Emergency Services shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Covered Person is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the provider determines that the Covered Person is able to travel using non-medical transportation or non-emergency medical transportation, and the Covered Person is in a condition to, and in fact does, give informed consent to the provider to be treated as a Non-Network provider.

Employee shall mean a person who the Participating Employer considers to be a common-law Employee and who is on the regular payroll of the Participating Employer for work performed, receiving W-2 wages. The term does not include individuals who perform services for the Employer through a leasing organization or entity/person who provides workers to others, leased Employees within the meaning of Section 414(n) of the Internal Revenue Code, individuals considered to be contract Employees, independent contractors or any other individual not receiving such W-2 wages and not considered to be a common-law Employee of a Participating Employer.

Employee Director shall mean 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.

End Stage Renal Disease shall mean permanent kidney failure, requiring dialysis and/or an anticipated kidney transplant, entitling the Covered Person to Medicare coverage.

Enrollment Date shall mean the first day coverage is effective under the Plan. If coverage ends and later resumes, a new Enrollment Date begins. If the individual is eligible to enroll and timely enrolls for coverage when eligible after initially satisfying the Employer's Waiting Period, the Enrollment Date is the first day of the Waiting Period.

Erectile Dysfunction (Impotence or ED) shall mean the inability to achieve or sustain an erection suitable for sexual intercourse. Causes include medications, chronic illnesses, poor blood flow to the penis, drinking too much alcohol, or being too tired. The diagnosis and treatment of erectile dysfunction must be medically necessary.

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

Essential Health Benefits shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization: maternity and newborn care; mental health and substance abuse 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.

Experimental and/or **Investigational ("Experimental")** shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an approved clinical trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the care and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental:

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

2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
    a) maximum tolerated dose;
    b) toxicity;
    c) safety;
    d) efficacy; and
    e) efficacy as compared with the standard means of treatment or diagnosis; or

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    a) maximum tolerated dose;
    b) toxicity;
    c) safety;
    d) efficacy; and
    e) efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;

2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or

3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Subject to a medical opinion, if no other FDA approved treatment is feasible and as a result the Covered Person faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

Experimental Drugs shall mean drugs that are not commercially available for purchase and/or they are not approved by the U.S. Food and Drug Administration for general use.

Family Unit shall mean the covered Employee and his/her family members who are covered as dependents under the Plan.

Final Post-Service Appeal shall mean a post-service appeal, which constitutes the last internal appeal available to the claimant, to be filed with the Plan Administrator, Plan

Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals. The term "Final Post-Service Appeal" shall only refer to such appeals if medical services and/or supplies have already been provided. Upon filing, adjudication and conclusion of this appeal, external review becomes available to the claimant; otherwise in accordance with applicable terms found within the Plan Document and applicable law. The Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, reserves the right to allocate certain discretionary authority as it applies to adjudication of Final Post-Service Appeals to the Plan Appointed Claim Evaluator (PACE).

Foster Child(ren) shall mean a Child for whom an Employee has assumed a legal obligation to support and care, provided:

1. Such Child normally lives with the Employee in a parent-child relationship; and

2. The Employee has a legal right to claim such Child as a dependent on his Federal income tax return if the Child resides with the Employee for a period of six (6) months or longer.

Full-Time Active Permanent refers to an Employee who is regularly scheduled to work at least 30 hours per week. Such term does not include seasonal, part-time Employees, volunteers, or independent contractors.

Generic Drug shall mean a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacists as being generic.

Genetic Information shall mean information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory test that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Habilitative Services shall mean Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

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

Home Health Care Services and Supplies include part-time or intermittent nursing care by or under the supervision of the registered nurse (R.N.); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

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

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

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

Hospice Unit shall mean a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated people who are expected to die within six (6) months.

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

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.);

has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Incurred shall mean the date the service is rendered, or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered More specifically, covered expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Freestanding Emergency Department means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

Independent Review Organization (or IRO) shall mean an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations pursuant to Federal External review process as defined by the Affordable Care Act.

Injury shall mean an accidental physical Injury to the body caused by unexpected external means.

Inpatient Respite Care shall mean short-term care (i.e., five days or less per benefit period) that is provided to relieve family members and other unpaid caregivers who care for the patient in their private residence Respite care must be provided in a hospice facility.

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

Leave of Absence shall mean a period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer’s rules, policies, procedures and practices where applicable.

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

Legal Separation and/or Legally Separated shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

Marriage and/or Family Counseling shall mean 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.

Maximum Allowable Charge shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate/PPO Allowance, if one exists.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprise Bills" within the section "Additional Coverage Details,") if no negotiated rate/PPO Allowance exists, the Maximum Allowable Charge will be the Qualifying Payment Amount, or an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

For claims under the Claim Review and Audit Program, the Maximum Allowable Charge is the Allowable Claim Limit.

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

Medical Record Review shall mean the process by which the Plan, based upon a Medical Record Review and audit determines that a different treatment or different quantity of a Prescription Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

Medical Care Necessity, Medically Necessary, Medical Necessity and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Covered Person for the purposes of evaluation, diagnosis or treatment of that Covered Person's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Covered Person's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Covered Person's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Person's Sickness or Injury without adversely affecting the Covered Person's medical condition. The service must meet all of the following requirements:

1. Its purpose must be to restore health;

2. It must not be primarily custodial in nature;

3. It is ordered by a Physician for the diagnosis or treatment of a Sickness or Injury; and

4. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not necessarily mean that it is "Medically Necessary". In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that all other services are "Medically Necessary".

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

Medicare shall mean the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by the Centers for Medicare and Medicaid Services (CMS) and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

Mental Disorder, Behavioral Disorder, or Neurodevelopmental Disorder shall mean any disease or condition regardless of whether the cause is organic, that is classified as a Mental Disorder, Behavioral Disorder, or Neurodevelopmental Disorder in the current edition of **International Classification of Diseases**, published by the U.S. Department of Health and Human Services or is listed in the current edition of **Diagnostic and Statistical Manual of Mental Disorders**, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA The Mental Health Parity Provisions shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).

2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).

4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

Morbid Obesity is diagnosed by determining Body Mass Index (BMI). BMI is defined by the ratio of an individual's height to his or her weight. Normal BMI ranges from 20-25. An individual is considered morbidly obese if he or she is 100 pounds over his/her ideal body weight, has a BMI of 40 or more, or 35 or more and experiencing obesity-related health conditions, such as high blood pressure or diabetes.

No-Fault Auto Insurance shall mean the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Orthospinology shall mean 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.

Out-of-Pocket shall mean the cost borne directly by Covered Person without the benefit of insurance or additional Out-of-Pocket expenses, Deductibles, Co-payments and Co-Insurance.

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

Participating Employer shall mean The Langdale Company or one of its affiliates, whose Employees are eligible to be covered under the Plan.

Participating Health Care Facility shall mean a Hospital or Hospital outpatient department, critical access Hospital, Ambulatory Surgical Center, or other provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The later, amended version of the law is commonly referred to as "the Affordable Care Act". For more information, go to http://www.healthcare.gov.

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

Physician shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Surgery, Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other

practitioner of the healing arts who is licensed and regulated by a state or Federal agency and is acting within the scope of his or her license.

Plan shall mean The Langdale Company Employee Benefit Plan, which is a welfare benefits Plan under ERISA for certain Employees of The Langdale Company and affiliated Participating Employers. The Plan is described in this document.

Plan Appointed Claim Evaluator (PACE) shall mean an entity appointed by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, with authority to make final, binding (insofar and to the same extent as a decision by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, would be deemed to be binding), claims processing decisions in response to Final Post-Service Appeals. In instances where the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, delegates fiduciary authority to the PACE, the PACE may exercise the same level of discretionary authority as that which the Plan Administrator Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, may otherwise exercise. The PACE's fiduciary duties extend only to those determinations actually made by the PACE. The PACE may perform other tasks on behalf of and in consultation with the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, but the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. The PACE shall at all times strictly abide by and make determination in accordance with the terms of the Plan and applicable law in light of the facts, law, medical records, and all other information submitted to the PACE.

Plan Year shall mean the 12-month period on which the Plan's records are kept – i.e. January 1 through December 31.

Pregnancy shall mean childbirth and conditions associated therewith.

Preferred Provider Organization (PPO) shall mean a health care provider who agrees by contract to charge reduced fees to persons covered under this Plan.

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

PPO Charge/Allowance shall mean the discounted amount a participating provider will charge for a medical expense per agreement with the PPO Network.

Prior to Effective Date or After Termination Date shall mean dates occurring before a Covered Person gains eligibility from the Plan, or dates occurring after a Covered Person loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

Qualifying Payment Amount means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Plan Administrator (if calculated by the Plan Administrator), for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning fewer than three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

Recognized Amount shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a provider's billed charge or the Qualifying Payment Amount.

Safety Helmet. An additional Deductible as shown in the Schedule of Benefits will apply before any benefits are paid if you are injured while operating a motorcycle or a two-wheeled vehicle, three-wheeled, or four-wheeled all terrain motor vehicle without a safety helmet.

Seasonal Employee shall mean an employee who is hired into a position for which the customary annual employment is six months or less.

Seasonal Worker shall mean a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including (but not limited to) workers covered by 29 CFR 500.20(s)(1), and retail workers employed exclusively during holiday seasons. Employers may apply a reasonable, good faith interpretation of the term seasonal worker and a reasonable good faith interpretation of 29 CFR 500.20(s)(1) (including as applied by analogy to workers and employment positions not otherwise covered under 29 CFR 500.20(s)(1)).

Seatbelt. An additional Deductible as stated in the Schedule of Benefits will apply before any benefits are paid if the Covered Person is injured in an automobile accident while not wearing a seatbelt according to State law.

Sickness shall mean illness, disease or Pregnancy. There are no benefits for Pregnancy of covered dependent Children.

Skilled Nursing/Extended Care Facility shall mean a facility that fully meets all of these tests:

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

(2) Its services are provided for compensation under the fulltime supervision of a Physician.

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

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

(5) It has an effective utilization review Plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial Care, educational care or care of Mental Disorders, Behavioral Disorders, or Neurodevelopmental Disorders.

(7) It is approved and licensed by Medicare.

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

Special Enrollee shall mean a Covered Person who timely enrolls under the Plan during a HIPAA Special Enrollment or Change in Status Event as discussed under the Enrollment provisions of the Plan.

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

Spouse shall mean a person to whom the Employee is married, and whose marriage has been licensed in accordance with the law of the jurisdiction in which the marriage occurred. The term “Spouse” will not include a person who asserts a spousal relationship pursuant to a common-law marriage. The Plan Administrator may require documentation providing such licensed relationship.

Sterilization shall mean voluntary sterilization for women (tubal ligation or tubal occlusion/tubal blocking procedures, partial or total salpingectomy only) and voluntary sterilization for men (vasectomy only).

Subrogation shall mean the assumption by a third party (as a second creditor or an insurance company) of another's legal right to collect a debt or damages.

Substance Abuse and/or Substance Use Disorder shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.
The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

Surgical Procedures (or Surgery) shall mean any of the following:

- The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
- The manipulative reduction of a fracture or dislocation or the manipulation of a joint, including application of cast or traction;
- The removal by endoscopic means of a stone or other foreign object from any part of the body, or the diagnostic examination by endoscopic means of any part of the body;
- Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
- Obstetrical delivery and dilation and curettage;
- Biopsy.

Telemedicine shall mean the use of electronic information and telecommunications technology to provide medical diagnosis and treatment to Covered Persons in remote areas. Telecommunications technologies may include videoconferencing, the internet, store-and-forwarding imaging, streaming media, and terrestrial and wireless communications.

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

Total Disability (Totally Disabled) means: In the case of a dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Waiting Period shall mean that period of time that an Employee must be employed in an Eligible Class of Employees prior to initial eligibility for coverage under the Plan. The employment Waiting Period is 60 days as a member of an Eligible Class of Employees. Langboard, Inc. hourly Employees must complete a Waiting Period of 90 days.

11. PLAN EXCLUSIONS

NOTE: All exclusions related to Prescription Drugs are shown in *Section 12: Prescription Drug Benefits*.

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

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

(2) **Administrative Costs.** Charges that are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

(3) **After Hours Charges and Weekend Charges.**

(4) **After the Termination Date.** Charges that are Incurred by the Covered Person on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

(5) **Alcohol.** Involving a Covered Person who has taken part in any activity made illegal either due to the use of alcohol or a state of intoxication, even if the cause of the Sickness or Injury is not related to the use of alcohol. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions).

(6) **Breast Pump Kits,** except as stated in *Section 5: Schedule of Benefits*.

(7) **Breastfeeding Supplies** other than those contained in the breast pump kit described in Section 5: Schedule of Benefits including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or convenience (e.g., nursing pads).

(8) **Circumcision** without medical necessity except for circumcision of newborn males.

(9) **Complications of Non-Covered Treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

(10) **Confined Persons.** That are for services, supplies, and/or treatment of any Covered Person that were Incurred while confined and/or arising from confinement in a prison, jail or other penal institution.

(11) **Cosmetic Services.** That are Incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an accident; (b) because of infection or Sickness; (c) because of congenital Disease, developmental condition or anomaly of a covered dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Sickness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

(12) **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care. Charges incurred for Hospitalization primarily for x-ray, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test not connected with an actual Sickness or Injury.

(13) **Deductible.** Charges arising from care, supplies, treatment, and/or services that are amounts applied toward satisfaction of Deductibles and expenses that are defined as the Covered Person's responsibility in accordance with the terms of the Plan.

(14) **Dental.** Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes; however, benefits will be paid for charges incurred for dental treatment required because of Injury to natural teeth due to an accident when said accident occurred within one year prior to said

treatment or dental treatment required because of medical care (such as x-ray treatment for oral cancer or chemotherapy).

(15) **Detoxification.** Treatment for detoxification is strictly limited to medical necessity.

(16) **Educational or Vocational Testing.** Services for educational or vocational testing or training.

(17) **Excess Charges.** Charge(s) or portion of a charge or charges that exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

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

(19) **Expenses Paid or Payable by a Third Party.** Where a third party caused or contributed to an illness or Injury or disease of a Covered Person, the third party retains the obligation for payment of medical expenses incurred due to such Injury or illness or disease, even though such expenses may be advanced by the Plan for the Covered Person's convenience. Any advance made is subject to the Plan's subrogation and reimbursement rights as described elsewhere in this document.

(20) **Experimental or Investigational.** This Plan does not cover any charge for care, supplies, treatment, and/or services that are Experimental or Investigational, expect for Routine Patient Care Costs in Approved Clinical Trials.

(21) **Eye Care.** Radial keratotomy or other eye Surgery to correct near-sightedness. Also, routine eye examinations, including refractions, eyeglasses, lenses for the eyes and exams for their fitting, unless required due to intraocular Surgery or accidentally bodily Injury to the eye. This exclusion does not apply to aphakic patients and soft lenses or scleral shells intended to use as corneal bandages. Routine eye exams are allowed for glaucoma and diabetes.

(22) **Fatty Tissue Removal.** Procedure or surgery to remove fatty tissue such as abdominoplasty, thighplasty or brachioplasty. Breast reduction may be considered if criteria are met and deemed medically necessary through the precertification process but is excluded for cosmetic purposes or to make one feel better about their appearance. Panniculectomy is covered under the Plan unless it is considered not medically necessary as defined in Section 6. Additional Coverage Details.

(23) **Foot Care.** Routine foot care for treatment of weak, strained, flat, unstable or unbalanced feet, and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease) and corrective shoes.

a. The following diseases and medical conditions may be considered medically necessary and not considered routine foot care:

Bunion	Ingrown Toenail
Bursitis	Neuroma
Hammer toe	Plantar Fasciitis
Heel Spur	Sprain/Strain of the Foot
Infections	Warts, including Plantar Warts

(24) **Foreign Care.** Charges for medical or Hospital services and supplies, or Prescription Drugs for a Covered Person incurred in and/or purchased through a foreign country.

(25) **Gender-Affirming Operation.** Care and services related to a gender-affirming operation.

(26) **Government Coverage.** Care treatment or supplies furnished by a program or agency funded by any government or provided for by reason of the past or present services of any person in the armed forces of a government. This does not apply to Medicaid or when otherwise prohibited by Federal law.

(27) **Government-Operated Facilities.** That meet the following requirements:

a. That are furnished to the Covered Person in any veteran's Hospital, military Hospital, institution or facility operated by the United States government or by any State government or any agency or instrumentality of such governments.

b. That can be paid for by any government agency, even if the patient waives his rights to those services or supplies except to the extent this provision would violate state or federal law, including the Medicare Secondary Payer Act.

NOTE: This exclusion does not apply to treatment of non-service related disabilities or for inpatient care provided in a military or other Federal government Hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

(28) **Hazardous Pursuit, Hobby or Activity.** This Plan does not cover any charge for care, supplies, treatment, and/or services that of an Injury or sickness that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity

is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Covered Person's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm including but not limited to: hang gliding, skydiving, bungee jumping, parasailing, use of all terrain vehicles, rock climbing, use of explosives, automobile racing, motorcycle racing, aircraft racing, or speed boat racing, reckless operation of a vehicle or other machinery, and travel to countries with advisory warnings.

(29) **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy that are payable up to $200.

(30) **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.

(31) **Hospital Employees.** Professional services billed by a Physician or nurse who is an Employee of a Hospital or Skilled Nursing/Extended Care Facility and paid by the Hospital or facility for the service.

(32) **Hypnosis.** Treatment by hypnosis or any type of goal oriented or behavior modification therapy, such as to (but not limited to) quit smoking or weight loss, except as part of the Physician's treatment of a Mental Disorder or when hypnosis is used in lieu of an anesthetic.

(33) **Illegal Acts.** That are for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies, even if the cause of the Sickness or Injury is not related to the commission of the illegal act. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions).

(34) **Illegal Drugs or Medications.** That are services, supplies, care or treatment to a Covered Person for Injury or Sickness Incurred while the Covered Person was voluntarily taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician, even if the cause of the Sickness or Injury is not related to the use the controlled substance,

drug, hallucinogen or narcotic. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions).

(35) **Incurred by Other Persons.** That are expenses actually incurred by other persons.

(36) **Infertility.** Care and treatment for infertility, artificial insemination or in vitro fertilization, actual or attempted impregnation or fertilization which involved either a Covered Person or surrogate.

(37) **Injectable Drugs.** Except as stated in *Section 12: Prescription Drug Benefits*.

(38) **Massage Therapy.** Charges and supplies related to massage therapy.

(39) **Medically Necessary.** This Plan does not cover any charge for care, supplies, treatment, and/or services that are not Medically Necessary.

(40) **Military Service.** That are related to conditions determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

(41) **Missed Appointments.** Charges for missed appointment, completion of claim forms or providing medical information to determine coverage, and/or charges for telephone consultation are not covered under this Plan.

(42) **Negligence.** That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution, or provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

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

(44) **No Coverage.** That are Incurred at a time when no coverage is in force for the applicable Covered Person and/or dependent.

(45) **No Legal Obligation.** That are for services provided to a Covered Person for which the provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Covered Person or Plan has no

legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Covered Person or the Plan, may be liable for necessitating the fees, care, supplies, or services.

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

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

(48) **Non-Prescription Drugs.** That are for drugs for use outside of a Hospital or other inpatient facility that can be purchased over the counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Routine Preventive Care, subject to the Affordable Care Act and the Families First Coronavirus Response Act (FFCRA).

(49) **Not Acceptable.** That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

(50) **Not Covered Provider.** That are performed by providers that do not satisfy all the requirements per the provider definition as defined within this Plan.

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

(52) **Obesity.** Care and treatment of obesity, including but not limited to gastric by-pass surgery and gastric banding, weight loss or dietary control whether or not it is, in any case, a part of the treatment Plan for another Sickness. This Plan offers limited bariatric benefit, refer to Gastric Sleeve Surgery in Section 6. Additional Coverage Details. Obesity screening and counseling, when part of Preventive/Wellness exam, are covered under the Plan.

(53) **Occupational.** For any condition, Sickness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit. If you are covered as a dependent under this Plan and you are self-

employed or employed by an employer that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers compensation insurance will cover your costs, but if you do not have such coverage you may end up with no coverage at all.

(54) **Other than Attending Physician.** That are other than those certified by a Physician who is attending the Covered Person as being required for the treatment of Injury or Disease and performed by an appropriate provider.

(55) **Pain Control Devices.** Charges for implanted devices for control of pain in excess of one device, internal battery replacement and/or implantation per Calendar Year.

(56) **Penile Implant.** Charges incurred for a penile implant, unless medically necessary

(57) **Personal Comfort Items.** Personal comfort items or their equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non-Hospital adjustable beds.

(58) **Plan Design Exclusions.** Charges excluded by the Plan design as mentioned in this document.

(59) **Postage, Shipping, Handling Charges, Etc.** That are for any postage, shipping or handling charges which may occur in the transmittal of information to the Third-Party Administrator, including interest or financing charges.

(60) **Pregnancy of Child.** Care and treatment of Pregnancy and Complications of Pregnancy for a dependent Child. Prenatal care is covered to the extent required by law. NOTE: Preventive care charges for Pregnancy are covered under the Routine Preventive Care benefit in the Additional Coverage Details section.

(61) **Prior to Coverage.** This Plan does not cover any charge for care, supplies, treatment, and/or services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

(62) **Professional (and Semi-Professional) Athletics (Injury/Sickness).** That are in connection with any Injury or Sickness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

(63) **Prohibited by Law.** To the extent that payment under this Plan is prohibited by law, such services are not covered.

(64) **Provider Error.** That are required as a result of unreasonable provider error.

(65) **Provider Negligence.** No benefits are payable in connection with expenses resulting from or associated with: (a) the unintended retention of a foreign object in a patient following an invasive procedure, (b) errors involving the use/administration of medications, gases, intravenous fluids and/or biological drugs, including the use of contaminated or expired substances, (c) a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products or tissue, (d) injuries acquired following admission to a health care facility, unless resulting entirely from the patient's own negligence or while intending to do harm to himself/herself, (e) surgery performed on the wrong patient or body part, or performance of the wrong surgical procedure, (f) burns or Stage 3 or 4 pressure ulcers acquired following admission to a health care facility, (g) expenses relating to the repair or replacement of a defective implant/device, or (h) intravascular air embolism or blockage, catheter-associated urinary tract infection or vascular catheter-associated infection.

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

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

(68) **Robotic Charges.** Robotic charges are not eligible under the Plan. This Plan considers computer-aided tools and techniques charges (inclusive of HCPCS code S2900) to be integral to the primary surgical procedure and not a separately reimbursed service.

(69) **Self-inflicted.** This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions). However, if a member is participating in a high-risk activity, the Plan may exclude benefits.

(70) **Services Before or After Coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

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

(72) **Subrogation, Reimbursement, and/or Third-Party Responsibility.** This Plan does not cover any charge for care, supplies, treatment, and/or services that of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions.

(73) **Supplies.** Non-sterile or sterile supplies that can be purchased without a physician's order including, but not limited to: bandages, gauze, tape, alcohol, betadine, etc.

(74) **Surgical Sterilization Reversal.** Care and treatment for reversal of vasectomy, tubal ligation or tubal occlusion/tubal blocking procedures.

(75) **Surrogate Pregnancy.** Maternity services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with a Gestational Surrogacy Contract or Arrangement are excluded. This exclusion applies to all expenses for prenatal, intrapartal, and postpartal Maternity/OB Care, and Health Care Services rendered to the Covered Person acting as a Gestational Surrogate, unless the services are for Routine Preventive Care and/or pregnancy expenses, which will be covered in accordance with the Plan's provisions.

(76) **Travel or Accommodations.** Charges for travel or for travel outside the United States or its territories or accommodations, for services or supplies, whether or not recommended by a Physician. Travel by ambulance is covered as stated in this Plan within the United States. Accommodations in select U.S. areas are covered under the Plan with prior approval from the Plan Administrator.

(77) **Unreasonable.** Charges arising from care, supplies, treatment, and/or services that are required to treat Sickness or Injuries arising from and due to error(s) caused at the time of treatment by the treating provider, including, but not limited to, a Physician or Hospital, wherein such Sickness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense, which was caused directly or indirectly by the treating provider, and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating provider whose error caused the loss(es).

(78) **Vehicle Accident.** That are for treatment of any Injury where it is determined that a Covered Person was involved in a motorcycle accident while not wearing a

helmet or in an automobile accident while not wearing a seatbelt (or car seat), even if the cause of the Sickness or Injury is not related to the failure of the Covered Person to wear a helmet or seatbelt (or car seat). This exclusion does not apply: (a) to Covered Persons who were passengers on public transportation, ride for hire or livery services or (b) when a seatbelt or helmet is not required by law.

(79) **War/Riot.** That incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Covered Person is a member of the armed forces of any country, or during service by a Covered Person in the armed forces of any country, or voluntary participation in a riot. This exclusion does not apply to any Covered Person who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

The exclusions listed above, as well as all the terms of the Plan, shall be interpreted in accordance with the laws that govern the Plan. With respect to any Sickness or Injury which is otherwise covered by the Plan, the Plan will not deny benefits provided for treatment of the Sickness or Injury if the Sickness or Injury results from being the victim of an act of domestic violence or a documented medical condition (including both physical and mental health conditions).

12. PRESCRIPTION DRUG BENEFITS

The Langdale Company Employee Benefit Plan (the "Plan") participates in a managed care pharmacy benefit program administered by ProCare Rx. Please see *Section 5: Schedule of Benefits* for a listing of the prescription drug benefits.

NOTE: Certain drugs for the treatment of cancer ("Oncology Drugs") will be considered under Section 13: Claim Review and Audit. Eligible claims will be evaluated to determine the Allowable Claim Limits, and benefits will be paid for covered expenses based upon the Plan's provisions applicable to the provider type, place of service and type of service as described in *Section 6: Additional Coverage Details*.

USING THE MEDICAL/PRESCRIPTION DRUG CARD

With the pharmacy benefit program you will:

(1) Receive a medical/prescription drug card to be used at pharmacies; and

(2) Pay a co-payment or coinsurance for each covered prescription.

There is no paperwork with the medical/prescription drug card. When you use your card, you just pay the appropriate co-payment or coinsurance and the pharmacist files claims for you.

PHARMACY NETWORK

This Plan has a Preferred Network and Non-Preferred Network of pharmacies available to you. Your co-payment and coinsurance is higher when you use Non-Preferred Network pharmacies. Please see *Section 5: Schedule of Benefits* for details.

To verify whether the pharmacy you use is part of the Preferred Network, please call ProCare Rx at 1-800-699-3542 or contact the Plan Administrator.

In certain cases, this Plan may secure medication from special vendors.

CO-PAYMENT AND SUPPLY

The co-payment or coinsurance is applied to each covered Prescription Drug charge and is shown in the Section 5: Schedule of Benefits. The Prescription Drug co-payment and coinsurance amounts are not covered charges under the Medical Plan. Maintenance medications may be obtained through a retail pharmacy (34-day supply), or through an approved 90-day retail pharmacy (90-day supply).

COVERED PRESCRIPTION DRUGS

(1) All Prescription Drugs prescribed by a Physician that require a prescription either by federal or state law, except for the Prescription Drugs excluded in this Plan.
(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity that are filled at an approved compounding pharmacy. There is a $250 maximum allowable that includes your and the Plan's cost share. Any amount over $250 will become your responsibility.
(3) Insulin, insulin needles/syringes, glucose testing strips, ketone testing strips and ketone tablets.
(4) Prenatal Vitamins.
(5) The Patient Protection and Affordable Care Act (PPACA) approved Preventive Medicines, as described in *Section 5: Schedule of Benefits*.
(6) B-12 injections covered by the Plan.

FORMULARY – PREFERRED BRAND NAME DRUGS

Your plan has a formulary, which is a preferred listing of medications. Prescription drug coverage includes a preferred list of commonly prescribed medications selected for their medical effectiveness and savings potential. During the year, ProCare Rx reviews and updates the list regularly based on continual evaluation of available drugs. Based on this evaluation, a new drug or a generic for an existing brand name drug may be added to the list. To find out if a drug has been added to the list, please contact ProCare Rx. If you choose to use a preferred formulary medication your financial responsibility will be lower than if you choose the non-preferred medication.

GENERIC DRUG

Use of generic drugs and formularies play a critical role in the success of the pharmacy plan. Mandatory generic use applies to all prescriptions written, including prescriptions where your doctor requests a brand name drug. Keep in mind that you should ask your physician if there is an FDA-approved generic alternative whenever he or she is prescribing a brand name drug. Generic drugs are not always available because the original manufacturer's patent has not yet expired. Generics provide the same therapeutic benefits as their brand name counterparts – at a substantial savings to you or your plan.

Generic drugs are pharmaceutically equivalent drugs for brand name drugs. When a drug is first made, the manufacturer applies for a patent, so that no one else can make the drug. The manufacturer gives the drug a name, and that becomes the brand name. Until the patent expires, only the original manufacturer can produce the drug. After a patent expires, other companies can make a drug using the same ingredients. The result is a drug comparable in quality but different in appearance. A common example is aspirin. Bayer™ and Ecotrin® are brands of aspirin made by two companies. You can also buy generic aspirin made by other companies.

Generics are less expensive, too, because the brand name manufacturer pays the cost of research and development for the product. The generic manufacturer pays just for the rights to use the actual ingredients. The Food and Drug Administration (FDA), doctors and pharmacists review generic products regularly to make sure they are safe.

SPECIALTY DRUGS

Specialty Drugs are limited to drugs provided through the Specialty Concierge Services, except when billed as part of an office visit under the health plan benefit. Specialty Drugs obtained through the Specialty Concierge Services are provided at no cost to Covered Persons. Covered Persons are required to provide certain documentation to receive these services.

COVERAGE FOR VACCINES

The pharmacy benefit program covers all ACIP-recommended immunizations for routine use in children and adults, as described in *Section 5: Schedule of Benefits*, with a prescription when provided by a Network Pharmacy and administered in compliance with applicable state law and pharmacy certification requirements. Influenza vaccine does not require a prescription.

STEP THERAPY & COVERAGE LIMITATIONS FOR SOME PRESCRIPTION DRUGS

Step Therapy manages drug costs within specific therapy classes by ensuring that patients try first-step drug treatment (usually generics) before a higher cost brand-name drug is covered.

Within specific therapy classes, multiple drugs are available to treat the same condition. Step therapy points a new patient to a first-step, lower cost, clinically effective drug in each therapy group. Evidence-based clinical protocols are used to select first-step drugs. The step therapy program applies edits to drugs in specific therapeutic classes at the point of service. Coverage for second-line therapies is determined at the member level based on the presence or absence of first-line drugs in the member's claims history. Only claims for members whose histories do not show use of first-line products are rejected for payment at the point of service.

Some prescription medications will have a limited supply per calendar year. Specific criteria relating to these coverage limitations can be obtained from the Plan Administrator or ProCareRx.

EXCLUSIONS:

Drugs Or Services Not Covered Or Requiring 100 Percent Co-Payment

The pharmacy benefit program has the following exclusions:

- Cosmetic medications require 100 percent co-payment (hair growth agents, photo-aged skin products, Botox for cosmetic purposes, dermatological bleaching agents)
- Tretinoin agents used in the treatment of acne and/or for cosmetic purposes (Retin-A) except through age 17, prior authorization required
- Fertility agents oral or injectable require 100 percent co-payment
- Contraceptives that are covered under the Medical Plan (see *Section 5: Schedule of Benefits*)
- Approved Impotence & Erectile Dysfunction products – six (6) tablets per calendar month are allowed. Additional medication during that calendar month require 100 percent co-payment
- Weight management agents used to suppress appetite and control fat absorption require 100 percent co-payment
- Injectable medications, except those listed as Covered Medications.
- Serums (including allergy serums), toxoids and vaccine agents not listed as Covered
- Non-legend/Over-the-counter medications – nonprescription drugs and vitamins
- Drugs dispensed while in a hospital or similar facility – these drugs may be covered as a Hospital expense by the Medical Plan
- More refills than your doctor approves
- Refills more than one year after the original prescription date
- Experimental drugs or those limited by federal law to investigational use
- Sera, blood or blood plasma
- Drugs for an injury or illness covered under Worker's Compensation
- Any charge for the administration of a covered Prescription Drug
- Any drug or medicine that is consumed or administered at the place where it is dispensed
- Devices of any type, even though such devices may require a prescription. All Durable medical equipment including, (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, crutches, ostomy supplies, peak flow meters or any similar device
- A charge excluded under Plan Exclusions for Medical Benefits
- A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs

13. CLAIM REVIEW AND AUDIT PROGRAM

The Plan has arranged with ELAP Services, LLC ("ELAP") for a program of claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically appropriate. Benefits for claims which are selected for review and auditing may be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a usual, customary or reasonable fee determination.

Medical care providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits, and allowed the rights and privileges to file an appeal of the determination which are the same rights and privileges accorded to Covered Persons; and, in return, the provider must agree not to bill the Covered Person for charges which were not covered as a result of the claim review and audit. This will in no way affect the rights of the Covered Person to file an appeal under the Plan. Please refer to the section, "Procedures for Claims and Appeals" for additional information regarding Covered Person and provider appeals.

Any Covered Person who receives a balance-due billing from a medical care provider for these charges should contact ELAP or the Plan Administrator right away for assistance.

The Plan Administrator is identified in the General Information section of this Summary Plan Description. ELAP may be contacted at:

ELAP Services, LLC
1550 Liberty Ridge
Suite 330
Wayne, PA 19087
Phone: 610-321-1030; Fax 610-321-1031

The Covered Person must pay for any normal cost-sharing features of the Plan, such as Deductibles, coinsurance and Co-Payments, and any amounts otherwise excluded or limited according to the terms of the Plan.

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of Covered Medical Expense that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the provider of service and the Covered Person. In the event that the Plan Administrator does not receive information adequate for the claim review and audit within the time limits required under applicable regulations, it will be necessary to deny the claim. Should such a denial be necessary, the Covered Person and/or the provider of service may appeal the denial in accordance with the provisions which may be found in the section, "Procedures for Claims and Appeals" in this Summary Plan Description.

In the following provisions of the Claim Review and Audit Program, the term "Plan Administrator" shall be deemed to mean ELAP:

“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 Sickness 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. Professional Providers. The Allowable Claim Limits for professional providers shall be determined using the following:

i. For general medical and primary care claims, the Medicare allowed amount in the geographic area plus an additional 40%;
ii. For specialist medical and surgical care claims, the Medicare allowed amount in the geographic area plus an additional 55%;
iii. For anesthesiologist claims, the Medicare allowed amount in the geographic area plus an additional 100%;

iv. For ambulance and air ambulance claims, the Medicare allowed amount in the geographic area plus an additional 20%; or

v. For other non-facility claims and supplies (such as, but not limited to, Durable Medical Equipment, laboratory services and supplies, and mid-level providers, etc.), the Medicare allowed amount in the geographic area.

For purposes of determining the proper Allowable Claim Limits for professional providers in categories (i), (ii), (iii), (iv), or (v), above, the Plan Administrator shall determine the applicable category for each claim based on the taxonomy code used by the professional provider for that claim. The Plan Administrator determines in its sole discretion the type of provider for determining Allowable Claim Limits, as detailed above.

While this Plan typically pays professional providers based on the Medicare allowed amounts above, certain services may be reimbursed at 110% of the Medicare allowed amount for the service. These services may include, but are not limited to, routine diagnostic tests, evaluation services, telehealth and services for ongoing therapy. A full list of services subject to this rule can be found here: www.planlimit.com/prof1. This list will be updated at least annually to reflect the Plan's current plan design.

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, ELAP 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. **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.

iii. **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.

In the event that a determination of Allowable Claim Limit for a Claim exceeds the actual Charges billed for the services and/or supplies, the actual Charges billed for the Claim shall be the Allowable Claim Limit.

14. CLAIMS AND APPEALS

A Covered Person becomes a "claimant" when he or she makes a request for a Plan benefit(s) in accordance with these claims procedures. These procedures describe how benefit claims and appeals are made and decided under the Plan, and applicable timelines. All claims must be received by the Plan Administrator within 120 days from date of service.

CLAIMS FOR BENEFITS

Three Claim Types

As described below, there are three categories of claims that can be made under the Plan, each with somewhat different claim and appeal rules. The DOL regulations set different requirements based on the type of claim involved. The primary difference is the timeframe within which claims and appeals must be determined. It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding what type of claim and/or what claims procedure to follow, please contact the Plan Administrator.

Under the Plan, there are three types of claims:

- Pre-service
- Concurrent Care
- Post-service

Pre-service Claims

A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim".

Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the claimant, hinder the claimant's ability to regain maximum function (compared to treatment without delay), or subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim". In such circumstances, the claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the claimant must comply with the Plan's requirements with respect to notice required

after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

Concurrent Claims

A "Concurrent Claim" arises when the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claims

A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

How To File A Claim

A Pre-service Non-Urgent Care Claim (including a Concurrent Claim that also is a Pre-service Non-Urgent Care Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Plan Administrator and/or WiseThrive LLC in accordance with the Plan's procedure and the Utilization Management Program.

A Post-service Claim is considered to be filed when the information required of claims (listed below) is received in writing by the Plan Administrator.

For Plan reimbursements, submit bills for service rendered.

ALL BILLS AND CLAIMS MUST BE RECEIVED BY THE PLAN ADMINISTRATOR WITHIN 120 DAYS FROM DATE OF SERVICE.

ALL BILLS AND CLAIMS MUST SHOW:

- Name of Plan
- Group number of Plan
- Employee's name
- Name of claimant
- Name, address, telephone number and Tax ID of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedures codes
- Date of service
- Charges

Send the above via U.S. Postal Service to the Plan Administrator, within 120 days from date of service to this address:

TLC Benefits Solutions, Inc. (Plan Administrator)
P.O. Box 947
Valdosta, GA 31603-0947
229-249-0940 or 877-949-0940

Upon receipt of this information, the claim will be deemed to be filed with the Plan. All questions about how to file a claim should be directed to the Plan Administrator.

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 (a) in the case of an incorrectly filed Pre-service Non-urgent Claim, the claimant shall be notified as soon as possible but no later than 5 days following receipt by the Plan of the incorrectly filed claim. The notice will describe the proper procedures for filing a claim. This notice may be given verbally unless written notice is specifically requested by the claimant.

Appointment of Authorized Representative

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

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a claimant's treating health care practitioner to act as the claimant's authorized representative without completion of the authorized representative form.

Timing of Claim Decisions

Pre-service Urgent Care Claims

- If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
- If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
- The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
    - The Plan's receipt of the specified information.
    - The end of the period afforded the claimant to provide the information.
- If there is an adverse benefit determination, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's determination on review, may be transmitted between the Plan and claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the external review process.

Pre-service Non-urgent Care Claims

- A determination will be made in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim.

Concurrent Claims

- Plan Notice of Reduction or Termination. If the Plan has determined that an initially approved course of treatment should be reduced or terminated (other than by Plan amendment or Plan termination), this will be treated as an adverse benefit determination, and the claimant will be notified sufficiently in advance to allow the claimant to appeal the decision before the care is reduced or terminated.
- Request by Claimant Involving Non-urgent Care. If the claimant has requested that the Plan extend an initially approved course of treatment beyond the period of time or number of treatments that has been approved, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims

- A determination will be made within a reasonable period of time, but not later than 30 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 Plan is not able to decide a pre-service or post-service 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 Plan's control that justify the extension and the date by which a decision is expected.

If an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be given 45 days from receipt of the notice within which to provide the information requested. The period of time for deciding the claim will be tolled from the date on which the notification of the extension is sent to the claimant, until the date on which the claimant timely responds to the request for information. If the requested information is not provided, the claim may be decided without that information.

Calculating Time Periods

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

Adverse Benefit Determination

An "adverse benefit determination" is defined as a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial reduction, termination, or failure to provide or make a payment for a claim that is based on:

- A determination of an individual's eligibility to participate in a plan or health insurance coverage;
- A determination that a benefit is not a covered benefit;
- The imposition of a source-of-injury exclusion, PPO provider network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

Although it is not a claim for benefits, the definition of an adverse benefit determination also includes a rescission of coverage under the Plan. A "rescission of coverage" is defined as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Notice of an adverse benefit determination for a rescission will be sent 30 days in advance of the retroactive termination of coverage.

Notification of an Adverse Benefit Determination

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

1. A reference to the specific portion(s) of the Plan Document and Summary Plan Description upon which a denial is based;

2. The date of service, the health-care provider, the claim amount (if applicable), denial code and its corresponding meaning, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

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

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

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

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

7. The contact information for the Department of Labor's Employee Benefits Security Administration and any applicable state consumer assistance program.

INTERNAL APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Full and Fair Review of All Claims

Pursuant to the Department of Labor (DOL) regulations, the Plan's claims and appeals procedures provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination.

First Internal Appeal Level

Requirements for First Appeal

The claimant must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. (The 180-day period is reduced to 30 days if appealing the Plan's decision to reduce or terminate a previously approved ongoing course of treatment before the end of the approved period of time or number of treatments.) To file an appeal in writing, the claimant's appeal must be addressed to the Plan Administrator and mailed as follows:

TLC Benefits Solutions, Inc.
P. O. Box 947
Valdosta, GA 31603-0947
229-249-0940 or 877-949-0940

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

1. The name of the claimant;

2. The claimant's address and telephone number;

3. The group name or group identification number;

4. All facts, theories, and documents supporting the claim for benefits. Failure to include any facts, theories, or supporting documentation in the written appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise arguments which support his claim if he fails to include them in the written appeal;

5. A statement in clear and concise terms of why the claimant disagrees with the reason(s) given for denying the claim or with the prior handling of the claim; and

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

Review of Adverse Benefit Determination on First Appeal

The first appeal of an adverse benefit determination will be reviewed and decided by the Plan Administrator. 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 the Plan Administrator will take into account all information submitted by the claimant, whether or not presented or available at the initial benefit decision. The Plan Administrator 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, the Plan Administrator 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 and Rationale

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. If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert shall be provided on request by the claimant, regardless of whether the advice was relied on by the Plan. Before issuing a final decision on appeal that is based on a rationale that was not included in the initial determination, the Plan will provide the claimant free of charge, with the rationale as soon as possible and sufficiently in advance of the final internal adverse benefit determination to give the claimant a reasonable opportunity to respond.

Timing of Notification of Benefit Determination on First Appeal

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

Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim – Pre-service Non-urgent or Post-service.

Post-service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

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

Manner and Content of Notification of Adverse Benefit Determination on First Appeal.

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

1. The date of service, the healthcare provider, the claim amount (if applicable), denial code and its corresponding meaning, and a statement describing the

availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

2. Reference to the specific portion(s) of the Plan Document and Summary Plan Description on which the denial is based;

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

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

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

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

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

8. A description of the Plan's review procedures and the time limits applicable to the procedures;

9. A description of available internal appeals and external review processes;

10. The contact information for any applicable health insurance consumer assistance or ombudsman;

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

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

SECOND AND FINAL INTERNAL APPEAL LEVEL

Adverse Decision on First Internal Appeal; Requirements for Second and Final Internal Appeal

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

TLC Benefit Solutions, Inc.
P.O. Box 947
Valdosta, GA 31603-0947

The second appeal of an adverse benefit determination will be reviewed and decided by the Plan Administrator.

Timing of Notification of Benefit Determination on Second and Final Internal Appeal

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

Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim – Pre-service Non-urgent or Post-service.

Post-service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

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

Manner and Content of Notification of Final Internal Adverse Benefit Determination on Second Appeal

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

Benefit Determination on First Appeal". The Plan must include a discussion of the reason(s) for the final internal adverse benefit determination.

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

The Plan must provide, free of charge, any new or additional evidence considered, relied upon, or generated in connection with a claim sufficiently in advance of a final internal adverse benefit determination to give the claimant opportunity to respond prior to the deadline. In addition, before the Plan can base a final internal adverse benefit determination on new or additional rationale, it must provide the claimant with such rationale sufficiently in advance of deadline to allow the enrollee an opportunity to respond.

Decision on Second and Final Internal Appeal

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied.

Exhaustion of Internal Appeals Process

All internal claim review procedures provided for in the Plan must be exhausted before claimant can seek external review, unless the Plan fails to strictly adhere to the set forth requirements.

Final Internal Adverse Benefit Determination

Upon receipt, review, adjudication and conclusion of a Final Post-Service Appeal, if it is determined by the Plan fiduciary – either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the Plan Appointed Claim Evaluator (PACE) – that benefits and/or coverage is not available from the Plan as it relates to claims for benefits submitted to the Plan; when such a final adverse benefit determination is made, by either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the PACE, the determination will be final and binding on all interested parties.

EXTERNAL REVIEW PROCESS

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Covered Person or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Covered Person or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An adverse benefit determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the “expedited external review” paragraph in this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of a Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
    a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.
    b. The adverse benefit determination or the Final Internal Adverse Benefit Determination does not relate to the claimant’s failure to meet the

requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).

c. The claimant has exhausted the Plan's internal appeal process (unless the claimant is not required to exhaust the internal appeals process under the final regulations) and rendered the appeal available for standard external review.
d. The claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

    a. An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the final regulations would seriously jeopardize the life or health of the claimant or would jeopardize

the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal.

b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or the Plan Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, 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 for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

CONTINUED COVERAGE PENDING APPEAL

The claimant's coverage will continue pending the outcome of an appeal, except when appeal is pursuant to a rescission of coverage.

PROVIDER OF SERVICE APPEAL RIGHTS

A claimant may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a claimant to a provider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the provider in the same manner as a claimant's appeal, and will respond to the provider and the claimant with the results of the review accordingly. Any such appeal from a provider of service must be made within the time limits and under the conditions for filing an appeal specified under Section 14: Claims and Appeals, above**. Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Medical Expenses directly from the Plan, waiving any right to recover such expenses from the claimant, and comply with the conditions of the section, "Requirements for Appeal," above.**

For purposes of this section, the provider's waiver to pursue Covered Medical Expenses does not include the following amounts, which are the responsibility of the claimant:

- Deductibles;
- Co-Payments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan;
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits. **Note: This does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the section, "Claim Review and Audit Program."** The provider must agree to waive the right to balance bill for these amounts.

Also, for purposes of this section, if a provider indicates on a Form UB92 or on a CMS – 1500 Form (or similar claim form) that the provider has an assignment of benefits, then the Plan will require no further evidence that benefits are legally assigned to that provider.

Contact the Claims Administrator or the Plan Administrator for additional information regarding provider of service appeals.

LIMITATION OF ACTION

You must exhaust the appeals process before bringing a lawsuit for judicial review. Further, any legal action for judicial review must be brought 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.

ASSIGNMENTS

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Covered Person of the Plan, at the discretion of the Plan

Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Co-Payments and coinsurance amounts, to a medical provider. If a provider accepts said arrangement, the provider's rights to receive Plan benefits are equal to those of the Covered Person, and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Co-Payments, and coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Covered Person of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the Covered Person, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Covered Person shall at any time, either during the time in which he or she is a Covered Person in the Plan, or following his or her termination as a Covered Person, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document. **NON-U.S. PROVIDERS**

A provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non-U.S. Provider". Claims for medical care, supplies, or services provided by a Non-U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan exclusions, limitations, maximums and other provisions. assignment of benefits to a Non-U.S. Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If assignment of benefits is not authorized, the claimant is responsible for making all payments to Non-U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the claimant be made. If payment was made by the claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the claimant shall be that amount. If payment was made by the claimant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non U.S. Provider must satisfy all applicable credentialing and licensing requirements; and claims for benefits must be submitted to the Plan in English.

15. COORDINATION OF BENEFITS

Coordination of benefits sets out rules for the order of payment of Allowable Expenses when two or more plans – including Medicare – cover an individual. When a Covered Person is covered by this Plan and one or more other plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will coordinate coverage (i.e. may be entitled to reduce benefits payable under the secondary/subsequent plans by the amount paid by the primary plan(s)).

WHEN THIS PLAN IS SECONDARY COVERAGE

This Plan contains a non-profit provision integrating it with other similar plans under which an individual may be covered so that the total benefits available during the Calendar Year will not exceed the benefits of this Plan that would have been provided in the absence of Coordination of Benefits.

If, in the integration method of determining the benefits of this Plan with those of another plan, the rules set forth in the following Benefit Plan Payment Order paragraph would require this Plan to be the secondary payer, then the Plan shall determine its Allowable Expense without regard to the existence of other coverage; however, the Plan shall pay the lesser of (1) the Plan's Allowable Expense minus the amount paid by the primary plan and (2) the primary plan's allowable expense minus the amount paid by the primary plan.

Covered Persons for whom the Plan is secondary coverage under the rules, described in the Benefit Plan Payment Order section, not primary coverage, must file all medical and pharmacy expenses with the primary payer initially, and then provide an Explanation of Benefits (EOB) to the Plan Administrator.

BENEFIT PLAN

This provision will coordinate the medical and pharmacy benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans.

(1) Group or group-type plans, including franchise or blanket benefit plans, whether or not insured.

(2) Blue Cross and Blue Shield group plans.

(3) Group or group-type coverage through HMOs, and other prepayment, group practice and individual practice plans.

(4) Federal government plans or programs. This includes Medicare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan that, by its terms, does not allow coordination, or Marketplace plans.

(6) The medical benefits coverage in group, group-type, and individual no fault auto insurance, uninsured coverage and underinsured motorist coverage, by whatever names they are called.

EXCESS INSURANCE

If at the time of injury, sickness, disease or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

a) any primary payer besides the Plan;

b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;

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

d) worker's compensation or other liability insurance company; or

e) any other source, including, but not limited to, the following:

    a. Crime victim restitution funds
    b. Civil restitution funds
    c. No-fault restitution funds such as vaccine injury compensation funds
    d. Any medical, applicable disability or other benefit payments
    e. School insurance coverage

VEHICLE LIMITATION

When medical payments are available under any vehicle insurance (including no-fault automobile insurance, uninsured motorist coverage, or underinsured motorist coverage), the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the exclusions in this Plan up to the maximum amount available to the Covered Person under applicable state law, regardless of a Covered Person's election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classifications.

BENEFIT PLAN PAYMENT ORDER

When two or more plans provide benefits for the same Allowable Expense, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits by the following rules, up to the Allowable Expense:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member, subscriber, or retiree) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

Special Rule: If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay before Plan A.

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

(c) If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan providing non-continuation coverage is primary and the plan providing continuation coverage is secondary.

(d) When a child is covered as a dependent and the parents are not separated (whether or not they have ever been married) or divorced, these rules will apply:

(i) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced, not married, or legally separated (whether or not they were ever married), these rules will apply:

(i) The plan of the parent with custody will be considered first.

(ii) The plan of the spouse of the parent with the custody of the child will be considered second.

(iii) The plan of the parent not having custody of the child will be considered third.

(iv) The plan of the spouse of the parent without custody will be considered next.

(v) This rule will be in place of items (i) through (iv) above when it applies. A court decree may state which parent is primarily responsible for medical benefits of the child. In this case, and if the plan of that parent has knowledge of the terms of the decree, the plan of that parent will be determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period during which any benefits are actually paid or provided before the entity has that actual knowledge.

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

(f) If none of the above rules determines the order of benefits, the benefits of the plan which covered the person for the longer period of time is primary.

(3) Medicare will pay primary, secondary or last to the extent stated in Federal law. When Medicare is the primary payer, this Plan will base its payment upon benefits Medicare pays under Parts A and B. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on information available through CMS.

This Plan will be primary to Medicare as may be required, if the Medicare eligibility is based solely upon the diagnosis of End Stage Renal Disease (ESRD). The Plan will become secondary to Medicare at the earliest point permitted by law.

This Plan will pay primary to Medicare only as required by the Medicare Secondary Payer rules. Nothing herein shall be construed as providing for a longer period during which this Plan will be primary.

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

CLAIMS DETERMINATION PERIOD

Benefits will be coordinated on a Plan year basis (i.e. January 1 through December 31). This is called the claim determination period.

RIGHT TO RECEIVE OR RELEASE NECESSARY INFORMATION

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Expenses.

FACILITY OF PAYMENT

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan, and the Plan will not pay that amount again.

RIGHT OF RECOVERY

In accordance with *Section 16: Recovery of Payments* of this SPD, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess. Please see *Section 16: Recovery of Payments* for more details.

MEDICAID COVERAGE

A Covered Person's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the State Medicaid program; and the Plan will honor any subrogation rights the State may have with respect to benefits which are payable under the Plan.

16. RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan ("Erroneous Payments"). As a result, the Plan may pay benefits that are later found to be greater than the Maximum Allowed Amount.

In such cases, the Plan has the right to recover the amount of any Erroneous Payment directly from the person or entity who received such payment, from other payers, and/or from the Employee or dependent on whose behalf such payment was made.

The Plan has the right to recover benefits it has paid on an Employee's or dependent's behalf that were:

- Made in error;
- Due to a mistake or misstatement in fact;
- Due to fraud or misrepresentation;
- In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions;
- Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

Recipients of Erroneous Payments shall return or refund the amount of such Erroneous Payment to the Plan within 30 days of discovery or demand. Recipients include a covered Employee, dependent, medical provider, another benefit plan, insurer or any other person or entity who receives an Erroneous Payment exceeding the amount of benefits payable under the terms of the Plan.

The person or entity receiving an Erroneous Payment may not apply such payment to another expense. The Plan Administrator shall have no obligation to secure payment for the expense for which the Erroneous Payment was made or to which it was applied.

The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an Erroneous Payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan

Sponsor, to the extent permitted by law. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand. Any Erroneous Payments not repaid within 30 days of discovery or demand shall incur prejudgment interest of 1.5% per month.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Further, Employees, dependents, and/or their beneficiaries, estate, heirs, guardian, personal representative, or assigns shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Covered Person(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

If the Plan must bring an action against an Employee, dependent, provider or other person or entity to enforce the provisions of this section, then that, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

17. THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PAYMENT CONDITION

This section explained how your benefits are impacted if you suffer a Sickness or Injury that is caused by and/or payable by a third party other than the Plan.

For example, if a third party is responsible for payment for a Sickness or Injury for which you received a settlement, judgment, insurance proceeds, 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. You must reimburse the Plan even if you have not been "made whole" for your Sickness or Injury.

Please contact the Plan Administrator if you have any questions regarding this section.

A. CONDITIONAL PAYMENT OF BENEFITS

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

2. Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from anyone or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the

Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Persons) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

B. **SUBROGATION**

1. As condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's

behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Covered Person(s) fails to file a claim or pursue damages against:

   a. The responsible party, its insurer, or any other source on behalf of that party.
   b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
   c. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
   d. Workers' compensation or other liability insurance company.
   e. Any other source of Coverage, including, but not limited to, the following:
      (1) Crime victim restitution funds
      (2) Civil restitution funds
      (3) No-fault restitution funds such as vaccine injury compensation funds
      (4) Any medical, applicable disability or other benefit payments
      (5) School insurance coverage

   then the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

C. **RIGHT OF REIMBURSEMENT**

1. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically

designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person(s) obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

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

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

D. COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS

1. Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Covered Person understands that he/she is required to:

    a. Notify the Plan or it's authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

b. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
c. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

E. RELEASE OF LIABLITY

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) ("Incurred") prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

F. EXCESS INSURANCE

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under

the Plan's *Coordination of Benefits* section. The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of Coverage, including, but not limited to, the following:
    a. Crime victim restitution funds
    b. Civil restitution funds
    c. No-fault restitution funds such as vaccine injury compensation funds
    d. Any medical, applicable disability or other benefit payments
    e. School insurance coverage

G. SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

H. WRONGFUL DEATH

In the event that the Covered Person(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

I. OBLIGATIONS

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

    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.

b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
f. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
g. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
h. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.
i. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
j. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
k. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person(s)' cooperation or adherence to these terms.

J. OFFSET

If timely repayment is not made, or the Covered Person and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the

Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

K. MINOR STATUS

1. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

L. LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

M. SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

18. COBRA CONTINUATION OPTIONS

INTRODUCTION

If you lose your Plan coverage, you may have the right to temporarily extend it under the federal law Consolidated Budget Reconciliation Act of 1985 (COBRA).

This section generally explains COBRA continuation coverage, when COBRA coverage may become available to you and your family, and what you need to do to protect the right to receive it. Please read this information carefully. The Plan offers no greater COBRA rights than what the COBRA statute requires. You should contact your Plan Administrator if you have questions about your right to continue coverage.

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

WHAT IS COBRA COVERAGE?

COBRA coverage is a continuation of Plan coverage when that coverage would otherwise end because of certain events called "qualifying events". Specific qualifying events are listed below. After a qualifying event occurs and any required notice of that event is properly given, COBRA coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

The word "you" below generally refers to each person covered by the Plan who is or may become a qualified beneficiary.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

WHAT ARE QUALIFYING EVENTS?

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because of one of the following qualifying events:

(1) Your hours of employment are reduced; or

(2) Your employment ends for any reason (other than your gross misconduct).

If you are the spouse of an employee, you will become a qualified beneficiary if you lose coverage under the Plan because of any of the following qualifying events:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason (other than for gross misconduct); or

(4) You become divorced or legally separated from your spouse; or

(5) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

If you are the dependent child of an employee, you will become a qualified beneficiary if you lose coverage under the Plan because of any of the following qualifying events:

(1) Your parent-employee dies;

(2) Your parent-employee's hours of employment are reduced;

(3) Your parent-employee's employment ends for any reason (other than for gross misconduct);

(4) Your parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);

(5) Your parents become divorced or legally separated; or

(6) You no longer meet the Plan's definition of a dependent child and are therefore no longer eligible.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has received proper notice that a qualifying event has occurred. When the qualifying event is the end of employment, the reduction of hours of employment, the death of the employee, or the employee's becoming entitled to Medicare benefits (under

Part A, Part B, or both), your employer will give the required notice to the Plan Administrator.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in writing within 60 days after the later of the qualifying event at the following address:

Plan Administrator – TLC Benefit Solutions, Inc.
P. O. Box 947
Valdosta, GA 31603
Tel: (229) 249-0940
Toll Free: (877) 949-0940

You will need to provide a copy of court orders or any other paperwork that is needed in order to determine COBRA eligibility.

Notice can be given by the covered employee, by a qualified beneficiary, or by a representative of either.

If you send a notice through the mail, the notice must be post-marked within the 60-day period described above. **If your notice is not properly and timely given, you will lose your right to elect COBRA.**

ELECTING COBRA COVERAGE

Once the Plan Administrator receives notice and satisfactory proof that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary. At that time, you will receive information about the cost of COBRA coverage, and how to elect and pay for COBRA. **To elect COBRA, you must complete the election form that will be provided to you and timely return the form within a 60-day election period.**

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

ELECTING COBRA AFTER LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact the Plan Administrator for more information about these special rules.

COST OF COBRA COVERAGE

Each qualified beneficiary is required to pay for the entire cost of COBRA coverage, plus an administrative fee. The amount may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to disability, 150 percent) of the cost of the Plan (including both employer and employee contributions) for coverage of a similarly situated Covered Person or beneficiary who is not receiving COBRA coverage. You will be notified of the cost in your COBRA election materials. The amount of your COBRA premiums may change from time to time as the law allows and will most likely increase over time.

PAYING FOR COBRA COVERAGE

You must make your first payment for COBRA coverage no later than 45 days after the date you elect COBRA. Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated through the time you make the first payment. **If you do not make your first payment for COBRA coverage in full within 45 days after the date of your COBRA election, you will lose all COBRA rights under the Plan.**

Monthly payments for each subsequent month of coverage are due on the first day of the month for that month's COBRA coverage, subject to a 30-day grace period. **If you do not make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage.**

If you have questions regarding paying for COBRA coverage, please contact the Plan Administrator.

HOW LONG DOES COBRA COVERAGE LAST?

As explained above, COBRA coverage is a temporary continuation of Plan coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended. Please contact the Plan Administrator for Plan procedures and applicable deadlines governing requests for COBRA extensions.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you provide timely written notice to the Plan Administrator, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if you provide timely written notice to the Plan Administrator within 60 days of the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

OTHER INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

A child who is born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary if the covered employee has elected COBRA coverage for himself or herself. Continuation coverage may be elected for the child, provided the child satisfies the otherwise applicable plan eligibility and enrollment requirements, and provided that timely notice of the birth or adoption is given under the applicable terms of the Plan. If timely notice is not given, the child cannot be added to COBRA continuation coverage. The child's COBRA coverage begins when the child begins participation in the Plan, and it lasts for as long as COBRA lasts for other similarly situated qualified beneficiaries in the family.

TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

The coverage periods described above are maximum coverage periods. COBRA coverage will terminate before the end of the maximum coverage if:

(1) Any required premium is not paid in full and on time;
(2) The qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both), after electing COBRA (you should provide notice if Medicare entitlement occurs);
(3) The employer ceases to provide any group health plan for its employees; or
(4) In the case of a disability extension, the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled (you should provide notice if the Social Security Administration makes this determination).

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Covered Person or beneficiary not receiving continuation coverage (such as fraud).

COVERAGE OPTIONS OTHER THAN COBRA

There may be coverage options other than COBRA for you and your family. Under The Patient Protection and Affordable Care Act (PPACA), health coverage is available through the Health Insurance Marketplace. In the Marketplace, you may be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace.

IF YOU HAVE QUESTIONS

Questions about your rights under COBRA, and other questions about the Plan, can be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

In order to protect your and your family's rights, you should update any changes in your address and the addresses of family members. Updates should be provided to the Plan Administrator. You should also keep for your records a copy of any notices and other communications you send to the Plan Administrator regarding COBRA.

19. OTHER FEDERAL LAWS THAT APPLY

The Plan is a welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The Plan is also a non-grandfathered health plan subject to the requirements of The Patient Protection and Affordable Care Act (PPACA). Other federal laws also govern the Plan, which are briefly summarized below. For more information, please contact the Plan Administrator.

HIPAA Privacy & Security

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your protected health information.

The Langdale Company Employee Benefit Plan (the "Plan") will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, Plan administration, or as required or permitted by law.

A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Plan's Notice of Privacy Practices ("Privacy Notice"), which is furnished to all Covered Persons at the time of enrollment, is available upon written request, and can also be accessed on the Plan's internet site at: www.tlcbenefitsolutions.net.

HIPAA Privacy

Commitment to Protecting Health Information
The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Covered Person's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Covered Person's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.
3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not

in the Covered Person's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Covered Person.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Covered Person's Rights

The Covered Person has the following rights regarding PHI about him/her:

1. Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Covered Person has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and include how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Officer.
5. Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Covered Person wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must

be clearly identified. The Plan must respond to the Covered Person's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.

6. Amendment: The Covered Person has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Questions or Complaints

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:
Compliance Officer
TLC Benefit Solutions, Inc.
P.O. Box 947
Valdosta, GA 31601
Phone: 229-249-0940
Fax: 229-249-9840

HIPAA Security

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

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Director of Employee Benefits.

iii. Employee Benefits Department employees.
iv. Information Technology Department.

b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Covered Person's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Privacy Officer And Contact Person

The HIPAA Privacy and Security Officer for the Plan, whose responsibility is the development and implementation of policies and procedures to ensure compliance with HIPAA, shall be the individual whose job title is "Privacy Officer". The contact person or office responsible for receiving complaints regarding health information privacy, and who is able to give further information concerning matters covered by the Privacy Notice, is the Privacy Officer.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998, is a Federal law that mandates that group health plans which provide medical and surgical benefits shall provide to those who are receiving benefits in connection with the mastectomy and who elect breast reconstruction in connection with the mastectomy, coverage for:

(1) Reconstruction of the breast on which the mastectomy has been performed;
(2) Surgery and reconstruction of the other breast to produce asymmetrical appearance and;
(3) Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

This coverage is to be determined in consultation with the attending physician and the patient. Such coverage, if available, is subject to annual deductible and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the Plan.

Newborns' and Mothers' Health Protection Act (NMHPA)

Under Federal law, group health Plans offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

However, the Plan may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, the Plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under Federal law, require that a physician or other health care provider obtain Prior Authorization for prescribing a length of stay of up to 48 hours (or 96 hours as applicable). The Plan may impose a Prior Authorization requirement for hospital stays beyond this period.

For information on services that require Prior Authorization, please see *Section 8: Utilization Management Program*, or contact the Plan Administrator.

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans to ensure that financial requirements (such as copays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or Substance Use Disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. MHPAEA does not mandate that a plan provide MH/SUD benefits.

The Plan is in compliance with MHPAEA, and the Plan's terms governing MH/SUD benefits shall be interpreted in compliance with MHPAEA.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits the Plan from:

- Requesting or requiring individuals or their family members to undergo genetic testing.
- Using genetic information to determine eligibility for coverage or to impose preexisting condition exclusions.
- Collecting genetic information for underwriting purposes or with respect to any individual prior to enrollment or coverage.
- Adjusting group premium or contribution amounts on the basis of genetic information.

The Plan will not discriminate in individual eligibility, benefits or premiums based on any genetic information. The Plan will not require genetic testing of Covered Persons or intentionally gather genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes.

What is "genetic information"?

Genetic information means information about an individual's genetic tests the genetic tests of family members of the individual, family medical history or any request for and receipt of genetic services by an individual or a family member. The term also includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to an individual using assisted reproductive technology, genetic information about the embryo.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

A Covered 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 his/her dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

Plan coverage may be continued under USERRA for up to the lesser of:

(1) The 24-month period beginning on the date on which the Employee's absence begins; or
(2) The day after the date on which the Employee fails to apply for or return to a position of employment, as required by USERRA.

An Employee who elects to continue coverage under USERRA may be required to pay not more than 102 percent of the full premium under the Plan (determined in the same manner as the applicable COBRA premium) associated with such coverage for other Employees. In the case of an Employee who performs service in the uniformed services for less than 31 days, such Employee may not be required to pay more than the Employee's share, if any, for such Plan coverage.

To the extent allowed by law, COBRA coverage and USERRA coverage run concurrently.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible dependents in Plan coverage immediately upon returning to active employment, even if you and your dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting period.

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

20. PLAN ADMINISTRATION

The Plan is administered by TLC Benefit Solutions, Inc. ("Plan Administrator), in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan Administrator (or the Plan Appointed Claim Evaluator (PACE) insofar as it relates to Final Post-Service Appeals) shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Person's rights; and to determine all questions of fact and law arising under the Plan.

The Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, reserves the right to allocate certain discretionary authority as it applies to assessment and final determinative authority on and regarding Final Post-Service Appeal[s], to the "PACE".

The PACE's fiduciary duties extend only to those determinations actually made by the PACE, and with which the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan complies. An entity that may perform services as the PACE may perform other tasks on behalf of and in consultation with the Plan Administrator and/or Plan Sponsor, but not as the PACE, and the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. The Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed to act on behalf of the Plan, is prohibited from referring to the PACE, in accordance with applicable law and/or pre-existing contract, in all other matters, including but not limited to, other appeals that are "not" Final Post-Service Appeals.

The PACE shall at all times strictly abide by and make determination(s) in accordance with the terms of the Plan and applicable law. In instances where the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, delegates fiduciary authority to the PACE to make a determination regarding a Final Post-Service Appeal, the PACE shall have discretion to interpret the terms of this Plan, and the PACE possesses all duties and rights otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, in this limited scope only. In such instances, the PACE's determinations will be final and binding on all interested parties, and failure to comply with said determination by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, shall absolve the PACE of any and all fiduciary (and other) liability, responsibility, obligations, and/or duties.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the

Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Covered Person is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

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

2. To determine all questions of eligibility, status and coverage under the Plan.

3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms.

4. To make factual findings.

5. To decide disputes which may arise relative to a Covered Person's rights and/or availability of benefits.

6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials.

7. To keep and maintain the Plan documents and all other records pertaining to the Plan.

8. To appoint and supervise a third party administrator to pay claims.

9. To perform all necessary reporting as required by ERISA

10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.

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

12. To perform each and every function necessary for or related to the Plan's administration.

Duties and Rights of the PACE

When the PACE is assigned by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, the task of making a determination, regarding a Final Post-Service Appeal, the PACE shall possess the rights and exercise the duties otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, only insofar as it relates to said Final Post-Service Appeals. Assignment is achieved by and when the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan advances a request for a Final Post-Service Appeal, received by the Plan or its authorized agent(s), to the PACE with instructions to provide a directive regarding the Final Post-Service Appeal.

Prescription Drug Benefits

ProCare Rx is the claims fiduciary with respect to prescription drug benefit claims administration. Please see *Section 12: Prescription Drug Benefits* for more information.

ELAP Services, LLC ("ELAP")

Notwithstanding any provisions of this Plan Document and Summary Plan Description to the contrary, the Plan Sponsor has the authority to, and hereby does, allocate certain responsibility to ELAP Services, LLC ("ELAP"). The responsibility allocated to ELAP is limited to discretionary authority and decision-making authority with respect to the review and audit of certain claims in accordance with the applicable Plan provisions under Section 13, "Claim Review and Audit Program". Such claims selected as eligible for review and audit shall be identified by ELAP under guidelines to which the Plan Sponsor has agreed and shall be referred to ELAP by the Plan Administrator. ELAP shall have no authority, responsibility or liability other than with respect to the Claim Review and Audit Program.

Duties of ELAP.

ELAP shall have the following duties with respect to the Claim Review and Audit Program:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, benefits, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
4. To make factual and legal findings;
5. To decide disputes which may arise relative to benefits payable under the Plan and negotiating settlements, if appropriate;
6. To perform the duties in conjunction with the provisions of the Claim Review and Audit Program; and
7. To keep and maintain records pertaining to the Claim Review and Audit Program.

The duties of ELAP shall be limited to those set forth above.

Utilization Management Program

The Plan Administrator has delegated fiduciary responsibility and discretionary authority to administer the Plan's Utilization Management (UM) program to WiseThrive LLC. Such duties include:

- Processing notifications and requests for Prior Authorization pursuant to the Plan's requirements;

- Determining appeals from non-authorizations submitted by healthcare providers

The Plan Administrator determines appeals from Covered Persons and their representatives. Please see *Section 8: Utilization Management Program* for additional details.

Transplant Program

The Langdale Company Employee Benefit Plan (the "Plan") includes a special carve-out program for human organ and tissue transplant benefits, which are fully-insured and administered by HCC Life Insurance Company (the "Transplant Policy"). Claims and appeals for benefits under the Transplant Policy are governed by the terms of the Transplant Policy plan documents, and administered by HCC Life Insurance Company. Please see *Section 7: Transplant Program* for details.

Statements

All statements made by the Company or by a Covered Person will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application

for benefits and a copy of the instrument containing such representation is or has been furnished to the Covered Person.

Any Covered Person who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Covered Person may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors

To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan Administrator in its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Covered Person or former Covered Person, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a dependent of such Covered Person or former Covered Person, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care providers.

Binding Arbitration

Note: *You are enrolled in a plan provided by your Employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. You may pursue voluntary binding arbitration after you have completed an appeal under ERISA. If you have any other dispute which does not involve an adverse benefit decision, this Binding Arbitration provision applies.*

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal

Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Covered Person and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Covered Person and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Covered Person waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Covered Person.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Covered Person making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Covered Person and the Plan Administrator, or by order of the court, if the Covered Person and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Plan Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Covered Person subsequently requests payment with respect to the voided check, the Plan Sponsor for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA, and any other applicable State law(s).

21. GENERAL PLAN INFORMATION

PLAN NAME: The Langdale Company Employee Benefit Plan

PLAN NUMBER: 572

PLAN SPONSOR'S TAX ID NUMBER: 58-0542427

PLAN TYPE: Welfare Benefits Plan (Group Health Plan)

PLAN YEAR: January 1 – December 31

PLAN ADMINISTRATION:

Self-funded (with the exception of organ and tissue transplant benefits)

Fully-Insured (organ and tissue transplant benefits)

SOURCE OF BENEFITS: General assets of Participating Employers

SOURCE OF CONTRIBUTIONS: Employee and Participating Employers

PLAN EFFECTIVE DATE: November 5, 1990; Restated January 1, 2023

PLAN SPONSOR INFORMATION:

The Langdale Company
1202 Madison Highway
Valdosta, Georgia 31601
Phone: (229) 333-2500

PLAN ADMINISTRATOR;

TLC Benefit Solutions, Inc.
P.O. Box 947
Valdosta, Georgia 31603
Phone: (229) 249-0940
Toll Free: (877) 949-0940

AGENT FOR SERVICE OF LEGAL PROCESS:

Vice President of Human Resources
The Langdale Company
1202 Madison Highway
Valdosta, Georgia 31601

Service of legal process may also be made on the Plan Administrator TLC Benefit Solutions, Inc.

PARTICIPATING EMPLOYERS WHOSE EMPLOYEES MAY BE COVERED:

Fussell Tire & Service, Inc.
Industrial Cutting Tools, Inc.
Kinderlou Forest Development, LLC
Kinderlou Forest Golf Club, LLC
LANCO Trucking, Inc.
Langboard, Inc.
The Langdale Company
Langdale Farms LLC
Langdale Forest Products Co.
Langdale Fuel Co.
Langdale Industries, Inc.
Langdale Powersports, LLC
Langdale Timber Company
Langdale Woodlands, LLC
Lowndes Bancshares, Inc., d.b.a. Commercial Banking Company
Southern Builders Supply of Valdosta, Inc.
Southland Forest Products, Inc.
TLC Benefit Solutions, Inc.
TLC Building Components, Inc.
TLC Mouldings, Inc.
TLC Wood Additives

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Registered Agent.

Amendment or Termination of the Plan

The Plan Sponsor reserves the right, at any time, to amend, suspend or terminate the Plan, in whole or in part, for any reason. Only the Plan Sponsor has the authority to amend or terminate the Plan. Such authority of the Plan Sponsor may be exercised by the Vice President of Human Resources after consultation with the President and upon approval of the President. All amendments will be made via a written instrument signed by the Plan Sponsor. The Vice President of Human Resources may sign such amendment.

Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Rescission of Coverage for Misrepresentation or Fraud

Rescission is the cancellation or discontinuance of coverage under the Plan that has retroactive effect.

The Plan will rescind Plan coverage if a Covered Person commits fraud or makes an intentional misrepresentation of a material fact in connection with eligibility for coverage, a claim for benefits, enrollment information, or any other matter affecting a Covered Person's receipt of Plan coverage or benefits.

With respect to eligibility, when you enroll a Spouse or Child in the Plan, you represent the following –

- The Spouse or Child is eligible under the terms of the plan; and
- You will provide evidence of eligibility on request;

Further, you understand that –

The plan is relying on your representation of eligibility in accepting the enrollment of your Spouse and Children;

Your failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and

Your failure to provide evidence of eligibility will result in disenrollment of the Spouse and/or Child, which may be retroactive to the date as of which the Spouse and/or Child became ineligible for plan coverage, as determined by the Plan Administrator.

Conformity to Law

This Plan shall be interpreted to comply with the requirements, to the extent required, of any applicable law or regulation to which it is subject, including but not limited to, the Employee Retirement Income Security Act of 1974 (ERISA), the Internal Revenue Code (IRC), the Patient Protection and Affordable Care Act (PPACA), and the Consolidated Appropriations Act, 2021 (CAA 2021).

Clerical Error

Any clerical error by a Participating Employer, the Plan Administrator, or an agent of either, in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered. The Plan reserves the right to recover any overpayments, as described in the Recovery of Payments section of this SPD.

22. STATEMENT OF ERISA RIGHTS

As a Covered Person in The Langdale Company Employee Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

Receive Information About Your Plan And Benefits

Examine, without charge, at your Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts, if any, and a copy of the latest annual report (Form 5500 Series), if a report is required, that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

Upon written request to the Plan Administrator, obtain copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, if any, and copies of the latest annual report (Form 5500 Series), if a report is required, and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue group health plan 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 must pay for such coverage. Please refer to Section 18: COBRA Continuation Options and the documents governing the Plan's rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for Covered Persons, ERISA imposes obligations upon the persons who are responsible for the operation of the Plan. These persons are referred to as "fiduciaries". 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 Covered Persons 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents (without charge) relating to the decision, and to appeal any denial, all within certain time schedules. Please see *Section 14: Claims and Appeals* for more 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 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 to 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, and if you have exhausted the claims and appeal procedures that are available to you 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 medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money (if the Plan is considered to have 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. However, no legal action may be commenced or maintained against the Plan prior to your exhaustion of the Plan's claims procedures described in *Section 14: Claims and Appeals*.

Assistance With Your Questions

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

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