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Maryfield, Inc. dba Pennybyrn
Amendment 40

Effective January 1, 2024 the Plan Document and the Summary Plan Description to which this Amendment is attached are both amended as follows.

WHEREAS, Maryfield, Inc. dba Pennybyrn ("Plan Sponsor") maintains the Maryfield, Inc. dba Pennybyrn Employee Group Health & Welfare Plan;

WHEREAS, Plan Sponsor wishes to amend and restate the Plan accordingly as provided in the attached Summary Plan Description;

NOW, THEREFORE, IT IS AGREED, that the Maryfield, Inc. dba Pennybyrn Employee Group Health & Welfare Plan (the "Plan") is hereby amended and restated as set forth in the document entitled "Summary Plan Description for Plan Participants of Maryfield, Inc. dba Pennybyrn Employee Group Health & Welfare Plan," attached hereto;

It is understood and agreed by the Maryfield, Inc. dba Pennybyrn Employee Group Health & Welfare Plan that the above stated Amendment 40 is acceptable and will be the basis for the administration of the Maryfield, Inc. Pennybyrn Employee Group Health & Welfare Plan until otherwise stated in writing by the Plan Administrator.

Accepted on Behalf of the Maryfield, Inc. dba Pennybyrn Employee Group Health & Welfare Plan:

By: DocuSigned by: Vonda Hollingsworth 00773E4AA8474FB... (Signature)

Printed Name: Vonda Hollingsworth

Title: Vice President/Group Administrator

Date: 12/19/2023 | 10:58 PST

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PENNYBYRN at MARYFIELD
A Continuing Care Retirement Community

SUMMARY PLAN DESCRIPTION

FOR

Maryfield, Inc. dba Pennybyrn

EMPLOYEE GROUP HEALTH AND WELFARE PLAN

Amended and Restated January 1, 2024

IMPORTANT NOTICE

The enclosed Schedule of Benefits is an outline of benefits of the Employee Group Health and Welfare Plan provided by your Employer. The basis of payment of the benefits described in this Schedule of Benefits will be determined by the provider of services and claims rules of the Plan. All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein.

This Summary Plan Description contains a summary in English of your Plan rights and benefits under your Group Health Plan. If you speak Spanish only and have difficulty understanding any part of the Summary Plan Description, contact MedCost Benefit Services Customer Service at 800-795-1023. Office hours are from 8:30 a.m. to 5:00 p.m. (Eastern Time) Monday through Friday.

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TABLE OF CONTENTS

DocuSign Envelope ID: 20B80240-1FE1-4328-99D8-A5B6043B33C7

NOTICE OF NON-DISCRIMINATION
DISCRIMINATION IS AGAINST THE LAW

Maryfield, Inc. dba Pennybyrn complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Maryfield, Inc. dba Pennybyrn does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Maryfield, Inc. dba Pennybyrn:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact MedCost Benefit Services Customer Service at (800) 795-1023.

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English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (800) 795-1023.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 795-1023.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 795-1023.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 795-1023.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 795-1023 번으로 전화해 주십시오.

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 795-1023.

العربية **(Arabic)**:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (800) 795-1023

Hmoob (Hmong): LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 795-1023.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 795-1023.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 795-1023.

ગુજરાતી (Gujarati): **સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** (800) 795-1023.

ប្រយ័ត្ន៖ (Mon-Khmer Cambodian): បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (800) 795-1023 ។

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 795-1023.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (800) 795-1023 पर कॉल करें।

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ (800) 795-1023.

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(800) 795-1023 まで、お電話にてご連絡ください。

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INTRODUCTION

Note to Plan Participants

- Capitalized terms have specific meanings when used in this document. The meanings of these capitalized terms are in the *Defined Terms* section of this document.
- This Summary Plan Description describes the circumstances when this Plan pays for health care. All decisions regarding health care are up to the Plan Participant and his or her Physician. There may be circumstances when a Plan Participant and his or her Physician determine that health care, which is not covered by this Plan, is appropriate. The Plan Sponsor does not provide nor ensure quality of care.
- Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Copays, exclusions, limitations, definitions, eligibility and the like.
- The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.
- If the Plan is terminated, amended, or benefits are eliminated, the rights of Plan Participants are limited to Covered Charges incurred before termination, amendment or elimination.

Purpose

- This document is a Summary Plan Description of *Maryfield, Inc. dba Pennybyrn Employee Group Health & Welfare Plan* (the Plan).
- The Plan described is designed to protect Plan Participants against certain health expenses.
- The Plan Sponsor established this Plan to provide for the payment or reimbursement of covered health expenses incurred by Plan Participants.
- The Plan is not to be construed as a contract for or a guarantee of employment. Nothing in this Plan shall be deemed to:
  - Affect the right of the Employer to discipline or discharge any Employee at any time.
  - Affect the right of any Employee to terminate his or her employment at any time.
  - Give the Employer the right to require any Employee to remain in its employ.
  - Give the Employee the right to be retained in the employ of the Employer.

Exclusive Benefit

- This Plan is established and shall be maintained for the exclusive benefit of eligible Plan Participants.
- The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.
- Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.
- No clerical errors made in keeping records pertaining to this coverage, or delays in making entries in such records will invalidate coverage otherwise validly in force, or continue coverage otherwise validly terminated. Upon discovery of an error, an adjustment of any benefits paid will be made.

Compliance / Limitation

- This Plan is established and shall be maintained with the intention of meeting the requirements of all pertinent laws. No oral interpretations can change this Plan.
- No action at law or in equity shall be brought to recover any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.
- No action at law or in equity can be brought to recover after the expiration of two (2) years after time when written proof of loss is required to be furnished to the Third Party Administrator.
- Failure to follow the eligibility or enrollment requirements, including timely application for coverage of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other health management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.
- Should any part of this Summary Plan Description for any reason be declared invalid, such decision shall not affect the validity of the remaining portion, which remaining portion shall remain in effect as if this Summary Plan Description has been executed with the invalid portion thereof eliminated.

Documents Sections

This summary plan document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

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- *Schedule of Benefits.* Provides an outline of the Plan's payment or reimbursement as well as limits on certain services. Also provides a description of Covered Medical Expenses and explains when the benefit applies and the types of charges covered.
- *General Provisions.* Explains Employee and Dependent eligibility for coverage under the Plan, funding of the Plan, Special Enrollment Rights and when the coverage takes effect and terminates.
- *Health Management Services.* Explains the Plan's programs used to help Plan Participants curb unnecessary and excessive charges, the Plan Participant's responsibilities for health management and possible penalties that may be assessed for failure to follow Health Management requirements.
- *Coverage of Medical Expenses.*
- *Medical Benefits Exclusions.* Provides a list of what charges are **not** covered.
- *Prescription Drug Benefits, Limitations & Exclusions.*
- *Dental Care Benefits, Limitations & Exclusions.*
- *Claims Procedures.* Describes how to submit a claim, how the Plan processes claims and explains the rules of the claim appeal process.
- *Coordination of Benefits.* Shows the Plan payment order when a Plan Participant is covered under more than one plan.
- *Reimbursement and/or Subrogation.* Explains the Plan's rights to recover payment of charges when a Plan Participant has a claim against another person or entity because of injuries sustained.
- *Continuation Coverage Rights Under COBRA.* Explains the continuation options that are available when a Plan Participant's coverage under the Plan ceases.
- *Defined Terms.* Defines those Plan terms that have a specific meaning.
- *Notice of Privacy Practices.* Explains how an employer may use and disclose a Plan Participant's Protected Health Information (PHI) in addition to the restrictions placed on such use and disclosure.

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FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of Fraud. The Plan will utilize all means necessary to support Fraud detection and investigation. It is a crime for a Covered Person to file a Claim containing any false, incomplete or misleading information with intent to Injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that you receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. Please note that the examples listed are not all inclusive.

These actions will result in denial of the Covered Person's Claim or termination from the Plan, and are subject to prosecution and punishment to the full extent under state and / or federal law.

A Covered Person must:

- file accurate Claims; if someone else - such as the Spouse or another Family member - files Claims on the Covered Person's behalf, the Covered Person should review the Claim Form before signing it;
- review the Explanation of Benefits (EOB) Form and be certain that benefits have been paid correctly based on his/her knowledge of the expenses incurred and the services rendered;
- never allow another person who is not his/her Dependent to seek medical treatment under his/her identity; and if the Covered Person's Plan identification card is lost, report the loss to the Plan immediately;
- provide complete and accurate information on Claim Forms and any other forms; and answer all questions to the best of his/her knowledge; and
- notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- bills for services or treatment that have never been received; and/or
- asks a Covered Person to sign a blank Claim Form; and/or
- asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB Form, or who know of or suspect any illegal activity, should call toll-free (800) 795-1023. All calls are strictly confidential.

RESCISSION OF COVERAGE

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Plan Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Plan Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Plan Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Plan Participants being canceled, and such cancellation may be retroactive.

A determination by the Plan that a Rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Plan Participant whose coverage is being rescinded will be provided a 30-day notice period as described under the *Patient Protection and Affordable Care Act (PPACA)* and applicable regulatory guidance. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

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NOTICE OF PRECERTIFICATION REQUIREMENTS

IMPORTANT NOTICE
Certain medical services require Precertification.

Precertification* is the process of collecting certain information before elective inpatient admissions and/or selected ambulatory procedures and services take place. Not all medical services are covered under the Plan. When Precertification is required, failure to follow the Precertification process as described herein in advance of a procedure or service may result in significant penalties as defined in this SPD, including non-coverage. Requests for Precertification and notification must be received before receipt of a service or procedure. Failure to contact MedCost for Precertification will relieve MedCost or the Employer from any financial liability for the applicable service(s) or product(s), unless otherwise stated in this SPD.

**Precertification means the utilization review process to determine whether the requested service, procedure, Prescription Drug, or medical device meets the clinical criteria for coverage. See the Health Management Services section.*

SCHEDULE OF BENEFITS 2024	
For access to information 24/7, go to ***www.medcost.com*** and go to Member Login to visit the personalized web site; use ID card with Member and Group ID numbers to create an account. For questions about claim status, benefits or other general questions, contact MedCost Benefit Services Customer Service at (800) 795-1023 or ***mbscs@medcost.com***; please include Member ID in body of email. This Schedule of Benefits is an outline of benefits of the Employee Benefit Plan provided by your Employer. The basis of payment of the benefits described in this Schedule of Benefits will be determined by the provider of services and claims rules of the Plan. All benefits described in this Schedule are subject to the exclusions and limitations described more fully in the remainder of the Summary Plan Description. ***See details of the following highlights in remainder of the Summary Plan Description.***	
Waiting Period / Effective Date *(New Hires)*	For Medical coverage or Medical & Dental coverage: Effective next day following 60 days of continuous, full-time employment with the Employer. For Dental only coverage: Effective next day following 90 days of continuous, full-time employment with the Employer.
Waiting Period *(Rehires)*	A previously covered Employee who terminates coverage and whose eligibility is reinstated within 13 weeks of his or her termination date will not be required to satisfy the Employer's Waiting Period.
Measurement Period	This Plan's Measurement Period is July 1st through June 30th unless the subsequent Stability Period begins in a leap year.
Stability Period	This Plan's Stability Period is October 1st through September 30th
Spousal Definition	The term "Spouse" shall mean the person of the opposite sex recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. (The Employer may require documentation proving a legal marital relationship.) *Note*: The Plan does not offer coverage to a domestic partner or a common-law spouse, even if the state in which the Employee lives recognizes such a partnership. Working spouse is subject to Plan's requirements. See remainder of Summary Plan Description for details.
Dependent Children	Coverage will end the end of the month during which the Dependent child's 26th birthday occurs.
Open Enrollment	Benefit choices made during the Open Enrollment period will become effective October 1st.
Leave of Absence	Disability or LOA - 3 months. FMLA - 12 weeks. *See remainder of Summary Plan Description.*
Pre-Existing Conditions	This Plan does not apply a Pre-Existing Conditions Exclusion Period to any member.
Wellness Program	
Maryfield, Inc. dba Pennybyrn is implementing a wellness Program beginning January 1, 2019, in which all covered Employees will be required to receive the free screenings listed by Human Resources and to participate in Personal Care Management, if he or she is contacted. Participation in the wellness program is mandatory, and those who do not comply will receive a higher premium rate after a one year grace period. Refer to Human Resources for more information on the program requirements and penalty. (Please note that the wellness program requirements are not applicable to COBRA participants.) Your Plan is committed to helping you achieve your best health. All covered Employees have the ability to avoid any applicable penalties relating to the wellness program. If you think you might be unable to meet a standard to avoid a penalty under this wellness program, you might qualify for an opportunity to avoid the penalty by different means. Contact Kristie Catlin in Human Resources at (336) 821-4018 and we will work with you and/or your doctor to find a wellness program with the same reward that is right for you and your health status.	
Network and Health Management	
Network	MedCost, MedCost national network (as assigned), and MedCost Virginia Plus, 5 Stone Therapy, LLC, Anderson Therapy Services
Travel Network (outside of NC, SC, and VA)	MedCost national network – national access. See Network Provider Plan and refer to ID card.
Precertification	• Hospital admissions and Residential Treatment* • Transplant services**

	• Hospital observation unit stays of more than 48 hours • Certain diagnostic services rendered as Outpatient or in Physician's Office (see Outpatient Review)*** • Dialysis services**** • Intensive Outpatient and Partial Hospitalization***** • Non-Emergent Air Ambulance ******
Percertification Penalties	*Non-precertified Room and Board charges will be denied. **Failure to precertify or participate in Case Management for transplant services will result in the application of Health Management penalties. ***Non-precertified diagnostic services listed under Outpatient Review will be denied. ****Failure to precertify dialysis will result in associated charges from the first treatment date being denied. *****Non-precertified days / visits will be denied. See Medical Benefit Exclusions and Defined Terms. ******Non-Emergent Air Ambulance services that are not precertified will be denied.
Outpatient Review	Precertification is required for MRI, CT and PET scans performed Outpatient or in Physician's office. Services performed in emergent situations (to rule out need for surgery or urgent treatment) are not subject to the requirement for Outpatient Review / Precertification.
Outpatient Review Penalty	Non-precertified diagnostic services listed under Outpatient Review will be denied.
Case Management	Life-altering injuries, illnesses and diagnoses need specialized care. MedCost has individualized intervention and care for those navigating severe health conditions. The goal of Case Management is to promote improved quality of life outcomes while ensuring the best use of available resources. The Behavioral Health Solution program, a partnership with Carolina Behavioral Health Alliance (CBHA), is a component of Case Management that includes additional information, support and care for Plan Participants who are receiving Plan benefits for Mental Health and / or Substance Use Disorders. See the remainder of the Summary Plan Description for additional details.
Case Management Penalty	You will be contacted by the MedCost Case Management program if you are identified as a potential participant for Case Management. Case Management is subject to a non-participation penalty of $2,500. Non-participation with Case Management will result in a reduction of your medical benefits for all services up to a maximum of $2,500. Preventive / Wellness Services and Emergency Services received in an Emergency Room are not subject to the Case Management penalty. See also separate benefit for Transplant Services. If it is unreasonably difficult, due to a medical condition, for you to participate in the Case Management program and avoid the penalty, or if it is medically inadvisable for you to participate in the Case Management program, contact your Human Resources Department, and we will work with you to develop another way to avoid the penalty.
Personal Care Management	Personal Care Management (PCM) is individualized care designed to help create positive outcomes for those who are suffering from chronic conditions.
Personal Care Management Penalty	Potential participants are identified through Claims and pharmacy data, as well as internal referrals. Participation in Personal Care Management is a required part of the Maryfield, Inc. dba Pennybyrn Wellness Program for covered Employees. Refer to the aforementioned Wellness Program in the Schedule of Benefits or contact Human Resources for details. Participation in PCM is voluntary for covered Dependents - there are no penalties or reductions of benefits for not participating. If you are contacted by a MedCost nurse mentor we hope you will choose to take advantage of this program that will help you achieve a healthier lifestyle.

Benefit Maximums / Deductibles / Out-of-Pocket

This Plan does not apply a Lifetime or Annual Benefit Maximum to each Plan Participant for the total claim expenses incurred and paid while covered under this Plan.

		In-Network	***Non-Network***
Deductible	Individual	$750	$1,500
	Family	$1,850	$4,500

Benefits are payable for Individual once the Individual Deductible is met. Family Deductible does not have to be met

before benefits can be paid for Individual.			
Out-of-Pocket	Individual	$4,000	$7,000
	Family	$9,500	$21,000
The Family Out-of-Pocket Maximum does not have to be met before an Individual's Out-of-Pocket Maximum is considered to be satisfied.			
		Out-of-Pocket Maximum includes Copays, Coinsurance, and Deductibles, and excludes non-covered services, premiums, and any applicable penalties.	
Carryover Deductible		Yes: Covered expenses that were incurred and applied towards the Deductible during the last three (3) months of the Benefit Year will be applied to the following year's Deductible.	
Coordinating		Network and Non-Network accumulate towards each other.	
Benefit Year		January 1st through December 31st	
Inpatient Hospital Services*			
		In-Network	***Non-Network***
Room and Board		80% after Deductible	60% after Deductible
		Includes the medical services and supplies furnished by a Hospital, Ambulatory Surgical Center or a Birthing Center; after 48 observation hours, a confinement will be considered an inpatient confinement and will **require** precertification. If you occupy a private Hospital room, you will pay the difference between the Hospital's charges for a private room and the charge for a semiprivate room. If the Hospital does not have semiprivate rooms or a semiprivate room is unavailable, or your medical condition requires a private room (as determined by the Claims Administrator), the Plan will consider the private room rate. Payment for Critical Care Room and Board will be based on the Hospital's ICU charge.	
Physician Inpatient Services		80% after Deductible	60% after Deductible
		The Plan covers professional services of a Physician for Inpatient surgical or medical services. When multiple procedures are performed during the same operative session, benefits will be based on Medically Necessary services. Allowable expenses will be determined based on the complexity of the procedures. 100% of the allowable expense for the most complex will be considered and 50% of the allowable expense or billed charge will be considered for each additional procedure. An assistant surgeon will be considered eligible when Medical Necessity has been determined based on standard practices. Benefits will be based on 20% of the allowable expense or billed charge.	
Other Inpatient Services		80% after Deductible	60% after Deductible
* Pursuant to the No Surprises Act, certain services billed by Non-Network Providers for services performed in In-Network facilities will be covered at the In-Network benefit level. For additional information, see the discussion of Protections Against Surprise Medical Bills in the Coverage of Medical Expenses section			
Emergency and Urgent Care Services			
		In-Network	***Non-Network***
Emergency Services *at Emergency Room, including related services*		$250 Copay Note: Copay waived if admitted.	$250 Copay Note: Copay waived if admitted.
Urgent Care		$15 Copay	60% after Deductible
Outpatient Hospital Services*			
		In-Network	***Non-Network***
Pre-Admission Testing		80% after Deductible	60% after Deductible
		The Plan will pay for diagnostic tests and X-rays when performed on an outpatient basis before a Hospital admission, provided the procedures are provided within 7 days of the admission, are related to the condition that causes the admission and are performed in lieu of tests while Hospital confined. Payment will be made even if tests show that the condition requires medical treatment prior to Hospital admission or the Hospital admission is not required.	
Outpatient / Ambulatory Surgery *Facility / Surgeon*		80% after Deductible	60% after Deductible
		When multiple procedures are performed during the same operative session, benefits will be based on Medically Necessary services. Allowable expenses will be determined based on the complexity of the procedures. 100% of the allowable expense for the most complex will be considered and 50% of the allowable expense or billed charge will be considered for each additional procedure. An assistant surgeon will be	

	considered eligible when Medical Necessity has been determined based on standard practices. Benefits will be based on 20% of the allowable expense or billed charge.	
Outpatient Laboratory & X-Ray Services	100%, Deductible waived	60% after Deductible
Outpatient Diagnostic Scans *MRI, CT, PET Precertification required*	80%; Deductible waived	60% after Deductible
Other Outpatient Services	80% after Deductible	60% after Deductible
* Pursuant to the No Surprises Act, certain services billed by Non-Network Providers for services performed in In-Network facilities will be covered at the In-Network benefit level. For additional information, see the discussion of Protections Against Surprise Medical Bills in the Coverage of Medical Expenses section.		
Physician Services		
	In-Network	***Non-Network***
Office Visit for Injury / Illness		
Primary Care	\$15 Copay	60% after Deductible
	General practitioner, family practitioner, internist, pediatrician.	
OB/GYN	\$20 Copay	60% after Deductible
Copay covers most services performed in and billed by the Physician's office. OB-GYN visits for the primary purpose of treating pregnancy will be covered under the Maternity benefit (below), not this Office Visit benefit.		
Specialist	\$40 Copay	60% after Deductible
Services Not covered as part of an office visit:	Services not covered as part of the office visit include, but are not limited to: high cost injections, infusion therapy, Outpatient and independent laboratory and X-ray services, MRI, CT scan, PET scan, chemotherapy, radiation therapy, dialysis services, prenatal and postnatal Physician visits, physical therapy, speech therapy, occupational therapy, sleep studies, and TMJ services/supplies.	
Office Lab & X-ray	As any office visit	As any office visit
Office Surgery	As any office visit	As any office visit
Second Surgical Opinions	As any office visit	As any office visit
	Benefits will be provided to determine the Medical Necessity of an elective surgical procedure. The second opinion must be made by a board-certified Physician who is affiliated in the appropriate specialty, and who is not an associate of the attending Physician.	
Routine Wellness / Preventive Services		
	In-Network	***Non-Network***
Routine Wellness / Preventive Services	100%; Deductible waived	100%; Deductible waived
	Includes physical or gynecological exam, well child care, laboratory services, X-ray services, immunizations / vaccines / flu shots, health history, developmental assessment, colorectal screening, pap smear, ovarian cancer screenings, PSAs, bone mass measurements, and contraceptive management. Includes FDA approved contraceptive methods / devices and sterilization procedures and education and counseling for women, including devices, injectables, and implants, excluding over-the-counter products. Includes injectable contraceptives administered in the Physician's office. Oral contraceptives, vaginal rings, and transdermal patches are covered under the Prescription Drug benefits. Gynecologists may perform the gynecological exam and pap smear, with the balance of the physical exam performed by another Physician. There will be no duplication of services. See also Advanced Cancer Screening and Nutritional Counseling**.** The Patient Protection and Affordable Care Act (PPACA), as part of Health Care Reform, contains a provision that requires your health plan to provide certain preventive care services with no cost-sharing, i.e., not subject to Copays, coinsurance, or Deductibles. * These services include, but are not limited to: routine physicals; pediatric wellness examination; selected preventive, diagnostic, and cancer screenings; and certain pediatric preventive services, including but not limited to, oral health assessment, sensory screening, and developmental and behavioral assessment. These preventive services are covered based on the guidelines and recommendations	

	of the United States Preventive Services Task Force (USPSTF). For a complete listing of these guidelines and recommendations please visit: **https://www.healthcare.gov/coverage/preventive-care-benefits/** **Preventive services for women without cost-share:** The following list is not all-inclusive. • well-woman visits / well-woman preventive care visit annually for an adult woman to obtain the recommended preventive services that are age and developmentally appropriate, including prenatal visits billed outside of global obstetric care; • screening for gestational diabetes; • testing for human papillomavirus (HPV test) annually or as recommended by Physician; • sterilization procedures and associated services rendered on the same day (reversal procedures not covered); • breastfeeding support and associated supplies and counseling; includes lactation support and counseling provided by a trained provider in conjunction with birth; and includes purchase, or rental cost up to purchase price, of breastfeeding equipment from a Network Provider or retail store (treated as In-Network); purchase is limited to one per Pregnancy (at a maximum of $300 for retail stores); and • screening and counseling for interpersonal and domestic violence. These preventive services for women are covered based on recommendations of the Independent Institute of Medicine and supported by the Health Resources and Services Administration. The services shown under this section, “Routine Wellness / Preventive Services,” are covered based on the guidelines and recommendations of the United States Preventive Services Task Force (USPSTF). For a complete listing of these guidelines and recommendations, please visit: **https://www.healthcare.gov/coverage/preventive-care-benefits/** *A plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for which a recommended preventive service will be available without cost-sharing to the extent not specified in a recommendation or guideline. This Plan also covers certain services as preventive as listed in **IRS Notice 2019-45**, including, but not limited to, blood pressure monitors, glucometers, and peak flow meters. In accordance with IRS guidance, these services are only covered as preventive under the Plan when provided in conjunction with a diagnosis of certain specified conditions (see IRS Notice 2019-45).		
Advanced Cancer Screening	100%; Deductible waived		100%; Deductible waived
	Includes Mammograms and Colonoscopies other than inpatient. Includes routine, diagnostic / therapeutic and related services. Includes polyp removal during routine colonoscopy when billed properly by the provider.		
Nutritional Counseling	100%; Deductible waived		As any Covered Medical Expense
	Includes medical nutritional counseling, up to 6 visits per Benefit Year, rendered by a licensed health care provider (in-Network when available), as required to provide appropriate guidance and education for diet related conditions or risk factors, including but not limited to diabetes, obesity, high cholesterol and high blood pressure.		
Other Services			
	In-Network		***Non-Network***
Acupuncture	$20 Copay		
	Limited to 10 visits per Benefit Year.		
Advanced Imaging *MRI, CT, PET scans* *Precertification required*	80%; Deductible waived		60% after Deductible
Allergy Services			
Office Visit	Primary Care	$15 Copay	60% after Deductible

	Specialist	$40 Copay	
Allergy Testing	100%; Deductible waived *		60% after Deductible
Allergy Treatment (injections and serums)	100%; Deductible waived		60% after Deductible
	The Plan will pay for Medically Necessary tests to determine the nature of allergies and for desensitization treatment (allergy "shots") to treat allergies. Test and treatment materials are included. The office visit Copay will be waived when immunization is the only service provided.		
Ambulance, Air* *Precertification required when non-emergent*	80% after In-Network Deductible		
	Benefits are for Medically Necessary air ambulance services. A charge for this item will be a Covered Charge when services are provided by, and in, an air ambulance traveling from the original pickup site to a Hospital or treatment facility when such a facility is the closest one that can provide covered services appropriate to the Plan Participant's condition, unless the Plan Administrator finds a longer trip is Medically Necessary. Non-emergency air ambulance services are eligible for coverage only when ground transportation is not medically appropriate due to the severity of the Injury or Illness, or the pick-up point is inaccessible by land, and such services are precertified. Non-emergency air ambulance services require verification of Medical Necessity or services will not be covered. * Pursuant to the No Surprises Act, certain services or items provided by Air Ambulance Providers will be covered at the In-Network benefit level. For additional information, see the discussion of Protections Against Surprise Medical Bills in the Coverage of Medical Expenses section.		
Ambulance, Ground	80% after In-Network Deductible		
	Benefits are for local Medically Necessary ground ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip is Medically Necessary. The Plan covers services in a ground ambulance traveling: • from a Plan Participant's home, scene of an Accident, or site of an emergency to a Hospital; • between Hospitals; and • between a Hospital and a Skilled Nursing Facility when such a facility is the closest one that can provide covered services appropriate to the Plan Participant's condition. Benefits may also be provided for ambulance services from a Hospital or Skilled Nursing Facility to a Plan Participant's home when this is Medically Necessary.		
Applied Behavioral Analysis (ABA) Therapy for Autism Spectrum Disorders (ASD)	As any Covered Medical Expense		As any Covered Medical Expense
	ABA therapy is covered for the treatment of Autism Spectrum Disorders (ASD) provided services are rendered by an appropriately credentialed Physician who is licensed for the provision of such services. Short-Term Therapy other than ABA therapy may be required for treatment of ASD. See also Short-Term Therapy for coverage of physical therapy, occupational therapy, and speech therapy. See also Learning Disorders / Developmental Testing under Medical Benefit Exclusions.		
Cardiac Rehabilitation	80% after Deductible		60% after Deductible
	Cardiac therapy is covered as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.		
Chemotherapy / Radiation	80% after Deductible		60% after Deductible
	Benefit includes treatment with radioactive substances as well as materials and services of technicians.		
Chiropractic Services *As any Specialist*	$40 Copay		
	Benefits limited to Benefit Year maximum of 30 visits. Benefits covered when performed by a licensed M.D., D.O. or D.C.; the following services are not within the scope of a chiropractor's scope of practice and are excluded by the Plan: administering or prescribing medicine or drugs; the practice of osteopathy; diagnostic services and surgery.		

Cupping Therapy	$20 Copay	
	Limited to 10 visits per Benefit Year.	
Diabetes Care Management	80% after Deductible	60% after Deductible
	The plan will provide coverage for Medically Necessary diabetes self-management training and educational services.	
Dialysis Management Program *Other than Inpatient - Precertification required*	80% after Network Deductible	
	Failure to precertify dialysis will result in associated charges from the first treatment date being denied. Charges for professional fees and services, supplies, medications, labs and facility fees related to outpatient dialysis are covered expenses. These services include but are not limited to hemodialysis, home hemodialysis, peritoneal dialysis and hemofiltration. Effective October 1, 2014, the Plan will allow billed charges at the defined benefit in the Schedule of Benefits for 42 outpatient dialysis treatments. This Plan does not provide network level benefits for dialysis providers; therefore, benefits are not subject to discount arrangements that the provider may have in place with any network. For subsequent treatments the Plan allowable for dialysis will be limited to 140% of current year Medicare composite allowable. The Plan will pay according to the schedule for the next 30 consecutive months of dialysis or until the Plan is secondary to other coverage, whichever occurs first. Thereafter, as permitted in 42 CFR § 411.161(c) and (d), Medicare will be the primary payer and the Plan will only pay secondary to Medicare or other coverage. The Plan will reimburse Medicare Part B premiums for the individual if and for as long as enrolled in Medicare Part B and receiving benefits under this provision. (Note: Medicare Part B premiums shall be reimbursed quarterly.)	
Durable Medical Equipment	80% after Deductible	60% after Deductible
	The Plan has benefits for the rental of Durable Medical Equipment (DME) if deemed Medically Necessary. DME includes, but is not limited to, apnea monitors, glucometers, oxygen equipment, Hospital type beds and wheelchairs. See Defined Terms. 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. Rentals are limited to a maximum of 13 months (or 36 months for oxygen equipment). This Plan also covers certain services as preventive as listed in **IRS Notice 2019-45**, including, but not limited to, blood pressure monitors, glucometers, and peak flow meters. In accordance with IRS guidance, these services are only covered as preventive under the Plan when provided in conjunction with a diagnosis of certain specified conditions (see IRS Notice 2019-45).	
Gender Dysphoria	Not covered	
Hearing Aids and Exams	Refer to Routine Wellness / Preventive Services for pediatric screening as required by PPACA.	
Home Health Care and Private Duty Nursing	80% after Deductible	60% after Deductible
	Benefits limited to Benefit Year maximum of 100 visits. Additional visits may be authorized by MedCost Case Management when (a) continued Medical Necessity is confirmed; and (b) additional visits would be provided in lieu of a higher level of care. Home health services include physical therapy, occupational therapy, speech therapy, home health aide, and skilled nursing provided by a Home Health Agency. Coverage of private duty nursing is limited to Medically Necessary services that (a) are not Custodial in nature; and (b) require the professional proficiency and skills of a licensed nurse (RN, LPN or LVN). Services and supplies are covered only for care and treatment of an Injury or Illness. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.	
Hospice Care	80% after Deductible	60% after Deductible
	Hospice care can provide the physical, psychological, spiritual and social support	

	needed to help terminally ill patients and their families cope with the Illness. Care includes services provided by a Hospice program in the patient's home, a Hospital or a Hospice. These services are covered as long as they are prescribed by a Physician and the covered patient's life expectancy is six months or less. Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Employee, covered Spouse and/or covered Dependent Children) are covered. Bereavement services must be furnished within six months following the patient's death.	
Infertility Services	As any office visit	As any office visit
	Infertility Services are available to covered Employee and covered spouse only. The Plan will cover diagnostic services to determine the cause of infertility. Treatment is not covered. See also Medical Benefit Exclusions, Infertility.	
Injectables and Infusion Therapy *See also Office Visit or Allergy Services*	80% after Deductible	30% after Deductible
	Certain Prescription Drugs must be purchased through the Plan's Specialty Pharmacy and will not be paid or reimbursed by the Plan if they are not. procured through the Plan's Specialty Pharmacy. *See Prescription Drug Benefits, Limitations & Exclusions* for details.	
Laboratory and X-Ray Services, (Independent, Radiologist, Pathologist) Other than Inpatient	100%; Deductible waived	60% after Deductible
Medical Supplies	80% after Deductible	60% after Deductible
	This Plan also covers certain services as preventive as listed in **IRS Notice 2019-45**, including, but not limited to, blood pressure monitors, glucometers, and peak flow meters. In accordance with IRS guidance, these services are only covered as preventive under the Plan when provided in conjunction with a diagnosis of certain specified conditions (see IRS Notice 2019-45). There may be coverage available for Medical Supplies under your pharmacy benefits. Please see your ID card for the Pharmacy Benefit Manager's contact information.	
Maternity Care Services		
Physician Global	80% after Deductible	60% after Deductible
Facility / Birthing Center *As any admission*	80% after Deductible	60% after Deductible
	Charges for the care and treatment of Pregnancy are covered the same as any other Illness for a covered Employee or covered Spouse. Charges for a Complication of Pregnancy are payable for the Pregnancy of a Dependent child. See Routine Wellness/Preventive Services for coverage of Prenatal Care with no cost-share for adult women, if billed independently. Maternity Care Services for Dependent daughters are limited to Prenatal Care with no cost-share as required by PPACA, if billed independently. Charges for labor, birth/delivery and post-delivery are not covered for Dependent daughters. See Routine Wellness/Preventive Services. See Defined Terms. NOTE: This benefit applies to OB-GYN office visits when the primary purpose of the visit is treating pregnancy. Other OB-GYN visits will be covered under the office visit benefit.	
Newborn Nursery *Physician / Facility*	80% after Deductible	60% after Deductible
	Routine newborn nursery and Physician care while the newborn is Hospital-confined typically includes room and board along with ancillary charges for the normal care of a newborn. Charges in these circumstances will be applied to the Plan of the newborn. Non-routine newborn nursery and Physician care will not be eligible for reimbursement under the Plan until the newborn is enrolled as a Dependent under the Plan enrollment provisions. Services related to non-routine newborn nursery will be paid under the Inpatient Hospital Service Benefit above.	

	For details about enrolling newborn children, please see “Enrollment Requirements for Newborn Children,” the Special Enrollment provisions, and “Open Enrollment,” all in the Enrollment section.	
Mental Health and Substance Use Disorder Services		
Inpatient	80% after Deductible	60% after Deductible
Outpatient Facility	80% after Deductible	60% after Deductible
Outpatient Physician	$15 Copay	60% after Deductible
	Psychiatrists (M.D.), psychologists (Ph.D.) or Masters of Social Work (M.S.W.) may bill the plan directly. Other licensed mental health practitioners may be asked to file claims under the direction of these professionals, depending on credentialing guidelines.	
Obesity, Non-Surgical Medical Treatment	As any Covered Medical Expense	As any Covered Medical Expense
	Medically Necessary non-surgical treatment of obesity is covered. This does not include any form of food supplement, exercise program, exercise equipment, weight control program, injection of any fluid, use of medications or educational program, if not otherwise covered.	
Orthotics	80% after Deductible	60% after Deductible
	Orthotics are covered for the initial purchase and fitting of an appliance designed for the support of weak or ineffective joints or muscles as a result of a disabling congenital condition or an Injury or Illness. Orthopedic foot appliances, including custom molded foot orthotics, may be covered when used as an integral part of a brace, applied tightly thereto, or when used to treat a condition requiring more than a supportive device of the foot. Shoe inserts are not considered orthotic devices by this Plan and are not covered.	
Prosthetics and Implants	80% after Deductible	60% after Deductible
	Benefit covers the initial purchase and fitting of a fitted artificial device to replace or augment a missing or impaired part of the body. However, prosthetics that are implanted as part of a surgical procedure will be covered under the surgery benefit (above). Repair and replacement of a device will not be made more than once every 5 years, unless it is determined Medically Necessary due to a pathological change, such as growth, shrinkage, or atrophy that results in improper fit. Replacements will not be made because the device is lost, misplaced, or stolen.	
Short-Term Rehabilitative Therapy *As any Specialist*	$40 Copay	60% after Deductible
	The Plan provides coverage for short-term rehabilitative therapy that is part of a rehabilitation program, including the therapies listed when provided in the most medically appropriate setting. See also Applied Behavioral Analysis (ABA) Therapy for Autism Spectrum Disorders (ASD) under Other Services in this Schedule of Benefits.	
Occupational	Occupational therapy is covered when performed by a licensed occupational therapist or a Physician working within the scope of his/her license. Therapy must be ordered by a Physician, result from an Injury or Illness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.	
Physical	Physical therapy is covered when performed by a licensed physical therapist or a Physician working within the scope of his/her license. The therapy must be in accord with a Physician’s exact orders as to type, frequency and duration and for conditions that are subject to significant improvement through short-term therapy.	
Speech	Speech therapy is covered when performed by a licensed speech therapist or a Physician working within the scope of his/her license; therapy must be ordered by a Physician: a) for speech disorders; b) following surgery for correction of a congenital condition of the oral cavity, throat or nasal complex; or c) to restore speech to a person who has lost existing speech function as a result of injury or an illness that is other than a learning or mental disorder.	
Skilled Nursing Facility	80% after In-Network Deductible	
	Benefits limited to Benefit Year maximum of 90 days. Benefits are payable if and when the patient is confined as a bed patient in the facility; the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and the attending Physician completes a treatment plan that includes a diagnosis, the proposed course of treatment and the	

<table>
<tr><td></td><td colspan="2">projected date of discharge from the Skilled Nursing Facility. Covered charges for a Plan Participant's care in these facilities are limited to the facility's semiprivate room rate.</td></tr>
<tr><td>Sleep Studies</td><td>80% after Deductible</td><td>60% after Deductible</td></tr>
<tr><td>Smoking Cessation</td><td colspan="2">100%; Deductible waived for Over-the-Counter
(prescriptions for smoking cessation covered under the drug card)</td></tr>
<tr><td>Telemedicine</td><td>As any other office visit</td><td>As any other office visit</td></tr>
<tr><td rowspan="4">Telemedicine Services – COVID-19 Public Health Emergency
other than Teladoc</td><td>As any Covered Medical Expense</td><td>As any Covered Medical Expense</td></tr>
<tr><td colspan="2">This benefit includes coverage of Covered Medical Expenses that are delivered by means of Telemedicine as identified on the Centers for Medicare and Medicaid Services (CMS).

*Note: This listing is currently available (as of April 28, 2020, updated February 13, 2023) at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. The Plan will also maintain a copy of this listing.</td></tr>
<tr><td colspan="2">80% after In-Network Deductible</td></tr>
<tr><td colspan="2">Benefits limited to Lifetime maximum of $1,500.
The Plan will cover Medically Necessary services for care and treatment of TMJ; includes Surgical and Non-Surgical.</td></tr>
<tr><td rowspan="3">Transplant Services</td><td>Approved / Designated Facility</td><td>Non-Approved / Non-Designated Facility</td></tr>
<tr><td>100%; Deductible waived</td><td>Not covered</td></tr>
<tr><td colspan="2">MedCost Health Management must be notified PRIOR to a Transplant evaluation.
All Transplant Services MUST be precertified and require participation in Case Management. Failure to precertify or participate in Case Management will result in the application of Health Management penalties. Refer to Health Management Services for details. Human organ and tissue transplants are covered except those classified as "Experimental and/or Investigational."

*Travel and lodging will be paid by the Plan for the patient and one companion or caregiver (for both parents or for both guardians if the patient is a minor), up to a Lifetime maximum of $10,000. Travel must be to a Designated Transplant Provider that is more than 60 miles from the patient's home.

Donor Charges:
Both the recipient and the donor are entitled to benefits of Transplant Service coverage under this Plan when the recipient is a Plan Participant. Benefits provided to the donor will be charged against the recipient's coverage.

The Plan will pay for typing, surgical procedure, mobilization, storage expenses, and other costs directly related to the donation of a human organ or human tissue used in a covered Transplant procedure.

If a Plan Participant wishes to be a donor, the Plan will cover donor charges only if the recipient is also a Plan Participant. Donor expenses for recipients who are not Plan Participants are not covered under this Plan.

Claim Steps:
• When a Plan Participant is the recipient of an organ from a non-Plan donor, eligible expenses should be filed using the Plan Participant's name and his or her alternate identification number.
• To help identify non-Plan donor claims billed under the Plan Participant recipient's information, the donor claim should include the following:
o Diagnosis that indicates donor;
o Attachment that indicates the patient is a donor; and
o Donor's information in the comments field of the UB-04 or other electronic claim.

*Exclusions:
*Charges for the following are not covered:</td></tr>
</table>

	• mileage for sightseeing or visits to friends / relatives; • alcohol; • clothing; • entertainment (i.e., movies or rentals, visits to museums, mileage for sightseeing, compact discs, games, etc.); • expenses for persons other than the patient and his/her covered companion or caregiver; • expenses for lodging when member or companion is staying with a relative or friend; • travel and non-medical room and board for a live donor or for family members of the donor; • gift cards; • groceries (i.e., grocery stores, Wal-Mart, K-Mart, etc.); • laundry service / supplies; • non-legible receipts (i.e., food or lodging); • paper products (i.e., paper plates, paper towels, napkins, etc.); • parking fees incurred other than at hotel / motel or Hospital; • personal care services (i.e., massage, spa, hair care services, etc.); • personal hygiene items (i.e., toothbrush, deodorant, etc.); • personal services (i.e., child care, house sitting, kennel care, etc.); • shoes / slippers; • souvenirs (i.e., T-shirts, sweatshirts, toys, etc.); • telephone bills / calls / phone cards; • tobacco or medical marijuana; and • valet parking.	
	In-Network	***Non-Network***
Vision Care	Routine Eye Exam - $10 Copay. Benefit limited to one exam in a Benefit Year. No Coverage Provided for Frames, Lenses or Contacts.	
	80% after In-Network Deductible	
	Following cancer treatment. Benefits limited to Lifetime maximum of one wig.	
Yoga up to 20 visits per year	$10 Copay	$10 Copay
All Other Covered Services	80% after Deductible	60% after Deductible
Additional Services Covered Under the Medical Benefits		
Anesthetics and other certain items including administration	Certain items including anesthetics; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions are covered, including the administration thereof.	

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Dental Services	Certain dental procedures are Covered Charges under Medical Benefits: • Removal of wisdom teeth; • If required to diagnose an Injury to jaw, month or face; • If the Injury did not result from chewing or biting; and • If treatment is given while the Plan Participant is covered for medical benefits under this Plan. • When medically necessary, replacement of teeth lost as a direct result of chemotherapy and/or radiation treatment No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures. Oral surgeons will be paid at the Network level of benefits. Covered Dental services include the repair of appliances damaged in the Accident that caused the Injury. If Dental services must be performed in a Hospital to safeguard against a medical condition (such as hemophilia) that might become life threatening, charges for the Medically Necessary Hospital services are covered. However, in no event will any charges for routine Dental services be covered under the Plan. For Employees with both Medical and Dental coverage, Oral Surgery and Removal of Wisdom Teeth shall be covered under the medical benefits. Oral Surgery and Removal of Wisdom Teeth shall be covered under Dental for Employees who have elected Dental Only coverage. Note: The Plan will pay for anesthesia and Hospital or facility charges for services performed in a Hospital or Ambulatory Surgical Center in connection with dental procedures for (1) Dependent Children under the age of 9 and (2) Plan Participants with physical or mental conditions for which such services are Medically Necessary. The Physician must certify that anesthesia is required to safely and effectively perform the procedures. Prior authorization is required.
Family Therapy / Counseling	Family Therapy / Counseling is considered an eligible expense when provided by a licensed mental health practitioner.
Genetic Testing	Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is considered Medically Necessary (and therefore covered) based on the diagnosis, provided: • a person has symptoms or signs of a genetically-linked inheritable disease or • the testing is performed as part of oncology treatment. Genetic testing requires documentation of Medical Necessity via medical records or a letter of Medical Necessity if: • it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome or • the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer reviewed, evidence-based, scientific literature to directly impact treatment options as outlined in the letter of Medical Necessity noted above. • in accordance with the guidelines and recommendations established under PPACA for preventive services for women with no cost-share. If genetic testing is determined to be Medically Necessary and meets the criteria outlined above, genetic counseling may be covered. Genetic counseling is limited to 3 visits per Benefit Year.
Prescription Drugs	Prescription Drugs are covered as defined in the *Defined Terms* section of this booklet. *Note:* Benefits payable for prescription drugs under Prescription Drug Benefits will not be provided under any other Plan provisions.

Reconstructive Surgery	Covered Charges are: • surgical correction of a congenital anomaly in a covered Dependent child; • treatment of an Accidental bodily Injury; and • reconstructive breast surgery following mastectomy. This mammoplasty coverage, in compliance with the *Women's Health and Cancer Rights Act of 1998*, will include reimbursement for: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (3) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.
Routine Costs Associated with a Clinical Trial	Includes charges for Routine Patient Costs incurred by a Qualified Individual in an Approved Clinical Trial subject to the terms of this Plan. The Plan may require a copy of the Approved Clinical Trial's patient consent packet before determining if any benefits are payable by the Plan (see Routine Patient Costs). Coverage is provided only for Routine Patient Costs of services associated with the Approved Clinical Trial, and only to the extent such Routine Patient Costs have not been, or are not, funded by other resources. See also Medical Benefit Exclusions and Defined Terms for more information regarding coverage of Routine Patient Costs associated with an Approved Clinical Trial.
Sterilization Procedures	Sterilization procedures are covered as any expense unless otherwise noted in the SPD. Reversal procedures are not covered.
Termination of Pregnancy	Termination of Pregnancy is covered, but only when Medically Necessary to save the life of the mother.

Prescription Drug Benefits

Prescription Drug cost-sharing accumulates toward the Plan's overall In-Network Out-of-Pocket Maximum.

Note: When a Plan Participant uses a pharmaceutical manufacturer's drug coupon to obtain Plan Participant's prescription drug medications, the amount of the coupon will not accumulate toward the Prescription Drug Out-of-Pocket Maximum.

	Retail Pharmacy *Copay covers up to a 30 day supply.*	***Mail Order*** *Copay covers up to a 90 day supply.*
Generic	$10 Copay	$20 Copay
Preferred Brand	$25 Copay	$50 Copay
Non-Preferred Brand	$50 Copay	$100 Copay
Mandatory Specialty Pharmacy	$150 Copay per 30 day supply	
Miscellaneous Notes	Certain Prescription Drugs must be purchased through the Plan's Specialty Pharmacy and will not be paid or reimbursed by the Plan if they are not procured through the Plan's Specialty Pharmacy. See Prescription Drug Benefits, Limitations and Exclusions for more information. Except as may be required by PPACA, a Plan Participant will be required to pay the brand name Copay plus the difference in cost between the brand name and generic if (a) he/she chooses brand name when a generic is available; or (b) when the Physician orders brand name dispensing on the prescription and a generic is available. Includes Mandatory Diabetic Supplies program with $5 Copay. The $5 Copay applies to diabetic supplies only if the Plan Participant has enrolled in the Mandatory Diabetic Supply program. Regular retail Copays apply until Plan Participant enrolls as required by the Plan. Includes immunizations for flu, pneumonia, and shingles at 100% with $0 Copay. Contraceptives: includes oral contraceptives, transdermal patches, and vaginal ring Smoking Cessation products covered with $0 Copay with prescription (excludes Over-the-Counter – see medical benefits) **Preventive medications** are included for certain prescribed over-the-counter products without cost-share as required by PPACA.	

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		Contact the drug card administrator listed on your ID card with questions or more information about drug availability or coverage of specialty drugs. Please visit the MedCost website at ***www.medcost.com*** for a link to more pharmacy information. See the Summary Plan Description for details of Plan provisions, definitions and exclusions.
DENTAL SCHEDULE OF BENEFITS Call (800) 795-1023 to verify eligibility and benefits before a charge is incurred.		
Lifetime Deductibles		
Deductible	Individual	$100
	Family	$200
The Benefit Year is January 1st through December 31st.		
Dental is separate election from the medical benefits.		
Class A – *Preventive*		100%; Deductible waived
Class B – *Basic*		80% (after Lifetime Deductible is met)
Class C – *Major*		50% (after Lifetime Deductible is met)
Benefit Year Maximum *per Covered Plan Participant for Class A, B and C combined* -$1,500		
Class D - *Orthodontia*		Excluded.
Please refer to remainder of Summary Plan Description (SPD) for further details on benefit provisions, definitions and exclusions.		

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GENERAL PROVISIONS

A Plan Participant may contact the Plan Administrator for additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements. The Plan Administrator is responsible for determining and providing Plan benefits, not the Third Party Administrator.

ELIGIBILITY

Eligibility Requirements for Employee Coverage
A person is eligible for Employee coverage from the first day that he or she:

1. is a full-time Employee of the Employer. An Employee is considered to be full-time if he or she:
   a. has a scheduled workweek of 30 hours or more or at least 24 hours on weekends only, and is on the regular payroll of the Employer for that work, or
   b. was deemed to be full-time during the Measurement Period, and therefore is eligible for Employee coverage during the entire Stability Period. *See also Defined Terms.*

2. is in a class eligible for coverage, and

3. completes the employment Waiting Period of 60 days of continuous, full-time employment with the Employer for Medical coverage or Medical & Dental coverage, or 90 days of continuous, full-time employment with the Employer for Dental only coverage. A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

Effective Date of Employee Coverage
An Employee will be covered under this Plan as of first day that immediately follows his/her satisfaction of the following:
- The Eligibility Requirement.
- The Enrollment Requirements of the Plan.

Eligible Classes of Dependents
A Dependent's coverage will be effective on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

A Dependent is any one of the following persons:

1. A covered Employee's Spouse
The term “Spouse” shall mean the person of the opposite gender recognized as the Employee’s husband or wife under the laws of the state where the Employee lives. (The Employer may require documentation proving a legal marital relationship.)

A working Spouse who is eligible (whether or not enrolled) for other employer based health care benefits that are deemed to provide “Minimum Value”* as defined by the Patient Protection and Affordable Care Act (PPACA), is not eligible for coverage through the Maryfield, Inc. dba Pennybyrn Group Health and Welfare Plan and is not permitted to enroll for such coverage.

Maryfield, Inc. dba Pennybyrn requires written confirmation from such Spouse’s employer that his or her employer’s plan does not provide “Minimum m Value” coverage as defined by PPACA in order for the Spouse to enroll in the Maryfield, Inc. dba Pennybyrn Plan. It is the responsibility of the Employee to inform Human Resources immediately in the event of any change in his or her Spouse’s work status.

Should it be discovered that such working Spouse fraudulently enrolled for coverage or failed to immediately notify Human Resources of his or her employer’s plan providing “Minimum Value” coverage as defined by PPACA, the Employer retains the right, in its discretion, to provide remedial action to the Plan, including, but not limited to, reversing payment of any claims paid erroneously, revoking such Spouse’s coverage and / or terminating coverage of the Employee, the Spouse and any other covered dependents.

*“Minimum Value” is defined by PPACA at the following website: ***https://www.healthcare.gov/coverage/preventive-care-benefits/***

Note: The Plan does not offer coverage to a domestic partner or a common-law spouse, even if the state in which the Employee lives recognizes such a partnership.

2. Children from birth to the limiting age of 26 years

Dependent children under the age of 26 are eligible for coverage without regard to student status, marital status, primary residence status, tax dependent status or the amount of financial support from the parent.

If both parents of the eligible Dependent child have employer sponsored coverage, the Dependent child may enroll in either plan. Neither plan can deny enrollment.

Coverage will end at the end of the month during which the Dependent child's 26th birthday occurs, or in the event of the covered Employee's termination and refusal of, or loss of, COBRA continuation, whichever occurs first.

The term "children" shall include:

- Natural children.
- Adopted children, or children placed with a covered Employee in anticipation of adoption.
- Foster children.
- Step-children, as long as a natural parent remains married to the Employee and the natural parent resides in the Employee's household.
- A child for whom the covered Employee has legal guardianship and who lives with the covered Employee in a regular parent/child relationship. A parent/child relationship does not exist if either parent of the child also lives in the covered Employee's home.

A "child placed with a covered Employee in anticipation of adoption" refers to a child who the Employee intends to adopt (whether or not the adoption has become final) and who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

A **Qualified Medical Child Support Order** (QMCSO) means any judgment, decree or order (including approval or settlement agreement) issued by a court of competent jurisdiction. A QMCSO is a court order that creates or recognizes the right of a covered person's child (called an alternate recipient in the law) to receive benefits under the Plan. To be considered a QMCSO, the medical child support order must clearly specify the following information:

- the name and last known mailing address of the covered person and the name and mailing address of each child covered by the order;
- a reasonable description of the type of coverage to be provided by the Plan for each such child, or the manner in which the type of coverage is to be determined;
- the period to which the order applies; and
- each plan to which the order applies.

The Plan Sponsor and Plan Administrator is responsible for establishing reasonable, written procedures for determining if the court order is a QMCSO. The Plan Sponsor and Plan Administrator must notify the Covered Person and the child that a court order has been received and within a reasonable time inform the Covered Person and the child whether or not the court order is a QMCSO. If the court order is determined to be a QMCSO, the child is an alternate recipient and considered a beneficiary under the Plan. Reimbursement of benefit payments under the Plan pursuant to a QMCSO may be made to the child, the child's custodial parent or other designated representative, or if benefits are assigned, to the provider of care.

The court order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan. If a state has paid for medical services for the child under Medicaid for which the Plan was liable, the state may seek to recover those amounts paid from the Plan.

3. A covered Dependent child who is mentally or physically handicapped

Under the Limiting Age

If a covered child is mentally or physically handicapped before reaching the limiting age for an eligible Dependent, his or her coverage will be continued if it would otherwise end due to attainment of the limiting age.

After Reaching Limiting Age

The child's coverage will be continued after reaching the limiting age as long as: (a) he or she remains handicapped; (b) he or she remains unmarried and chiefly dependent on the covered Employee for support; (c) the covered

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Employee remains covered under the Plan; (d) the part of the Plan providing his or her coverage remains in force; and (e) the covered Employee continues to pay any part of the cost required for the child's coverage.

The covered Employee must provide proof of the child's handicap and dependence within 30 days of the date the child would otherwise no longer qualify as an eligible Dependent. The Plan will require proof of the child's continuing handicap and dependence. Proof will not be required more than once a year. Coverage for the child will end immediately if the proof is not satisfactory.

Eligibility Requirements for Dependent Coverage
A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

These persons are excluded as Dependents:
- other individuals living in the covered Employee's home, but who are not eligible as defined;
- the legally separated Spouse of the Employee under the laws of the state where the covered Employee lives;
- the divorced former Spouse of the covered Employee;
- any Spouse who is on active duty in any military service of any country; or
- any person who is covered under the Plan as an Employee.

If a person covered under 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 Deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

FUNDING
Cost of the Plan: Maryfield, Inc. dba Pennybyrn shares the cost of Employee and Dependent coverage under this Plan with the covered Employees.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

Effective October 1, 2013, Medical and Dental: Employees contribute toward the cost of coverage under the Plan through payroll deductions. Premium contributions for health coverage are allowed on a pre-tax basis in conjunction with a Section 125 plan offered by the Company. Section 125 plan elections are binding for one year unless a change recognized by the Section 125 plan occurs. Note that the option to drop coverage and thereby decrease premium contributions at a time other than the scheduled Section 125 plan enrollment period may be limited to a change recognized by the Company's Section 125 plan. Contact the Company's Human Resources Department for additional information.

Effective October 1, 2013, Dental Note: The Employer pays for all Employee Only Dental coverage. The Employer also pays for all of Family Dental coverage as long as the Employee also has Family Medical coverage. However, if the Employee does NOT have Family Medical coverage but elects to have Family Dental coverage, the Employee must pay for Dental coverage.

ENROLLMENT

Enrollment Requirements
If coverage is desired, an Employee must enroll for coverage by filling out and signing an enrollment application. If the Employee wants coverage for his/her Dependent(s), he/she is required to enroll for Dependent coverage also. The completed enrollment form must be received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

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Enrollment Requirements for Newborn Children
A newborn child of a Covered Employee is not automatically enrolled in this Plan. For coverage to begin at birth, the child must be enrolled in the Plan within 30 days following its birth. This means an enrollment form on behalf of the newborn is required to be completed to ensure accurate information and timely claims payments, and must be received by Human Resources within 30 days following the birth of the child. If the newborn child is not enrolled in this Plan within 30 days following its birth, there will be no payment from the Plan for expenses of the newborn and the covered Employee will be responsible for all expenses of the newborn. Such a newborn child will be permitted to be enrolled in the Plan in accordance with the Special Enrollment provisions with coverage effective as of the date of birth, or, the next Open Enrollment.

Special Enrollment Rights
Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including his spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days after the birth, marriage, adoption or placement for adoption.

The Plan will give Employees and/or Dependents who are eligible but not enrolled for coverage under the Plan the opportunity to enroll when the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage terminates as a result of loss of eligibility. Coverage under this Plan must be requested within 60 days after the loss of Medicaid or CHIP.

Effective May 1, 2010, the Plan will give Employees and/or Dependents who are eligible but not enrolled for coverage under the Plan the opportunity to enroll when the Employee and / or Dependent is determined to be eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP). Coverage under this Plan must be requested within 60 days of being determined to be eligible for the premium assistance.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more information, contact the Plan Administrator, Maryfield, Inc. dba Pennybyrn 1315 Greensboro Road, High Point, North Carolina 27260, 336-886-2444.

Special Enrollment Periods
Special enrollment periods are allowed due to certain losses of other coverage and changes in family status. A special enrollment period is allowed due to loss of other coverage if you:
- declined coverage when you first became eligible for it;
- stated in writing that coverage was declined due to the existence of other coverage;
- have now lost the other coverage; and
- request enrollment within 30 days after losing the other coverage (other than Medicaid or CHIP); or
- request enrollment within 60 days after losing eligibility for Medicaid or CHIP.

A special enrollment period is allowed due to a change in family status if you are an eligible Employee who has gained a Dependent through marriage, birth, adoption, or placement for adoption. In this situation, the special enrollment period is allowed for you and your eligible Dependents. The special enrollment period will be 30 days beginning on the date you gain at least one eligible Dependent for one of the reasons listed.

"Other coverage" for the purposes of determining if a special enrollment period will be allowed is defined as:
- group health coverage which ended because the employer ceased paying the contribution for it;
- group health coverage that ended due to a loss of eligibility caused by legal separation, divorce, death, termination of employment, or reduction in work hours;
- COBRA continuation coverage that has been exhausted; or
- non-employer provided coverage, including, but not limited to, student health insurance plans and individual policies, including on the health insurance Marketplace.

For persons enrolled during a special enrollment period due to a change in family status, coverage will begin:
- on the date of marriage, if the special enrollment period is due to marriage;
- on the new Dependent's date of birth, if the special enrollment period is due to the birth of a child;

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- on the date the new Dependent is adopted or placed for adoption if the special enrollment period is due to adoption or placement for adoption.

A special enrollment period is allowed due to a court or administrative order if the order requires a parent to provide health benefit plan coverage for a child, and the parent is eligible for Dependent coverage under the Plan.

If the eligible parent fails to enroll the child, he or she may be enrolled by the other parent, the Plan Administrator or a state child support enforcement agency of the state in which the child resides. Dependent coverage for the child will begin on the date he or she is enrolled under the terms of the order; or on the date specified in the order, if later.
Note: If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

Open Enrollment
During the Plan's annual Open Enrollment period, covered Employees will be able to change some of their benefit decisions based on which benefits and coverages are right for them and their Dependents, if any.

During the Plan's annual Open Enrollment period, an Employee will be able to enroll in the Plan.

In no event will any Employee be allowed to enroll for coverage under the Plan during the Open Enrollment period unless he or she has completed all of the Eligibility Requirements as set out on a previous page.

Benefit choices made during the Open Enrollment period will become effective October 1st and remain in effect and are binding until the next following October 1st unless a person experiences an event that qualified as a Special Enrollment event under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or an event that allows the person to change his or her election under a Section 125 plan (if the Employer offers a Section 125 plan).

A Plan Participant who fails to make an election during Open Enrollment will automatically retain his or her present coverage.

Plan Participants will receive detailed information regarding Open Enrollment from the Plan Sponsor.

TERMINATION OF COVERAGE

Termination of Employee Coverage
Employee coverage will end automatically upon the earliest of the following dates*:
- The date the Plan is terminated.
- The date the covered Employee ceases to be eligible for coverage under this Plan;
- The date the covered Employee retires or dies;
- The end of the period the covered Employee fails to make any required contribution for coverage;

*In certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. See the section *COVERAGE CONTINUATION RIGHTS UNDER COBRA.*

Employer-Certified Leave of Absence / Layoff / Disability
If a covered Employee is laid off, is disabled or takes an approved non-FMLA leave of absence, coverage can be continued under the Plan for up to 3 months, provided the required premiums are paid and the Plan does not terminate during this period. While continued, coverage will be that which was in force on the last day worked as an Eligible Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

The Plan reserves the right to choose a different plan for continuing coverage; however, any such plan will not be discriminatory.

Continuation during Family and Medical Leave (FMLA)
Regardless of the established leave policies mentioned above, if the Employer is subject to FMLA regulations, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

The following is a brief description of the main provisions of the Family and Medical Leave Act of 1993. It does not detail every provision of the Act. Employees should contact their Human Resources Department or the Plan

Administrator for additional information or a copy of the Company's written policy regarding compliance with the Family and Medical Leave Act.

The Act provides that a covered Employee may continue his or her coverage under the Plan for a maximum of 12 weeks during a qualified leave of absence, which includes any of the following:

- The birth of a child, or placement of a child for adoption or foster care;
- To care for a spouse, child, or parent with a serious health condition;
- As a medical leave when the Employee is unable to work due to a serious medical condition; or
- Any qualifying exigency (i.e., emergency or necessity) arising out of the fact that the Employee's spouse, son daughter or parent is a military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

Additionally, the Act provides that a covered Employee may continue his or her coverage under the Plan for a maximum of 26 weeks in a single 12-month period during a leave of absence to care for a service member with a serious injury or illness incurred in the line of duty. The covered Employee must be a spouse, son, daughter, parent or next of kin of the injured or ill service member.

To be eligible, the covered Employee must have been employed with the Company for at least 12 months, must have worked at least 1250 hours during the 12 months preceding the leave, and must be employed at a worksite where 50 or more employees are employed within 75 miles of that worksite*. The 12 months an Employee must have been employed do not have to be consecutive. Whether an Employee has worked at least 1250 hours during the preceding 12 months must be determined as of the date the leave is to begin.

(Employees who are exempt from the Fair Labor Standards Acts' minimum wage and overtime requirements, and who have been employed for at least 12 months are presumed to have met their 1250-hour eligibility.)

During an FMLA qualified leave of absence, the Employee's benefits under the Plan may continue as if he or she was actively at work. The Employee must continue to pay any part of the cost he or she was required to pay before the leave began.

Note: The Employer makes the determination as to whether the Company is subject to FMLA regulations, and whether or not the Employee meets the eligibility requirements for leave under FMLA. Employees should contact their Human Resources Department with questions related to FMLA.

Employees on Military Leave (USERRA)

1. In any case in which an Employee has coverage under the Plan, and such Employee is absent from such position of employment by reason of service in the uniformed services, the Employee may elect to continue coverage under the Plan as provided in this section. The maximum period of coverage of the Employee and the Employee's Dependents under such an election shall be the lesser of:
   a. The 24 month period beginning on the date on which the Employee's absence begins; or
   b. The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under the *UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (USERRA).*

2. An Employee who elects to continue Plan coverage under this section must pay 102% of his or her normal premium under the Plan. Except that, in the case of an Employee who performs service in the uniformed services for less than 30 days, such Employee will pay his or her normal contribution for the 30 days.

3. An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Plan upon re-employment. Except as provided in paragraph #4 below, upon re-employment and reinstatement of coverage no new exclusion or waiting period will be imposed in connection with the reinstatement of such coverage if an exclusion or waiting period would normally have been imposed. This paragraph applies to the Employee who is re-employed and to an individual who is covered by the Plan by reason of the reinstatement of the coverage of such Employee.

4. Paragraph #3 shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

Rehiring a Terminated Employee

A previously covered Employee who terminates coverage and whose eligibility is reinstated within 13 weeks of his or

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her termination date will not be required to satisfy the Employer's Waiting Period, if any. All other previously covered Employees who are reinstated will be treated as new hires and will be required to satisfy all eligibility and enrollment requirements. An Employee returning to work directly from COBRA coverage will not be required to satisfy the Employer's Waiting Period, if any. Refer to the Human Resources Department regarding any questions about rehire provisions.

Termination of Dependent Coverage

Dependent coverage will end automatically upon the earliest of the following dates*:

- The date the Plan is terminated.
- The date that the Employee's coverage under the Plan terminates for any reason including death.
- The date a covered Spouse loses coverage due to loss of dependency status.
- With respect to a covered dependent Spouse, the date the covered Spouse becomes eligible for coverage under any other group plan, regardless of whether coverage is elected under such other group plan.
- The end of the month during which the Dependent child's 26th birthday occurs.
- The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- With respect to a child required to be covered under the terms of a court or administrative order, the earlier of the date the order is no longer in effect, or the date the child becomes covered under another comparable plan of health benefits.

*In certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. See the section *COVERAGE CONTINUATION RIGHTS UNDER COBRA.*

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HEALTH MANAGEMENT SERVICES
Provided by MedCost Health Management

The patient or family member or attending Physician must call **800-795-1023** to receive precertification for the Health Management Services described below. **If precertification is not received, eligible expenses may be reduced.**

>>> PRECERTIFICATION IS NOT A GUARANTEE OF COVERAGE OR PAYMENT <<<

MedCost Health Management is designed ONLY to determine whether or not a proposed course of treatment is Medically Necessary and appropriate. Benefits under this Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions.

The Health Management Services include:

- Utilization Review
  - Precertification
  - Concurrent Review
  - Discharge Planning
- Outpatient Review
- Case Management
- Personal Care Management

Utilization Review
Utilization Review is a set of formal methods designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, providers or facilities. All medical benefits are subject to Utilization Review.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

Precertification
The following services must be precertified before medical and/or surgical services are provided:

- Hospital Admissions and / or Residential Treatment
- Transplant Services
- Hospital Observation Unit stays of more than 48 hours
- Certain diagnostic services rendered as outpatient or in Physician's office – See *Outpatient Review*
- Dialysis Services
- Intensive Outpatient and Partial Hospitalization
- Non-Emergent Air Ambulance

Maternity Note: The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. Under Federal law, group health plans and health insurance issuers 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 or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also under Federal law, plans and issuers 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, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Precertification for non-emergency admissions should be requested **at least 48 hours** before the service is provided. You should call MedCost Health Management at 800-795-1023 with the following information:

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- The name of the patient and relationship to the covered Employee;
- The name, patient identification number and address of the covered Employee;
- The name and group number of the Employer;
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay;
- The name and telephone number of the attending Physician;
- The diagnosis and/or type of surgery; and
- The proposed rendering of listed medical services.

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the MedCost Health Management within **72 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of confinement or use of other listed medical services appropriate for care. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Plan Participant does not received precertification for Hospital admissions or Residential Treatment, Room and Board charges for non-precertified days will be denied by the Plan.

If the Plan Participant does not receive precertification for Intensive Outpatient or Partial Hospitalization, non-precertified days / visits will be denied by the Plan.

In addition, for a Hospital confinement for which precertification is requested but has been determined to not be Medically Necessary, room and board will not be payable. Expenses for other covered services provided during the Hospital confinement (including x-ray and laboratory services, etc.) will be considered in accordance with applicable Plan provisions.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

Concurrent Review
After admission to the Medical Care facility, the utilization review administrator will monitor the Plan Participant's Medical Care Facility stay or use of other medical services, and coordinate with the attending Physician, Medical Care Facilities and Plan Participant.

Discharge Planning
If the attending Physician feels that it is Medically Necessary for a Plan Participant to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

If the Plan Participant does not receive authorization for additional inpatient days for a Hospital admission or Residential Treatment confinement, Room and Board charges for non-precertified days will be denied by the Plan.

In addition, for a Hospital confinement for which precertification is requested but has been determined to not be Medically Necessary, room and board will not be payable. Expenses for other covered services provided during the Hospital confinement (including x-ray and laboratory services, etc.) will be considered in accordance with applicable Plan provisions.

Please remember that precertification does not guarantee coverage or payment. Contact MedCost Benefit Services **Customer Service at 800-795-1023 to verify your eligibility and benefits.**

Outpatient Review
Outpatient Review concentrates on services that are costly or highly utilized. *Precertification is **required** for the following diagnostic procedures:

- **CT scan** performed as an Outpatient or in a Physician’s office
- **MRI** performed as an Outpatient or in a Physician’s office
- **PET** scan performed as an Outpatient or in a Physician’s office

*Services performed in emergent situations (to rule out need for surgery or urgent treatment) are not subject to the requirement for Outpatient Review / Precertification.

Precertification for these services should be requested **at least 48 hours** before the service is provided. You should call MedCost Health Management at 800-795-1023 with the following information:

- The name of the patient and relationship to the covered Employee
- The name, patient identification number and address of the covered Employee
- The name and address of the covered Employee
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of service to be provided
- The proposed rendering of listed medical services

If the Plan Participant does not receive precertification for these services, expenses will be denied due to lack of Medical Necessity.

Please remember that precertification does not guarantee coverage or payment. Contact MedCost Benefit Services Customer Service at 800-795-1023 to verify your eligibility and benefits.

Case Management

Life-altering injuries, illnesses and diagnoses need specialized care. MedCost has individualized intervention and care for those navigating severe health conditions. The goal of Case Management is to promote improved quality of life outcomes while ensuring the best use of available resources. Experienced and specialized registered nurses work with patients, caregivers and physicians to complement a doctor's prescribed plan of care by providing services such as patient advocacy, navigation assistance, early intervention, care coordination and resource management. Clinical pharmacists review specialty medication use and identify alternative treatment plans that are shared with the patient and clinical care team.

Sometimes, treatment that may not otherwise be covered by the Plan may be recommended as 'alternative treatment'. The Plan will provide benefits for alternative treatment that is approved and agreed upon by the Plan, the Covered Person and the Covered Person's doctor, if it is determined that such alternative treatment is Medically Necessary and cost effective. An example of alternative treatment is Home Health Care or Skilled Nursing beyond Plan limits. Providing benefits for alternative treatment in one situation does not require the Plan to provide similar benefits in another. This provision is not a waiver of the Plan's right to administer the Plan in strict accordance with its terms.

A case manager consults with the patient, the Family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. 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, Rehabilitation or Skilled Nursing Facility confinements;
- determining alternative care options; and,
- assisting in obtaining any necessary equipment and services.

This Plan has added a Behavioral Health Solution program as a component of Case Management, and has partnered with Carolina Behavioral Health Alliance (CBHA) to assist those Plan Participants receiving services through the Plan's Mental Disorders and Substance Use Disorders benefit with additional information, support and care.

The case manager will coordinate and implement the Case Management programs by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician and patient or authorized patient representative must all agree to the alternate treatment plan.

Once agreement has been reached, 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.

Note: **You will be contacted by the MedCost Case Management program if you are identified as a potential participant for Case Management. Case Management is subject to a non-participation penalty of $2,500. Non-participation with Case Management will result in a reduction of your medical benefits for all services up to a**

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maximum of $2,500. Preventive / Wellness Services and Emergency Services received in an Emergency Room are not subject to the Case Management penalty. See also Transplant Services and Dialysis Services in the Schedule of Benefits.

Personal Care Management
Personal Care Management (PCM) is individualized care designed to help create positive outcomes for those who are suffering from chronic conditions. Our nurse coaches use one-to-one collaborative conversation with targeted interventions to strengthen a person's own motivation and commitment to change. Our nurses partner with individuals to ensure their conditions are well managed and do not progress to a more serious level.

Potential participants are identified through Claims and pharmacy data, as well as internal referrals. Participation in Personal Care Management is a required part of the Maryfield, Inc. dba Pennybyrn Wellness Program for covered Employees. Refer to the aforementioned Wellness Program in the Schedule of Benefits or contact Human Resources for details.

Participation in PCM is voluntary for covered Dependents - there are no penalties or reductions of benefits for not participating. If you are contacted by a MedCost nurse mentor we hope you will choose to take advantage of this program that will help you achieve a healthier lifestyle.

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COVERAGE OF MEDICAL EXPENSES

Network Provider Plan
This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.
Therefore, when a Plan Participant uses a Network Provider, he/she will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Plan Participant's choice as to which Provider to use.

Under the following circumstances, the In-Network cost-sharing will be applied for certain Non-Network* services:

- If a Plan Participant has no choice of Network Providers in the specialty that the Plan Participant is seeking within the Network service area.
- If a Plan Participant has a Medical Emergency requiring immediate care and receives out-of-network Emergency Services;
- If a Plan Participant receives the services of a Non-Network Provider in a Network facility, and, with respect to Non-Ancillary Services only, the Plan Participant does not waive the protections against surprise medical bills;
- If a Plan Participant receives Non-Network services and the provider has accepted a negotiated discount arranged either through MedCost or through a third party contracted by MedCost and/or MedCost Benefit Services; and
- if a Plan Participant receives Air Ambulance Services from a Non-Network Provider.

For additional information, please refer to the discussion of Protections Against Surprise Medical Bills later in this section.

A list of Network Providers can be found at ***www.medcost.com.***

**Expenses incurred for treatment and services provided by Legacy Therapy on or after December 1, 2009 will be paid at the Network level of benefits. Legacy Therapy is located at 3001 Spring Forest Road, Raleigh, NC 27616.*

Transition of Care
To ensure quality and continuity of care, if a Plan Participant's provider is not, or ceases to be, a Network Provider for reasons other than quality-related reasons, fraud, or failure to adhere to Network Provider policies and procedures, or a provider ceases to be a Network Provider due to a change in the network utilized by the Plan, coverage may continue for a period of 90 days for treatment in progress for a Plan Participant who is:

- in her second or third trimester of Pregnancy; or
- receiving care for end-stage renal disease and dialysis; or
- receiving outpatient mental health treatment; or
- terminally ill, with anticipated life expectancy of six months or less; or
- undergoing an active course of treatment for which changing to a different provider would be likely to cause significant risk of harm to the Plan Participant's health; or
- undergoing chemotherapy or radiation therapy for treatment of cancer; or
- a candidate for a solid organ or bone marrow transplant.

Contact *mbsmedreview@medcost.com* to request continuation of care with a Non-Network Provider as outlined above. Your written request must be received by MedCost Benefit Services within 60 days of the provider's termination date, or the date the provider is no longer accessible as a Network Provider. If your request is approved, Covered Medical Expenses incurred in connection with care provided will be subject to the same Copays, Deductibles, coinsurance and limitations as when given by a Network Provider.

Deductibles / Copays
A Deductible is an amount of money that is paid once a Benefit Year per Plan Participant. Typically, there is one Deductible amount per Plan Participant and it must be paid before any money is paid by the Plan for any Covered Charges that are subject to the Deductible.

Each January 1st, a new Deductible amount is required. However, Covered Charges incurred in, and applied toward the Deductible in October, November and December will be applied to the Deductible in the next Benefit Year as well as the current Benefit Year. Deductibles accumulate toward the Out-Of-Pocket Maximum.

A Copay is a fixed amount of money that is paid each time a particular service is used. Typically, there may be Copays on some services and other services will not have any Copays. Copays accumulate toward the Out-Of-Pocket Maximum.

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A combination of the Network and Non-Network Deductible amounts will never exceed the Non-Network Deductible amount.

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

Out-of-Pocket Maximums

The Out-of-Pocket Maximum stated in the Schedule of Benefits is the maximum amount a Plan Participant will pay out of pocket for covered medical expenses in a Plan Year. This amount caps the Plan Participant's coinsurance percentage (for example, 20%). For the rest of that year, the Plan will pay 100% of certain allowable expenses exceeding the outlined amount.

The Out-of-Pocket Maximum includes Copays, Coinsurance, and Deductibles, and excludes non-covered services, premiums, and any applicable penalties.

Covered Medical Expense
The term Covered Medical Expense means an expense~~s~~ incurred for Covered Charges, but only if the expense is incurred while you and / or your Dependent(s) are covered by this Plan, and only to the extent that the services or supplies provided are recommended by a Physician and are Medically Necessary care and treatment of an Injury or Illness.

Covered Medical Expense includes expenses filed in accordance with coding guidelines as defined by the current Uniform Billing Code, Centers for Medicare and Medicaid, ICD-9 (or its successors), and CPT-4. This includes coding according to the American Medical Association's (AMA's) guidelines that state the code(s) reported / billed "accurately identifies the service performed." The term Covered Medical Expense also requires compliance with the HIPAA standardized code sets and thus only considers valid and current ICD-9 (or its successors), CPT-4, and HCPCS codes with their appropriate modifiers for adjudication. Inclusion or exclusion of a procedure in, or from, one of the aforementioned sets of coding guidelines does not imply any coverage or entitlement to reimbursement.

Covered Medical Expense includes professional fees incurred when a professional service has specifically been provided to a Covered Person. A claim filed for a professional fee for a computer generated report is not a Covered Medical Expense.

The term Covered Medical Expense does not include charges billed according to inappropriate billing practices, including, but not limited to, billing for undocumented services, billing for services not rendered, unbundling, up-coding or balance billing. Such services should not be billed to the patient. Charges that are not coded in compliance with industry standards will not be deemed Covered Medical Expenses.

All charges are subject to Usual, Customary and Reasonable (UCR) determination. To determine UCR, the Claims Administrator shall consider the following factors:

- the provider's "Usual" charges comprised of the fees that an individual provider most frequently charges for a specific type of treatment or service; and
- the "Customary" charges, based on one or more of the following:
  - statistically credible health care services data (updated no less than quarterly); or
  - a Preferred Provider (PPO) fee schedule; or
  - Medicare-based reimbursement; and
- the "Reasonable" charges, based on consideration of:
  - charges based on a negotiated discount arrangement with the provider at issue for the charges in question; or:
  - for Non-Network charges, each of the following:
    - the complexity or severity of the treatment or service at issue; and
    - the level of skill and experience involved in delivery of the treatment or service; and
    - the value of the treatment or service compared to other treatments or services.

Charges that are not coded in compliance with industry standards are presumed to be unreasonable.

Charges will be considered in excess of UCR if they exceed any of these three factors (Usual, Customary and Reasonable). Charges in excess of UCR will not be considered Covered Medical Expenses. When charges are in excess of UCR, you may incur costs associated with charges that exceed Usual, Customary and Reasonable charges.

In accordance with the No Surprises Act, the UCR amount for certain services provided by Non-Network Providers will be based on the lesser of the billed amount or the Qualifying Payment Amount (see Protections Against Surprise Medical Bills below).

Protections Against Surprise Medical Bills

Beginning January 1, 2022, Plan Participants are protected from certain surprise medical bills through a federal law known as the "No Surprises Act." These protections apply in each of the following situations:

- The Participant receives Emergency Services from a Non-Network Provider.
- The Participant receives Ancillary Services from a Non-Network Provider in a Network facility.
- The Participant receives Non-Ancillary Services from a Non-Network Provider in a Network facility and the Participant does not waive the surprise medical bill protections in accordance with the requirements of the law. The protections may only be waived in limited situations. In general, to waive the protections, the Non-Network Provider must give the Participant timely written notice and the Participant must consent in writing to receive services from the Non-Network Provider. If the Plan Participant waives the surprise medical bill protections, the Plan must be given a copy of this written notice and signed consent.
- The Participant receives Air Ambulance Services from a Non-Network Provider.

In each of these situations, the Plan Participant must pay the In-Network Benefit Level (even though services are received out-of-network), and the UCR amount (meaning the amount used to determine the Participant's cost-sharing) will be calculated based on the lesser of the billed amount or the Qualifying Payment Amount. In addition, amounts paid by the Plan Participant will count towards the in-network deductible and in-network out-of-pocket maximum.

In each situation where the surprise medical bill protections apply, the Plan Participant may not be balance billed by the Non-Network Provider or Non-Network Facility for amounts that exceed the UCR amount. The amount paid by the Plan to the provider or facility will be determined in accordance with the requirements of the No Surprises Act.

If you believe that you have been wrongly billed by a provider or facility for items or services which are protected under the No Surprises Act, you should contact 1-800-985-3059 or visit the HHS No Surprises website at www.cms.gov/nosurprises/consumers.

For additional information regarding surprise medical bill protections, refer to the notice which is provided at the end of this summary plan description.

Balance Billing
In the event 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 Plan Participant 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. However, balance billing is legal in many jurisdictions, and the Plan has no control over Non-Network providers that engage in balance billing practices.

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 Plan Participant 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 not 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 Plan Participant is responsible for any applicable payment of coinsurance, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Medical Record Review
The Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a Clean 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.

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The analysis will be employed to identify charges billed in error and/or charges that are not Usual, Customary, and Reasonable and/or Medically Necessary, if any, 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 Usual, Customary, and Reasonable amounts or other applicable provisions, as outlined in this SPD.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual, Customary, and Reasonable charge, in accordance with the terms of this SPD.

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MEDICAL BENEFIT EXCLUSIONS

Charges for the following **are not covered**:

Acupressure, biofeedback, hypnotherapy, massage therapy.

Administrative costs for completing claim forms or reports; for providing medical records requested by the Plan; postage, shipping and handling charges; interest or financing charges; telephone calls, conferences; consultations. This exclusion does not apply to the Telemedicine benefit.

Ambulance Services. Ambulance services for non-emergency travel, including but not limited to, home to routine Outpatient medical treatment, Physician visits, physical therapy or chemotherapy, or travel that is not Medically Necessary.

Appointments. Charges for broken or missed appointments.

Chelation therapy except as Medically Necessary for the treatment of heavy metal poisoning.

Claims. Claims submitted more than twelve (12) months after the date of service.

Complications arising from non-covered services or treatment. No benefits are payable for any care, treatment, services or supplies, whether or not prescribed by a Physician, for complications from a non-covered condition. (Complications from a non-covered abortion are covered. Complications of Pregnancy for a covered Dependent daughter are covered.)

Cosmetic surgery (elective) or other services and supplies that improve, alter or enhance appearance, whether or not for psychological reasons.

Custodial care. Services and supplies, including confinement, that are provided to an individual primarily to assist with his/her daily living activities. Custodial care includes assisting in activities of daily living such as walking, getting in and out of bed, bathing, dressing, eating and taking medications. This Exclusion does not apply to a formal Hospice care program.

The Plan will not pay for Hospital care, nursing home or Skilled Nursing facility care, home care, or a school or other institution for behavior and/or developmental modification or care, or any other service that is custodial in nature.

Dental care. The Plan does not pay for dental treatment, including orthodontia, except as specifically provided under *the Schedule of Benefits.*

Educational or vocational testing. Services for educational or vocational testing or training. This Exclusion does not apply to diabetic self-management programs for training for the use of diabetic supplies. *See also Learning Disorders / Developmental Testing.*

Excess charges. The part of an expense for care and treatment of an Injury or Illness that is in excess of the Usual and Reasonable Charge.

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

Experimental, Investigational or not Medically Necessary. Experimental or Investigational or not Medically Necessary means any supply, medicine, facility, equipment, service, or treatment that is not currently or at the time the charges were incurred recognized as an acceptable, safe, effective, and necessary medical practice for the medical condition for which the supply, medicine, facility, equipment, service, or treatment was provided or is proposed.

This exclusion may not apply when a patient is receiving treatment that follows published protocol of an Approved Clinical Trial and has satisfied the patient selection criteria, although the patient is not enrolled in the Approved Clinical Trial. To be considered a covered expense by the Plan, the treatment must be supported by clinical evidence with reasonable expectation that the treatment will improve the patient's medical condition and prognosis.*

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This exclusion may not apply when a patient is receiving treatment that follows published protocol of an Approved Clinical Trial and has satisfied the patient selection criteria. To be considered a covered expense by the Plan, the treatment must be supported by clinical evidence with reasonable expectation that the treatment will improve the patient's medical condition and prognosis. * See also Schedule of Benefits and Defined Terms for more information regarding coverage of Routine Patient Costs associated with an Approved Clinical Trial.

*For the purposes of determining if the "Experimental, Investigational or not Medically Necessary" exclusion shall not apply due to the clinical evidence providing a reasonable expectation that the treatment will improve the patient's medical condition and prognosis, such reasonable expectation shall be determined solely by the Plan. The Plan reserves the right to utilize resources qualified to assist in such determinations as warranted.

This exclusion may not apply to a drug which has been approved by the Federal Food and Drug Administration (FDA) for a specific medical condition, but which is sought to be provided for another medical condition. This is referred to as "off-label use". To be considered a covered expense by the Plan, off-label drugs being prescribed must have been:

1. Approved by the FDA for commercial distribution, and
2. Supported in reputable medical compendia* as effective and accepted treatment for the off-label condition.

*Reputable Medical Compendia includes, but is not limited to:

Accc-cancer.org	Cancer.gov
Chemoregimen.org	Compendia
FDA.gov	Medscape.com
Medlineplus.gov	NCCN.org
NIH.gov	U.S. Pharmacopoeia

Eye care. Glasses or lenses or their fitting; eye surgery to correct nearsightedness, farsightedness and/or astigmatism by changing the shape of the cornea. This Exclusion does not apply to aphakic patients and soft lenses, sclera shells intended for use as corneal bandages or as may be specifically stated in the *Schedule of Benefits*. This exclusion does not apply to coverage of pediatric screening as required by PPACA.

Foot care. Charges resulting from weak, unstable or flat feet; bunions; routine foot care including corn and callus treatment or removal; or nail trimming, unless necessary for diabetic foot care. This exclusion does not apply to surgery for the above listed conditions.

Orthopedic foot appliances, including custom molded foot orthotics, may be covered when used as an integral part of a brace, applied tightly thereto, or when used to treat a condition requiring more than a supportive device of the foot. Shoe inserts are not considered orthotic devices by this Plan and are not covered.

Foreign travel. Care, treatment or supplies outside of the United States if travel is for the sole purpose of obtaining medical services.

Genetic testing and counseling, except as noted in the *Schedule of Benefits* section of this document. Genetic testing for the purposes of determining the paternity of a child or the sex of a child is not covered.

Government coverage. Confinement, treatment or services that are paid for or furnished by the United States Government or one of its agencies. This does not apply to Medicaid or when otherwise prohibited by law.

Growth hormones unless Medically Necessary. See Prescription Drug Benefits, Limitations and Exclusions, and/or Specialty Pharmacy.

Hair loss, including wigs, toupees, hair transplants, hair prostheses, hair weaving, or any drug that promises hair growth, whether or not prescribed by a Physician. The Plan does cover wig following cancer treatment.

Hearing aids. Charges for services or supplies in connection with hearing aids or exams for their fitting unless

- required due to Accidental Injury; or
- hearing loss is a result of a surgical procedure.
- This exclusion does not apply to pediatric screening as required by PPACA.

Holistic or homeopathic medicine, except for yoga

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Hospital employees. The Plan will not pay for services billed directly by any person (Physician, nurse, therapist, etc.) who is an employee of a Medical Care facility and whose services are paid by the Medical Care facility.

Illegal Acts. Charges for services rendered as a result of an Injury or Illness which was caused by one of the following:

- Being illegally intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the Accident took place), while operating a motorized vehicle; or
- Engaging in a riot or public disturbance, aggravated assault, illegal occupation, or felony; or
- A Serious Illegal Act. A "Serious Illegal Act" is any act or series of acts for which a sentence to a term of imprisonment in excess of one year could be imposed (regardless of the individual's own criminal history) if the act were prosecuted as a criminal offense in the state where the act took place.

In each instance, it is not necessary that criminal charges be filed or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required. This exclusion does not apply to the victims of such acts. This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a covered medical condition (including both physical and mental health).

Immunizations and/or Vaccines needed for travel not required by the Employer.

Infertility. The Plan does not cover reversal of voluntary sterilization; medical services (surgical or therapeutic) to correct the cause of the infertility; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF); donation, preservation, preparation, analysis and storage of sperm, eggs or embryos; drug treatments for stimulating ovulation; any costs related to surrogate parenting; infertility services required because of a sex change by a Plan Participant or covered Spouse; or any assisted reproductive technology or related treatment. The Plan does not cover any costs for Infertility diagnosis or treatment if the covered Employee or covered Spouse has had a prior sterilization procedure or if infertility is the result of a normal physiological change such as menopause. The Plan does not pay for charges incurred by a surrogate mother, , or in connection with a Pregnancy or attempted Pregnancy involving a surrogate mother.

Learning Disorders / Developmental Testing. Services, treatment and diagnostic testing related to learning and/or developmental disorders unless it is medical treatment for a diagnosed medical condition, and not only for behaviors associated with that diagnosis.

Marital or pre-marital counseling.

Never Events – treatment or services for unintended injury or illness resulting from an adverse consequence of care that could reasonably have been prevented, including but not limited to: foreign object left in body after surgery, surgery performed on wrong body part, air embolism, blood incompatibility, etc. For more information see ***http://www.cms.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp#TopOfPage .***

No charge. Confinement, treatment or services for which the Plan Participant has no financial liability or that would be provided at no charge in the absence of insurance coverage.

No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.

No Physician recommendation. Confinement, care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment that is appropriate care for the Injury or Illness.

Further, charges will not be paid for services, supplies or treatment not commonly and customarily recognized throughout the Physician's profession, or by the American Medical Association (AMA) as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the AMA as having no medical value.

Non-Emergency Hospital Admissions. Any admission and related inpatient Hospital charges incurred on a Friday, Saturday, or Sunday unless the admission is necessary due to an emergency or if surgery is performed within 24 hours of the admission, unless the admission is pre-certified for medical necessity.

Non-Medical Examinations. Any physical examination for a non-medical purpose (such as when performed solely for the purpose of insurance, licensing, employment, foreign travel, school, sports, or fitness). This exclusion includes

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all administrative costs associated with such exams and other services. This exclusion does not apply to Medically Necessary physical examinations.

Not specified as covered. Non-Traditional Medical Services, treatments and supplies which are not specified as covered under this Plan. See Defined Terms.

Obesity. Surgical treatment of obesity, Morbid Obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Also excluded are vitamins, diet supplements, special diets, recreational therapy, education therapy, self-help training or enrollment in a health, athletic or similar club. *(See also Obesity, Non-Surgical Treatment in the Schedule of Benefits.)*
This exclusion does not apply to any preventive vitamins, supplements, or pediatric screenings that may be required by PPACA.

Occupational. No benefits will be provided for losses which result from an Illness or Injury:
- that arises out of or in the course of employment (including self-employment) with any employer who is eligible to obtain coverage under Workers' Compensation, or occupational disease law;
- for which the Plan Participant is eligible for benefits under any Workers' Compensation law or occupational disease law; or
- for which the Plan Participant is paid a Workers' Compensation benefit or occupational disease law benefit.

Personal Comfort Items. Services or supplies which constitute personal comfort or beautification items, television or telephone use, or in conjunction with custodial care, educational or training or expenses actually incurred by other persons except as specifically addressed elsewhere in this document. Personal comfort items include, but are not limited to: air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first aid supplies and non-hospital adjustable beds.

Plan design excludes. Charges excluded by the Plan design as described in this document.

Pregnancy of daughter. Care and treatment of Pregnancy for a dependent daughter, except as required by PPACA. Complications of Pregnancy are covered.

Prescription drugs. Benefits payable with the prescription drug card will not be provided under the medical benefits provisions.

Provider Error. Care, supplies, treatment, and/or services that are required as a result of unreasonable provider error. Providers are independent contractors, and they are solely responsible for injuries and damages to plan participants resulting from misconduct or negligence.

Psychological or psychiatric counseling incurred as a result of or in connection with behavior conduct and/or behavioral disorders, including but not limited to truancy, delinquency, tantrums or stealing where there is no underlying mental or emotional disorder.

Reimbursement. Treatment received or expenses incurred by a Plan Participant that are reimbursed, entitled to reimbursement, or is in any way indemnified by or through any public program except when this Plan is required by Federal Law to pay as primary.

Relative giving services. Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Plan Participant's physical condition to make the original device no longer functional.

Residential treatment for Mental Health and Substance Use Disorders is not covered for the following:
- The use of foster homes or halfway houses.
- For wilderness center training.
- For therapeutic boarding schools.
- For custodial care, situation or environmental change.

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Room and Board for Partial Hospitalization. Charges billed for Room and Board in connection with any Partial Hospitalization services are excluded.

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 ended under this Plan.

Sex Reassignment. Charges for services due to sex transformation, gender dysphoria, sexual reassignment or sex change are excluded. This exclusion includes, but is not limited to, medications, implants, hormone therapy, surgery, medical or psychiatric treatment, sex therapy programs or psychotherapy.

Sexual Dysfunctions. Charges for services due to sexual dysfunctions, including, but not limited to, medications, implants, hormone therapy, surgery, medical or psychiatric treatment, sex therapy programs or psychotherapy. This exclusion does not apply when the dysfunction arises from a covered Injury or Illness.

Subrogation. Claims directly related to or arising out of an Injury or Illness for which the Plan Participant has, or may have, any claim or right to recovery, when the completed and signed acknowledgement form (as described in the *Reimbursement and or Subrogation* section) is not delivered to the Claims Administrator within 12 months of the date that such form is first sent by the Claims Administrator to the Plan Participant.

Surgical sterilization reversal.

Termination of Pregnancy except as Medically Necessary to save the life of the mother.

Travel or Accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except as *specifically* stated in this *Summary Plan Description,* or for travel that is not Medically Necessary

War. Charges incurred as a result of war or any act of war, whether declared or undeclared, or for service related charges incurred while serving in the armed forces of any country.

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PRESCRIPTION DRUG BENEFITS, LIMITATIONS & EXCLUSIONS

Participating pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. Refer to your ID card for the name of the administrator of the pharmacy drug plan.

Copays
A Copay is applied to each covered retail pharmacy drug or mail order drug charge and is shown in the *Schedule of Benefits.* A Copay amount is not a covered charge under the medical benefits. Any one pharmacy prescription is limited to the supply shown in the *Schedule of Benefits*. Any one mail order prescription is limited to the supply shown in the *Schedule of Benefits*.

Plan Participants will be charged a dispensing fee and the cost of the ingredients of the drug, in addition to the applicable Copay, if a prescription is filled at a non-participating pharmacy or a participating pharmacy when the Plan Participant's ID card is not used.

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

Three-Tier Benefits
Your prescription drug benefit offers formulary drugs. In the formulary, prescription drugs are divided into three categories or tiers: generic (tier 1), preferred brand (tier 2) and non-preferred brand (tier 3). The placement of drugs in the formulary determines what Copay will be charged. The Pharmacy Administrator determines the placement of prescription drugs in the formulary at tier 1, 2 or 3. The list of prescription drugs may change from time to time. If you would like a free, updated copy of the formulary and a list of restricted access drugs and devices, please visit our website, ***www.medcost.com***, or call the pharmacy telephone number listed on you ID card.

Generic vs. Brand
Except as required by PPACA, a Plan Participant will be required to pay the brand name Copay plus the difference in cost between the brand name and generic if (a) he/she chooses brand name when a generic is available; or (b) when the Physician orders brand name dispensing on the prescription and a generic is available.

Diabetic Supply Program
Your Employer has joined with the prescription drug card administrator to help with the challenge of living with diabetes. The diabetic supply program will assist you with your therapy compliance and improve your quality of life by offering such products and services as:

- Valuable savings on products and services though the National Diabetic Pharmacies (NDP);
- Access to Certified Diabetes Educators and Registered Pharmacists;
- Reminder calls when it is time to reorder supplies and prescriptions;
- Education materials free of charge with every 90-day order;

The diabetic supply program also includes supplies such as:

- Home blood glucose monitor;
- Test strips;
- Lancets, and
- B-D Pens.

Note: This program is Mandatory. If you have questions or want more information regarding the diabetic supply program, please contact your Human Resources Department or call the prescription drug card administrator at the telephone number on your identification card.

Mandatory Specialty Pharmacy
Certain Prescription Drugs must be purchased through the Plan's Specialty Pharmacy and will not be paid or reimbursed by the Plan if they are not procured through the Plan's Specialty Pharmacy. This requirement may be waived for the first dispensing of a specialty drug obtained by a Plan Participant.

A Specialty Pharmacy is a program provided through the pharmacy benefit manager, or a preferred pricing arrangement with a Network provider. The Plan will notify and assist Plan Participants with coordination of care when appropriate to obtain medications from a preferred pricing arrangement with a Network provider.

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The Specialty Pharmacy or a Network provider with a preferred pricing arrangement can provide medications for medical conditions such as Crohn's disease, hemophilia, Hepatitis C, immunodeficiency, multiple sclerosis, and many others. Medications can be shipped directly to you or to your Physician.

Note*: For questions or for a complete list of available medications, log on to ***www.medcost.com* and click on the Pharmacy link, or call the pharmacy number listed on your ID card. These drugs are subject to change due to the availability of medications.

Covered Prescription Drugs

- Legend drugs or controlled substances that bear the statement "Caution – Federal law prohibits dispensing without a prescription" except those listed under *Prescription Plan Exclusions*.
- Compounded medications in which at least one ingredient is a legend drug, except minoxidil lotion, progesterone suppositories and any other non-FDA approved experimental drug.
- Prescription drugs for smoking cessation

Plan Limitations

The covered drug charge for any one prescription will be limited to:

- Refills only up to the number of times specified by a Physician.
- Refills up to one year from the date of order by a Physician.
- Some prescription drugs are subject to supply limits that restrict: (1) the amount dispensed per prescription; (2) the amount dispensed per month's supply; or (3) the amount dispensed per single Copay. In most cases, excess quantities will not be covered; however, you may be required to pay an additional Copay if excess quantities are allowed. You can visit our website, ***www.medcost.com***, or call the pharmacy telephone number listed on your ID card for a list of prescription drugs.
- Some prescription drugs may require Prior Approval in order to be covered. It is very important to make sure that Prior Approval is received before you go to the pharmacy.

Additionally, some prescription drugs may be subject to quantity limits based on criteria developed by the Pharmacy Administrator. Prior Approval is required before excess quantities of these drugs will be covered. If you need quantities in excess of the limit for a drug that is subject to quantity limits, it is important to make sure you have received Prior Approval.

A list of prescription drugs requiring Prior Approval to be covered or requiring Prior Approval for additional quantities can be found at ***www.medcost.com***, or you can call the pharmacy telephone number listed on your ID card.

Prescription Drug Plan Exclusions

This benefit will not cover a charge for any of the following:

Administration. Any charge for the administration of any drug or medicine.

Appetite suppressants, , dietary or vitamin supplements. This Exclusion does not apply to prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride, or to any preventive vitamins or supplements that may be required by PPACA.

Birth Control devices, injectables or topical contraceptives other than oral contraceptives, transdermal and vaginal ring.

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

Drugs used for **Cosmetic** purposes.

Devices of any type, even though such devices may require a prescription.

Experimental, Investigational or not Medically Necessary. This exclusion may not apply to a drug which has been approved by the Federal Food and Drug Administration (FDA) for a specific medical condition, but which is sought to be provided for another medical condition. This is referred to as "off-label use". To be considered a covered expense by the Plan, off-label drugs being prescribed must have been:

1. Approved by the FDA for commercial distribution, and
2. Supported in reputable medical compendia* as effective and accepted treatment for the off-label condition.

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*Reputable Medical Compendia includes, but is not limited to:

Accc-cancer.org	Cancer.gov
Chemoregimen.org	Compendia
FDA.gov	Medscape.com
Medlineplus.gov	NCCN.org
NIH.gov	U.S. Pharmacopoeia

FDA. Any drug not approved by the Food and Drug Administration.

Foreign travel. Care, treatment or supplies outside of the United States if travel is for the sole purpose of obtaining prescription drugs.

Immunizations or vaccines other than for flu, pneumonia, or shingles as defined in the Schedule of Benefits.

Infertility drugs.

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

Injectables. The Plan does not cover injectables other than insulin, Imitrex or those purchased through the Specialty Pharmacy, other than as required by PPACA.

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

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

No charge. A charge for Prescription Drugs that may be properly received without charge under local, state or federal programs.

No pharmacy benefit manager coverage. Medications not covered by the Pharmacy benefit. Note, to be eligible for coverage, all drugs (with the exception of injectable insulin), medicines, or supplies must have an accompanying prescription, including PPACA required medications.

Non-legend uses. A charge for FDA-approved drugs which are prescribed for non-FDA-approved uses.

Ostomy supplies

Refills. Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

Worker's Compensation. Prescription drug products for any condition, sickness, Illness or mental illness arising out of, or in the course of, employment for which compensation benefits are available for wage or profit including self-employment. The Plan will not pay if you are eligible to receive payment under a Worker's Compensation law or similar legislation, regardless of whether or not you make a claim or receive compensation.

IMPORTANT

Other exclusions may apply to your Plan. Visit ***www.medcost.com,*** or call the pharmacy telephone number listed on your ID card.

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DENTAL CARE BENEFITS, LIMITATIONS AND EXCLUSIONS

COVERED DENTAL SERVICES

Class A - Preventive and Diagnostic (non-orthodontic)

Routine oral exams. This includes the cleaning and scaling of teeth, including periodontal maintenance. Limit of 2 per Plan Participant each Benefit Year.

X-rays including:
- One bitewing X-ray series each Benefit Year.
- One full mouth X-ray every 3 Benefit Years.*

One fluoride treatment for covered Dependent children to age 18 each Benefit Year.

Space maintainers for covered Dependent children under age 15 to replace primary teeth.

Emergency palliative treatment for pain.

Sealants on the permanent molars of Dependent children under age 15, once per tooth in any Benefit Year.

Other dental X-rays or diagnostic services, not otherwise stated above, to determine Preventive Care.

*Full Mouth X-rays are defined as a radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone. They are usually done on the patient's first visit.

Class B - Basic (non-orthodontic)

Oral surgery *(For Employees with Dental Only Coverage. See special note under Dental Plan Exclusions.)*

Removal of wisdom teeth. *(For Employees with Dental Only Coverage. See special note under Dental Plan Exclusions.)*

Periodontic services (other than maintenance). Allowance includes the treatment plan, local anesthetics and postoperative care. Includes periodontal root planing and cleaning, as necessary for substantial bone and attachment loss. Includes occlusal adjustment, allowable only when done in conjunction with periodontal surgery.

Endodontics (root canals).

Extractions including local anesthesia and routine post-operative care.

Recementing bridges, crowns or inlays.

Fillings, other than gold.

General anesthetics including nitrous oxide.

Antibiotic drugs for the treatment of a dental condition.

Class C - Major (non-orthodontic)

Gold restorations*, including inlays, onlays and foil fillings.

(*The cost of gold restorations exceeding the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.)

Installation of:
- crowns;

- precision attachments for removable dentures;
- partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during 12 months following the installation.

Addition of clasp or rest to existing partial removable dentures.

Initial installation of fixed bridgework to replace one or more natural teeth.

Repair of crowns, bridgework and removable dentures.

Rebasing or relining of removable dentures.

Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if *one* of these tests is met:

1. The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
2. The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 6 months from the date the temporary denture was installed.

Implants.

Limitations

This Dental Plan is an optional benefit. A covered Employee must enroll his eligible Dependents in the Dental Plan before the following benefits are available. Contact your Employer for enrollment materials and information.

Dental benefits will be paid for Covered Expenses that a person incurs while covered by this Dental Plan, applicable to the Copayment percentages that correspond to Classes A, B and C covered expenses, once the Lifetime Deductible is met. Covered Expenses are the usual, customary and reasonable (UCR) charges made by a dentist or doctor for necessary dental treatment as outlined in this section. Each Covered Expense is considered incurred on the date the service or supply is provided to the Plan Participant.

Dental charges are the Usual, Customary and Reasonable (UCR) charges made by a Dentist or other Physician for the necessary care, appliances or other dental material listed as a covered dental charge. A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when an overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

Deductible

Before benefits that are subject to the Deductible can be paid, a Plan Participant must meet the Lifetime Deductible shown in the *Schedule of Benefits*.

Predetermination of Benefits

Before starting a dental treatment for which the charge is expected to be $1,000 or more, a predetermination of benefits form may be submitted. A regular dental claim form or electronic submission is acceptable with no date of service included and Block 1 marked appropriately as “Request for predetermination / preauthorization.” The Dentist should use the most current ADA version of the dental form (2006 or later) fully completed. The Dentist must itemize all recommended services and provide the correct ADA code, tooth number and costs per item. X-rays are not necessary, and if submitted, will not be returned. (Note: If the claim will require a review of X-rays, a request will be generated for this information.)

Send the request for Predetermination / Preauthorization form to the Claims Administrator as follows:
MedCost Benefit Services
PO Box 25987
EDI 56205
Winston-Salem, NC 27114-5987
Or by email to ***mbswebmail@medcost.com.***

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Plan Participant and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay. The Plan

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reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would have otherwise been payable.

Alternate Treatment
Many dental conditions can be treated in more than one way. This Plan has an “alternate treatment” clause that governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment that provides professionally satisfactory results at the most cost-effective level.

For example, of a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

Dental Plan Exclusions

A charge for the following is not covered:

Administrative costs of completing claim forms or reports or for providing dental records.

Broken or missed appointments.

Cosmetic dentistry (elective) or other services and supplies that improve, alter or enhance appearance, whether or not for psychological reasons.

Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

Treatment that does not meet accepted standards of **Dental** practice.

Experimental or Investigational. Services or supplies that do not meet accepted standards of dental practice, or are not necessary according to those standards, including charges for services or supplies that are experimental or investigational in nature, and charges not yet approved by the Council on Scientific Affairs / Dental Therapeutics of the American Dental Association.

Foreign travel. Care, treatment or supplies outside of the United States if travel is for the sole purpose of obtaining dental services.

Hygiene. Oral hygiene, plaque control programs or dietary instructions.

Labial Veneers.

Medical services. Services, to any extent, that are payable under any medical expense benefits of the Plan.

Treatment for which **No Charge** is made. This usually means treatment furnished by:
- the participant’s employer, labor union or similar group, in its dental or medical department or clinic; or
- a facility owned or operated by a governmental body; or
- any public program, except Medicaid, paid for or sponsored by a governmental body.

No listing. Services not included in the list of covered dental services.

Occlusal guards unless prescribed after osseous or periodontal surgery. The guard must be obtained within 3 months of the surgery. The Plan allows one guard per Lifetime per Covered Person.

Occupational. No benefits will be provided for losses which result from an Illness or Injury:
- that arises out of or in the course of employment (including self-employment) with any employer who is eligible to obtain coverage under Workers' Compensation, or occupational disease law;
- for which the Plan Participant is eligible for benefits under any Workers' Compensation law or occupational disease law; or
- for which the Plan Participant is paid a Workers' Compensation benefit or occupational disease law benefit.

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Oral surgery. *For Employees with both Medical and Dental coverage, see medical benefits for coverage. Oral surgery shall be covered under Dental for Employees who have elected Dental Only coverage.*

Orthognathic surgery.

Personalization. Personalization of dentures.

Replacement of lost, missing or stolen appliance or prosthetic device. The Plan will pay for replacing an appliance or device with a like appliance or device if:

- it is at least 10 years old and cannot be made usable, or
- it is damaged while in the Covered Person's mouth in an Injury and cannot be fixed.

Spare appliance or device.

Splinting. Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

Charges for the care or treatment of **Temporomandibular Joint syndrome** (TMJ).

Tooth transplants.

Removal of **Wisdom teeth.** *For Employees with both Medical and Dental coverage, see medical benefits for coverage. Removal of Wisdom teeth shall be covered under Dental for Employees who have elected Dental Only coverage.*

Worker's Compensation. Treatment needed due to a condition for which benefits are payable by Worker's Compensation or similar laws.

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CLAIMS PROCEDURES AND APPEALS

Claim Determinations Made In Accordance With Plan Documents
The Plan's claims procedures shall include administrative safeguards and processes designed to ensure and verify that benefit claims determinations are made in accordance with governing Plan Documents and, where appropriate, that the Plan's provisions have been applied consistently with respect to similarly situated Covered Persons.

Claim Defined
A "claim" represents a Clean Claim that is any request made by a Covered Person or a Covered Person's representative for benefits under the Plan that complies with the Plan's reasonable procedure for filing claims. A request for benefits includes a request for coverage determination, pre-authorization or approval of a plan benefit, or a utilization review determination in accordance with the terms of the Plan. Refer to Defined Terms, Clean Claim.

Requests for eligibility determinations are not claims for benefits. However, when a claim is denied because the Covered Person is not eligible for benefits under the terms of the Plan, the Covered Person has the right to appeal that determination in accordance with the Plan's claims procedures.

Claim Filing
Network providers will file medical claims to MedCost Benefit Services for you. If you incur a claim from a Non-Network provider, or a provider that does not file the claim, you can submit the claim by following these steps:

- Complete the Employee's portion of a claim form.
- Have the Physician or Dentist complete the Provider's portion of the claim form.
- Attach all related bills to the claim form. All bills **MUST** show:
  - Plan name (employer's name) and group number
  - Employee's name
  - Patient's name
  - Provider's name, address & phone number
  - Date(s) of services, diagnosis, type of service rendered including diagnosis or procedure code(s)
  - Charges

Send the completed claim form to:
MedCost Benefit Services *
P. O. Box 25987
EDI 56205
Winston-Salem, NC 27114-5987
Or by email to ***mbswebmail@medcost.com.***

Claims should be submitted to MedCost Benefit Services as soon a possible after the date of service, preferably within 90 days, but not more than 12 months. When a Plan Participant's coverage terminates for any reason, claims need to be submitted to MedCost Benefit Services within 90 days of termination of coverage. Refer to Defined Terms, Clean Claim.

Limitation of Liability
The Plan Sponsor shall not be obligated to pay any benefits under the Plan for any claim if the proof of loss for such claim was not submitted within the period provided in "Claim Filing" above, except in the case of legal incapacity of the Covered Person.

Urgent Care Claim
The term "urgent care claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Except as provided in the next sentence, whether a claim is an urgent care claim is to be determined by a person acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the Covered Person's medical condition determines is an urgent care claim involving urgent care shall be treated as an urgent care claim for purposes of these provisions.

For urgent care claims, the Claims Administrator will notify the Covered Person of its determination, whether adverse or not, as soon as possible but not later than 72 hours from receipt of the claim at the initial benefit determination level.

Notice of a benefit grant or denial may be provided orally, so long as a written or electronic notice of benefit grants or denials is sent to the Covered Person not later than 3 calendar days after the oral notification.

Pre-Service Claim
A pre-service claim is any claim for a medical benefit under this Plan that requires approval, in whole or in part, in advance of obtaining medical care. These are, for example, Claims that are subject to predetermination of benefits or pre-certification.

For pre-service claims, generally, the Claims Administrator must notify the Covered Person of its determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of the claim at the initial level.

One 15-day extension of time is available if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary due to a failure of the Covered Person to submit necessary information, the notice of extension shall specifically describe the required information, and the Covered Person shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Written or electronic notice of benefit grants or denials must be provided in the case of pre-service claims.

Post-Service Claim
A post-service claim is a claim for a Plan benefit that is not a claim involving Urgent Care or a pre-service claim; in other words, a claim that is a request for payment under the Plan for covered medical services already received by the claimant.

For post-service claims, generally, the Claims Administrator will notify the Covered Person of any adverse determination within a reasonable period of time, but not later than 30 days from receipt of the claim at the initial level.

One 15-day extension of time is available if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary due to a failure of the Covered Person to submit necessary information, the notice of extension shall specifically describe the required information, and the Covered Person shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Written or electronic notice of benefit grants or denials must be provided in the case of post-service claims.

Incomplete Claims Notice Disclosure
The Claims Administrator will determine whether a filed claim is incomplete. A claim is filed in accordance with reasonable filing procedures of the Plan, without regard to whether all information necessary to decide the claim accompanies the filing.

The Claims Administrator must notify the Covered Person or Covered Person’s representative of failure to follow proper claims filing procedures.

- With respect to urgent care claims, the Claims Administrator will provide incomplete claims notice within 24 hours of receipt of the claim.
- With respect to pre-service claims, notice of incomplete claims will be provided within 5 days of receipt of the claim.

Notification by the Claims Administrator may be oral, unless written notification is requested by the Covered Person or Covered Person’s authorized representative.

Notification of Adverse Benefit Determination
The Claims Administrator shall provide a Covered person with written or electronic notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the Covered Person, the following:

- The specific reason(s) for the adverse determination;
- References to the specific plan provisions upon which the determination is based;
- A description of any additional material or information necessary for the Covered Person to perfect the claim and any explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Covered Person's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
- If the Plan utilizes a specific internal rule, guideline, protocol, or other similar criterion in making the determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline protocol or other similar criterion was relied upon and that a copy of such rule, guideline, protocol or similar criterion will be provided free of charge to the Covered Person upon request;
- If the determination is based on not satisfying the criteria for clinical eligibility for coverage; experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the Covered Person's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
- In the case of a determination concerning an urgent care claim, a description of the expedited review process applicable to such claims.

Internal Appeal of Denied Claim and Review Procedure
A Covered Person will be notified in writing by the Claims Administrator if a claim, or any part of a claim, is denied. If a Covered person does not agree with the reason for the denial, the Covered Person may file a written appeal within 180 days after the receipt of the original claim determination.

An adverse benefit determination is eligible for internal appeal and review if it includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit that is based on:

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

The request for review must contain the Covered Person's name and identification number and the basis for the disagreement along with any information, questions, or comments the Covered Person thinks are appropriate, and should be sent to the office of the Claims Administrator. Copies of any relevant documentation (such as letters, claims, medical records, physician's statements, etc.) should be provided to the Claims Administrator.

The Covered Person's claim appeal will be reviewed and the decision made by someone who was not involved in the initial determination. The review shall not defer to the initial determination, and it shall take into account all comments, documents, records and other information submitted by the Covered Person without regard to whether such information was previously submitted or considered in the initial determination.

In addition, in deciding an appeal of any determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or is determined not to satisfy the criteria for clinical eligibility for coverage or is not appropriate, the appropriate reviewer shall consult with a health care professional, who was neither the person who was consulted in connection with the initial benefit determination, nor the subordinate of such person, and who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Claims Administrator must notify the Covered Person of the determination of an appeal for a pre-service claim within 30 days from receipt of the appeal.

The Claims Administrator must notify the Covered Person of the determination of an appeal for a post-service claim within 60 days from receipt of the appeal.

Expedited Internal Appeal
In the case of the review of urgent care determination, a request for an expedited appeal of a claim denial may be submitted orally or in writing by the Covered Person; and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Covered Person by telephone, facsimile, or other available similarly expeditious method.

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The Claims Administrator will notify the Covered Person, by telephone, of the determination of an expedited appeal within 24 hours from receipt of the expedited appeal. A written notification will be sent to the Covered Person within 3 days after notification by telephone.

External Review
When a Covered Person disagrees with an internal appeal decision, the Covered Person has 4 months following receipt of the appeal notice in which to request an external review. The external review will be conducted by an Independent Review Organization (IRO) that is accredited by URAC (Utilization Review Accreditation Committee).

Within 5 business days of receipt of a request for external review, the Claims Administrator will complete a preliminary review and issue a notification in writing to the Covered Person that the request is complete and eligible for external review.

If the request is not complete, the notification will include information or materials needed to make the request complete. The Covered Person is permitted a 4-month time period to submit the information or materials needed.

When all information has been received, the Claims Administrator will assign the request to an IRO, and will forward all information to the IRO.

The IRO will notify the Covered Person in writing of the request's eligibility and acceptance for external review. The Covered Person is permitted 10 business days in which to submit additional information that the IRO must consider in conducting the external review.

The IRO will forward to the Claims Administrator any additional information provided by the Covered Person and permit the Claims Administrator to reconsider and/or reverse the adverse determination.

If the Claims Administrator reverses the adverse determination, the external review will be terminated. If the Claims Administrator upholds its adverse determination, the external review process continues.

The IRO will provide written notice of its final external review decision within 45 days after the IRO received the request for external review. The notice will be provided to the Covered Person and to the Claims Administrator and will included detailed information that includes the reason(s) and rationale for the decision.

The determination by the IRO is binding except to the extent other remedies may be available under state or federal law to either the group health plan or to the Covered Person. Claims paid as a result of an IRO determination may be considered eligible Claims under this Plan.

Expedited External Review
An expedited external review may be requested for an adverse determination that involves a medical condition of the Covered Person for which the regulatory time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the Covered Person, or would jeopardize the Covered Person's ability to regain maximum function. In other words, an expedited external review may be requested to run concurrently with an expedited internal appeal.

Upon determination that a request is eligible for expedited external review, the Claims Administrator will assign an IRO and forward all documentation to the IRO electronically, or via facsimile.

The IRO will review the information and provide a final determination within 72 hours after receipt of the information.

The determination may be communicated to the Covered Person orally, but will also be provided in writing to the Covered Person and the Claims Administrator within 48 hours after the determination is made.

Authorized Representatives
A Covered Person's authorized representative, including a health care provider, is not precluded from acting on behalf of the Covered Person in pursuing a benefit claim or appeal. The Claims Administrator shall recognize a health care professional with knowledge of a Covered Person's medical condition as the Covered Person's representative in connection with an urgent care claim. The Claims Administrator may establish reasonable procedures for determining whether a person has been authorized to act on behalf of a Covered Person.

Payment of Benefits

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All benefits under the Plan are payable to the covered employee whose illness or injury or whose covered dependent's illness or injury is the basis of a claim.

In the event of incapacity of a covered employee and in the absence of written evidence to the Plan of the qualification of a guardian (or person acting under durable power of attorney) for the covered employee's estate, the Plan may, at its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such employee. In the event of death, the personal representative of the estate will act on behalf of the covered employee.

Benefits for expenses covered under the Plan may be assigned by a covered employee to the individual or institution rendering the services for which the expenses were incurred. No such assignment will bind the Plan unless it is in writing and unless it has been received and accepted by the Claims Administrator prior to the payment of the benefit assigned. The Claims Administrator will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered employee and the assignee, has been received by the Claims Administrator before the proof of loss is submitted. Payment of benefits will be made by the Plan in accordance with any assignment of rights made by or on behalf of a Covered Person if required by a Qualified Medical Child Support Order (QMCSO). The Plan will pay benefits in accordance with any assignment of rights under a state Medicaid law.

Assignment of Benefits
Assignment by a Plan Participant to the provider of the Plan Participant's right to submit claims for payment to the Plan, and receive payment from the Plan, may be achieved via an Assignment of Benefits, if and only if the provider accepts said Assignment of Benefit as consideration in full for services rendered. If benefits are paid, however, directly to the Plan Participant – despite there being an Assignment of Benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be the Plan Participant's responsibility to compensate the applicable provider(s). The Plan will not be responsible for determining whether an Assignment of Benefits is valid, and the Plan Participant shall retain final authority to revoke such Assignment of Benefits if a provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the Plan Participant, has been received.

No Plan Participant shall at any time, either during the time in which he or she is a Plan Participant in the Plan, or following his or her termination as a Plan Participant, 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 it fiduciaries.

A provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Network Provider will be considered 'assigned' to such provider and will be paid directly to such provider, whether or not a written Assignment of Benefits was executed. Notwithstanding any assignment or non-Assignment of Benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

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, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with the applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based on 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. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or Dependent on whose behalf such payment was made.

A Plan Participant, Dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. 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 person or entity receiving an erroneous payment may not apply such payment to another expense. 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 Plan Participant 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 Plan Participant 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. 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 or incur prejudgment interest at the legal rate, not to exceed 8% per annum. If the Plan must bring an action against a Plan Participant, provider or other person or entity to enforce the provisions of this section, then that Plan Participant, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) 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 Plan Participant(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.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Reimbursement and/or Subrogation provisions.
6. 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.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his/her covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

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 Plan Participant for any outstanding amount(s).

Recovery of Overpayments
If an overpayment is made under this Plan, the Claims Administrator reserves the right to determine and exercise one or all of the following options that it deems necessary to recover the overpayment to the Plan. The Claims Administrator may:

- request the overpayment from any Covered Person to whom such overpayment was made;
- request the overpayment from any provider to whom such overpayment was made; and/or
- deduct the overpayment of benefits from subsequent benefits payable to the Covered Person.

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Each Covered Person is deemed, through participation in the Plan, to authorize recovery of overpayments as described above.

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COORDINATION OF BENEFITS

When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's Spouse is covered by this Plan and by another plan or the couple's covered children are covered by two or more plans, the plans will coordinate benefits when a claim is received.

Coordination of Benefits (COB) sets out rules for the order of payment of Covered Charges when two or more plans, including Medicare, are paying. The insurance companies and/or third party administrators involved work together to pay up to 100% of the Plan Participant's covered expenses. This Plan uses the:
Credit banking method: When a plan is secondary, it shall reduce its benefits so that the total benefits paid by all plans during a claim period are not more than 100 percent of the total allowable expenses. The secondary plan shall calculate its savings by the amount that it paid as a secondary plan from the amount it would have paid had it been primary. These savings shall be recorded as a benefit reserve for the covered person and shall be used by the secondary plan to pay any allowable expenses, not otherwise paid, that are incurred by the covered person during the claim determination period.

COB applies to health care coverage that provides medical, vision, dental or health benefits by means of:
- A group plan on an insured basis;
- Plans that cover people as a group, including self-funded plans;
- Plans that are arranged through an employer, trustee or union;
- A prepayment plan such as an HMO, POS or PPO;
- Government plans; except Medicaid; and
- Single or family subscribed plans issued under a group plan.

The term "benefit plan" does not include:
- Hospital indemnity type plans;
- Types of plans for students;
- Franchise policies purchased by an individual;
- Automobile policies;
- Homeowners policies; and
- Other individual or family insurance policies for which premiums are paid by the Plan Participant.

For a charge to be considered under COB it must be a Usual, Customary and Reasonable (UCR) Charge as defined in the section entitled Coverage of Medical Expenses, and at least part of it must be covered under this Plan.

***Note*:** COB does not apply to Prescription Drug benefits. If a Plan is secondary for medical benefits, the assumption is that the Plan will also be secondary for Prescription Drug benefits.

In order for COB to work, the Plan may release or obtain claim information from any insurance company, organization or person. Accepting benefits under this Plan for incurred medical and/or dental expenses automatically requires a Plan Participant to give this Plan the information it requests about other plans and their payment of covered expenses.

If the Plan Administrator determines that this Plan has paid in error, the Plan will:
- Recover the amount paid to the Plan Participant or another benefit plan when the benefits should have been paid by the other benefit plan; or
- Repay other plans for benefits the Plan should have paid.

Benefits are coordinated on a Plan Year basis.

Rules for Benefits Plan Payment Order
When two or more plans provide benefits for the same charge, insurance companies and/or third party administrators will follow these rules.

1. Plans that do not have a coordination provision 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 up to the allowed charge:
   a. The benefits of the plan that covers the person directly (that is, as an Employee, Member or Subscriber) ("Plan A") are determined before those of the plan that covers the person as a Dependent ("Plan B").

b. The benefits of a benefit 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. Coverage provided an individual as a Retired Employee and as a Dependent of that individual's Spouse as an Active Employee will be determined under item 2.a. above. 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. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

d. When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
   i. The benefits of the benefit 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 benefit plan that 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 or legally separated, these rules will apply:
   i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
   ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
   iii. This rule will be in place of items above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
   iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
   v. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

3. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowed charges when paying secondary.

4. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

5. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

6. When there is dual coverage through both COBRA and other group health coverage the rules for determining which plan is primary will be applied in the standard order as they are listed above; in other words, the first rule that describes the situation is the rule to follow.
   a. Non-Dependent or Dependent (2.a. above). A plan covering an individual as an Employee, member, subscriber, or Retiree, is primary and the plan that covers the person as a Dependent is secondary.
   b. Active or inactive Employee (2.c. above). A plan covering an individual as an active Employee (neither laid-off nor retired) or as the Employee's Dependent is primary.
   c. Child covered under more than one plan (2.d. and 2.e. above). The second rule describes which parent's plan will be primary and which will be secondary in a variety of circumstances.
   d. Continuation coverage. A plan covering an individual as an Employee, member, subscriber or Retiree (or as that person's Dependent) is primary, and the continuation coverage (pursuant to state or federal law) is secondary.

Medicare as Secondary Payer

The federal Medicare Secondary Payer (MSP) rules require that, for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain situations. This means that the group health plan must not take Medicare entitlement into account in determining whether these individuals are eligible to participate in

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the Plan, or in providing benefits under the Plan. If you or your covered Dependent is eligible for Medicare, the following MSP rules apply:

If your employer has 20 or more Employees, either Medicare or the Plan can be chosen as the primary coverage for you, if you are an Employee who is eligible for Medicare because you are age 65 or older; and your covered Spouse is age 65 or older, regardless of your age.

If Medicare is elected as primary coverage, the law does not permit the Company's medical plan to provide benefits supplementing Medicare. Therefore, if you or your Dependent wishes to elect Medicare as your primary coverage, ***you must terminate participation in the Company's medical plan*** and have Medicare as your only coverage. You should contact the Company if you wish to terminate your participation in the Plan and have Medicare provide your medical benefits. Otherwise, participation in the Company's medical plan will continue to provide your primary medical benefits, with Medicare providing supplemental coverage.

If your employer has 100 or more Employees, medical benefits under the Plan will be paid before Medicare benefits for you and your covered Dependent who is under age 65; is eligible for Medicare because of disability; and is covered under the Plan because of your current employment status.

For all employers, medical benefits under the Plan will be paid before Medicare benefits for you or any covered Dependent qualifying for Medicare due to end-stage renal disease. The Plan will remain the primary payer only during the first thirty (30) months after the earlier of: (1) the date renal dialysis treatments are begun; or (2) the date of Medicare entitlement following a kidney transplant.

If this Plan is the primary payer under the above rules, it will provide the same medical benefits that it provides for other Plan Participants who are not entitled to Medicare benefits.

If Medicare is the primary payer for you or any of your covered Dependents, medical benefits will be paid in accordance with the *Coordination of Benefits* provisions of the Plan.

Note: To protect your financial liability it is in your best interest to enroll in Medicare Part B as soon as you become eligible.

Medicaid

If you or any of your covered Dependents qualify for coverage under Medicaid:

- Your medical benefits under this Plan will be paid before any Medicaid benefits are paid;
- Eligibility and benefits under this Plan are not affected by Medicaid eligibility; and
- Benefits for a Plan Participant who is also covered by Medicaid are subject to the state's rights to subrogation and reimbursement, if Medicaid benefits have been paid first for covered medical charges.

Right to Receive and Release Necessary Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any other plan. Any Plan Participant claiming benefits under this Plan shall furnish to the Plan Administrator, such information as requested and as may be necessary to implement this provision.

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REIMBURSEMENT AND / OR SUBROGATION

A. If a Plan Participant receives any benefits arising out of an Injury or Illness (herein, referred to collectively as "Injury") for which the Plan Participant has or may have any claim or right to recovery:

- payments under this Plan shall be made on the condition that this Plan will be reimbursed out of the proceeds of such claim of right to recovery;
- payment of benefits under this Plan shall be conditioned upon, and no payments under this Plan of benefits shall be made until, acknowledgment in a form specified by the Plan of the agreement of the Plan Participant, and his attorney, to the terms of this Section; and
- payment of benefits may be revoked, and the Plan may seek refunds of payments, where acknowledgment of the Plan's rights under this Section is hindered or breached.

B. The Plan Participant agrees:

- to refrain from doing anything to prejudice the Plan's rights to reimbursement or subrogation, or the pursuit of claims directly or indirectly to recover reimbursement of benefits paid;
- to cooperate fully and exclusively with the Plan and its appointed agents regarding subrogation rights, including executing and delivering all instruments and papers (including the execution of a subrogation form) and do whatever else is necessary to fully protect any and all subrogation or reimbursement rights;
- that any such funds received will be held in constructive trust for the reimbursement of the Plan inasmuch as the Plan Participant is not the rightful recipient of such funds and should not be in possession of any funds until the Plan has been fully reimbursed;
- to direct any attorneys or fiscal intermediaries to hold recovery of all funds related to the Injury in trust for the benefit of the Plan, and to direct that such parties deal exclusively with the cost recovery agent for the Plan;
- to assign to the Plan and its designees all rights against such agents and attorneys to enforce the direction to hold the funds in trust; and
- to reimburse the Plan in full before any amounts (including, but not limited to, attorney fees, expenses or costs), are deducted from such funds.

The Plan Participant shall be required to cooperate in the timely response to, and submission of, such acknowledgment form, requested related information and executed documents as may be required in order to facilitate benefit payment related to a subrogation claim. Failure to return the required completed and signed subrogation acknowledgment form and other requested documents to the Claims Administrator within 12 months from the date that such form (s) is (are) first sent by the Claims Administrator to the Plan Participant shall result in a loss of coverage for all claims directly related to or arising out of the Injury or Illness. The preceding sentence shall also apply to the obligations of Plan Participant's counsel under Paragraph E. below. (Please see also Medical Benefits Exclusions under Subrogation.)

C. Recoveries subject to the Plan's reimbursement claims shall include funds or rights acquired by the Covered Person (1) from any no fault insurance coverage, uninsured insurance coverage, underinsured insurance coverage, personal injury protection (PIP) insurance coverage, med-pay insurance coverage, other insurance policies or fund (this specifically includes, but is not limited to, the Plan Participant's own insurance coverage); (2) any person, entity, corporation, plan, association, liability coverage or other at fault party as a result of judgment, settlement, arbitration award, or any other arrangement; or (3) worker's compensation award, settlement or agreement.

D. Without limiting the preceding paragraph C., this Plan will be subrogated to all claims, demands, actions and right of recovery against any person, corporation and/or other entity who has or may have caused, contributed to or aggravated the Injury which the Plan Participant claims an entitlement to benefits under this Plan, and to any no fault insurance coverage, uninsured insurance coverage, underinsured insurance coverage, personal injury protection (PIP) insurance coverage, med-pay insurance coverage, other insurance policies or fund (this specifically includes, but is not limited to, the Plan Participant's own insurance coverage).

E. If the Plan Participant retains an attorney, the attorney must sign the forms specified by the Plan Administrator acknowledging and agreeing to the terms of this Section as a condition of payment of any benefits. By so acknowledging, the attorney indicates agreement that the Plan expressly rejects application of the "make whole" doctrine, the "common fund" doctrine, and any equitable or legal remedies or defenses that would preclude the100% reimbursement of the Plan out of first dollars recovered from any source, regardless of whether the Plan Participant will recover any funds from the source after reimbursement of the Plan and regardless of whether the attorney will be compensated or reimbursed for any fees, costs or expenses. The Plan will pay no costs or attorneys' fees, nor reduce its claims for reimbursement.

F. The amount of the Plan's subrogation interest will be deducted first from any recovery by or on behalf of the

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Plan Participant without regard to whether the Plan Participant is made whole. This paragraph is intended as an express and complete repudiation of the “make whole” doctrine, the “common fund” doctrine, or any equitable or legal remedy or defense to 100% reimbursement and should be interpreted consistent with this intention. If any party or insurance coverage or other source makes payment before this Plan pays, no benefits will be paid under this Plan to the extent of such payment.

G. If any action is taken by the Plan Participant, or his or her representatives to hinder, defeat or compromise the Plan’s rights under this Section, the Plan Participant agrees by receipt of benefits under this Plan, that the Plan may deduct from present or future claims for payment under this Plan, or any other plan or program of benefits (e.g., disability, sick pay or paid leave) until the Plan has recouped full reimbursement of all expenditures relating to the Injuries as set forth in this Section.

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CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction
Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA contains provisions giving certain former Employees, Spouses and Dependent children the right to temporary continuation of health coverage.

Beneficiary
A Qualified Beneficiary generally is any individual covered by a group health plan on the day before a Qualifying Event. A Qualified Beneficiary may be an Employee, the Employee's Spouse and Dependent children, and in certain cases, a Retired Employee, the Retired Employee's Spouse and Dependent children. COBRA continuation coverage is provided subject to your eligibility for coverage. See also Rescission of Coverage.

Qualifying Events
"Qualifying Events" are certain types of events that would cause, except for COBRA continuation coverage, an individual to lose health coverage. The type of Qualifying Event will determine who the Qualified Beneficiaries are and the required amount of time that a plan must offer the health coverage to them under COBRA. A plan, at its discretion, may provide longer periods of continuation coverage.

The types of qualifying events for **Employees** are:
- Voluntary or involuntary termination of employment for reasons other than "gross misconduct"
- Reduction in the number of hours of employment

The types of qualifying events for **Spouses** are:
- Termination of the covered Employee's employment for any reason other than "gross misconduct"
- Reduction in the hours worked by the covered Employee
- Covered Employee becoming entitled to Medicare
- Divorce or legal separation of the covered Employee
- Death of the covered Employee

The types of qualifying events for **Dependent children** are the same as for the Spouse with one addition:
- Loss of "Dependent child" status under the plan rules

Periods of Coverage

Qualifying Events	Beneficiary	Coverage
-Termination -Reduced hours	-Employee -Spouse -Dependent child	-18 months
-Employee entitled to Medicare -Divorce or legal separation -Death of covered employee	-Spouse -Dependent child	-36 months
-Loss of "dependent child" status	-Dependent child	-36 months

Your Rights; Notices and Elections Procedures
COBRA outlines procedures for Employees and family members to elect continuation coverage and for employers and plans to notify beneficiaries. The Qualifying Events contained in the law create rights and obligations for employers, plan administrators and qualified beneficiaries.

Qualified Beneficiaries have the right to elect to continue coverage that is identical to the coverage provided under the plan. Employers and plan administrators have an obligation to determine the specific rights of beneficiaries with respect to election, notification and type of coverage options.

NOTICE PROCEDURES

General Notices
An initial general notice must be furnished to covered Employees, their Spouses and newly hired Employees informing them of their rights under COBRA and describing provisions of the law.

COBRA information also is required to be contained in the Summary Plan Description (SPD) that participants receive. ERISA requires employers to furnish modified and updated SPDs containing certain plan information and summaries

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of material changes in plan requirements. Plan administrators must automatically furnish the SPD booklet 90 days after a person becomes a participant or beneficiary begins receiving benefits or within 120 days after the plan is subject to the reporting and disclosure provisions of the law.

Specific Notices
Specific notice requirements are triggered for employers, Qualified Beneficiaries and plan administrators when a Qualifying Event occurs. Employers must notify plan administrators within 30 days after an Employee's death, termination, reduced hours of employment, or entitlement to Medicare.

A Qualified Beneficiary must notify the plan administrator within 60 days after events such as divorce or legal separation or a child's ceasing to be covered as a Dependent under plan rules.

Disabled beneficiaries must notify plan administrators of Social Security disability determinations. A notice must be provided within 60 days of a disability determination and prior to expiration of the 18-month period of COBRA coverage. These beneficiaries also must notify the plan administrator within 30 days of a final determination that they are no longer disabled.

Plan administrators, upon notification of a Qualifying Event, must automatically provide a notice to Employees and family members of their election rights. The notice must be provided in person or by first class mail within 14 days of receiving information that a Qualifying Event has occurred.

Election
The election period is the time frame during which each Qualified Beneficiary may choose whether to continue health care coverage under an employer's group health plan. Qualified Beneficiaries have a 60-day period to elect whether to continue coverage. This period is measured from the later of the coverage loss date or the date the notice to elect COBRA coverage is sent. COBRA coverage is retroactive if elected and paid for by the Qualified Beneficiary.

A covered Employee or the covered Employee's Spouse may elect COBRA coverage on behalf of any other Qualified Beneficiary. Each Qualified Beneficiary, however, may independently elect COBRA coverage. A parent or legal guardian may elect on behalf of a minor child.

A waiver of coverage may be revoked by or on behalf of a Qualified Beneficiary prior to the end of the election period. A beneficiary may then reinstate coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

Covered Benefits
Qualified Beneficiaries must be offered benefits identical to those received immediately before qualifying for continuation coverage.

For example, a beneficiary may have had medical, hospitalization, dental, vision and prescription benefits under plans maintained by the employer. Assuming a Qualified Beneficiary had been covered by three separate health plans of his former employer on the day preceding the Qualifying Event, that individual has the right to elect to continue coverage in any of the three health plans.

Non-core benefits are vision and dental services, except where they are mandated by law in which case they become core benefits. Core benefits include all other benefits received by a beneficiary immediately before qualifying for COBRA coverage.

If a plan provides core and non-core benefits, individuals may generally elect either the entire package or just core benefits. Individuals do not have to be given the option to elect just the non-core benefits unless those were the only benefits carried under that particular plan before a qualifying event.

A change in the benefits under the plan for active Employees may apply to Qualified Beneficiaries. Beneficiaries also may change coverage during periods of open enrollment by the plan.

Duration of Coverage
COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible to pay for group coverage during a maximum of 18 months for Qualifying Events due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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Coverage begins on the date that coverage would otherwise have been lost by reason of a Qualifying Event and can end when:

- The last day of maximum coverage is reached
- Premiums are not paid on a timely basis
- The employer ceases to maintain any group health plan
- Coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary
- A beneficiary is entitled to Medicare benefits

Special rules for disabled individuals may extend the maximum periods of coverage. If a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of a termination of employment or reduction in hours of employment and the Qualified Beneficiary properly notifies the Plan Administrator of the disability determination, the 18-month period is expanded to 29 months.

Although COBRA specifies certain maximum required periods of time that continued health coverage must be offered to Qualified Beneficiaries, COBRA does not prohibit plans from offering continuation health coverage that goes beyond the COBRA periods.

Paying for COBRA Coverage

Beneficiaries may be required to pay the entire premium for coverage. It cannot exceed 102 % of the cost to the plan for similarly situated individuals who have not incurred a Qualifying Event. Premiums reflect the total cost of group health coverage, including both the portion paid by Employees and any portion paid by the employer before the Qualifying Event, plus 2% for administrative costs.

For disabled beneficiaries receiving an additional 11 months of coverage after the initial 18 months, the premium for those additional months may be increased to 150% of the plan's total cost of coverage.

Premiums due may be increased if the costs to the plan increase but generally must be fixed in advance of each 12-month premium cycle. The Plan must allow you to elect to pay premiums on a monthly basis if you ask to do so.

The initial premium payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the Qualifying Event. Premiums for successive periods of coverage are due on the date stated in the Pan with a minimum 30-day grace period for payments.

The due date may not be prior to the first day of the period of coverage. For example, the due date for the month of January could not be prior to January 1 and coverage for January could not be canceled if payment is made by January 31.

Premiums for the rest of the COBRA period must be made within 30 days after the due date for each such premium or such longer period as provided by the Pan. The Plan, however, is not obligated to send monthly premium notices.

COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to Deductibles, catastrophic and other benefit limits.

Claims Procedures

Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. Claims procedures are to be included in the SPD booklet.

You should submit a written claim for benefits to whoever is designated to operate the health plan (employer, Plan Administrator, etc.). If the claim is denied, notice of denial must be in writing and furnished generally within 90 days after the claim is filed. The notice should state the reasons for the denial, any additional information needed to support the claim and procedures for appealing the denial.

You have 60 days to appeal a denial and must receive a decision on the appeal within 60 days after that unless the plan:

- provides for a special hearing, or
- the decision must be made by a group, which meets only on a periodic basis.

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Contact the Plan Administrator for more information on filing a claim for benefits. Complete plan rules are available from employers or benefits offices. There can be charges up to 25 cents a page for copies of plan rules.

Coordination with Other Benefits
The Family and Medical Leave Act (FMLA), effective August 5, 1993, requires an employer to maintain coverage under any "group health plan" for an Employee on FMLA leave under the same conditions coverage would have been provided if the Employee had continued working. Coverage provided under the FMLA is not COBRA coverage, and FMLA leave is not a Qualifying Event under COBRA. A COBRA Qualifying Event may occur, however, when an employer's obligation to maintain health benefits under FMLA ceases, such as when an Employee notifies an employer of his or her intent not to return to work.

Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor, Employment Standards Administration.

Role of the Federal Government
Continuation coverage laws are administered by several agencies. The Departments of Labor and the Treasury have jurisdiction over private sector health plans. The United States Public Health Service administers the continuation coverage law as it affects public sector health plans.

The Labor Department's interpretative and regulatory responsibility is limited to the disclosure and notification requirements. If you need further information on your election or notification rights with a private sector plan, write to the nearest office of the Employee Benefits Security Administration or the U.S. Department of Labor, Employee Benefits Security Administration, Division of Technical Assistance and Inquiries, 200 Constitution Ave., N.W. (Room N-5619) Washington, D.C. 20210.

The Internal Revenue Service, which is in the Department of the Treasury, is responsible for publishing regulations on COBRA provisions relating to eligibility and premiums. Both Labor and Treasury share jurisdiction for enforcement.

The U.S. Public Health Service, located in the Department of Health and Human Services, has published Title XXII of the Public Health Service Act entitled "Requirements for Certain Group Health Plans for Certain State and Local Employees." Information about COBRA provisions concerning public sector employees is available from the:

U.S. Public Health Service Office of the Assistant Secretary for Health Grants Policy Branch (COBRA) 5600 Fishers Lane (Room 17A-45) Rockville, Maryland 20857

CONCLUSION
Rising medical costs have transformed health benefits from a privilege to a household necessity for most Americans. COBRA creates an opportunity for persons to retain this important benefit.

Workers need to be aware of changes in health care laws to preserve their benefit rights. A good starting point is reading your plan booklet. Most of the specific rules on COBRA benefits can be found there or with the person who manages your health benefits plan.

Be sure to periodically contact the Plan Administrator to find out about any changes in the type or level of benefits offered by the plan.

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ERISA RIGHTS OF PLAN PARTICIPANTS

As a participant of the Employee Benefit Plan sponsored by the Company, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (referred to as ERISA). ERISA provides that all Plan Participants shall be *entitled* to:

Receive Information about Your Plan and Benefits
You are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) if the Plan is required to file Form 5500 with the U.S. Department of Labor. Such Form 5500, if required to be filed by the Plan, is available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. (Note: Unfunded health and welfare plans covering less than 100 participants are not required to file Form 5500.)
- obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series, if required to be filed by the Plan) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's summary annual report, if the Plan is required by law to furnish each Plan participant with a copy of a summary annual report. (Note: Unfunded health and welfare plans are not required to issue a summary annual report to plan participants.)

Continue Group Health Plan Coverage
You may continue health care coverage for yourself, Spouse or other Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the document governing this Plan on the rules governing your COBRA continuation rights.

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

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

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

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either 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.)

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DEFINED TERMS

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

Accident is a non-occupational bodily Injury sustained independently of all other causes; that is sudden, direct and unforeseen, and is exact as to time and date.

Adverse Benefit Determination means any of the following:
1. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Plan Participant's eligibility to participate in the Plan.
2. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
3. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Air Ambulance Services include medical transport by helicopter or airplane for patients.

Ambulatory Surgical Center is a licensed facility, either free standing or as a part if a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures, and to which a patient is admitted to and discharged from within a 24-hour period.

An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, will not be considered to be an ambulatory surgical center.

Ancillary Services are (except as may be excluded by federal agency rulemaking under the No Surprises Act) the following items and services:
- items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists;
- diagnostic services (including radiology and laboratory services);
- items and services provided by such other specialty practitioners, as may be specified by federal agency rulemaking under the No Surprises Act; and
- items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

Approved Clinical Trial. An Approved Clinical Trial is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or a Life-threatening Condition likely to lead to death, unless the course of the disease or condition is interrupted. The Approved Clinical Trial must be federally funded by an appropriate agency of the federal government, conducted under an investigational new drug application reviewed by the Food and Drug Administration (or other appropriate federal agency), or a drug trial that is exempt from having an investigational new drug application. See also Schedule of Benefits, Medical Benefit Exclusions and the remainder of the Plan's Defined Terms for more information regarding coverage of Routine Patient Costs associated with an Approved Clinical Trial.

Assignment of Benefits means an arrangement whereby the Plan Participant, at the discretion of the Plan Administrator, assigns their rights to seek and receive payment of eligible Plan benefits, less Deductibles, Copayments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this SPD, to a provider. If a provider accepts said arrangement, providers' rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this SPD. A provider that accepts this arrangement indicates acceptance of an Assignment of Benefits and Deductibles, Copayments and the coinsurance percentage that is the responsibility of the Plan Participant, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Plan Participant as the sole beneficiary.

Benefit Year means the 12-month period in which Covered Medical Expenses accrue and are counted toward the annual Deductible and out-of-pocket limits, if applicable.

Birthing Center means a free standing facility that is licensed by the proper authority of the state in which it is located and that:
- provides prenatal care, delivery and immediate postpartum care; and

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- operates under the direction of a Physician who is a specialist in obstetrics and gynecology; and
- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; and
- provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a licensed registered nurse (R.N.) or certified nurse midwife; and
- has a written agreement with a local Hospital for emergency transfer of a patient or a newborn child, with written procedures for such transfer being displayed and understood by staff members.

Brand Name means a trade name medication.

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

Chiropractic Care is treatment to prevent and treat health problems by using spinal adjustments in order to correct misalignments, or subluxations.

Clean Claim. A Clean Claim is one that can be processed in accordance with the terms of this document without obtaining additional information from the service provider or a 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 and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Charges 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 Charges 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 Plan Participant has failed to submit required forms or additional information to the Plan as well.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.

Complications of Pregnancy. The Plan considers the following conditions as complications of pregnancy:
- miscarriage or missed abortion;
- eclampsia;
- ectopic pregnancy;
- nephrosis or acute nephritis;
- cardiac decompression;
- hyperemesis gravidarum;
- other pregnancy related conditions that are medically severe.

False labor; occasional spotting; morning sickness; prescribed rest or like conditions not recognized as complications of pregnancy are not covered by the Plan.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan. See section entitled *Coverage of Medical Expenses*.

Covered Medical Expense(s). See section entitled *Coverage of Medical Expenses.*

Covered Person means any person meeting the eligibility requirements for coverage as specified in the Plan and properly enrolled in the Plan.

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

Dependent means the covered Spouse and/or covered child(ren) of the Covered Employee.

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Designated Transplant Provider means a Physician or health care facility that has met the strict medical criteria of MedCost Health Management and/or the Plan's stop loss carrier, for the transplantation of human organs and/or tissues.

Drug Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Durable Medical Equipment means items which:

- are primarily used to serve a medical purpose;
- are generally not useful to a person in the absence of sickness or injury;
- can withstand repeated use; and
- are appropriate to use in a patient's home for activities of daily living. These are walking, eating, drinking, dressing, toileting, transferring (for example, from wheelchair to bed) and bathing.

Durable medical equipment includes, but is not limited to, apnea monitors, glucometers, oxygen equipment, hospital type beds; traction equipment; wheelchairs; and walkers , as well as any supplies necessary to the function of the equipment. Durable medical equipment does not include: exercise equipment and whirlpool baths; air conditioners, dehumidifiers and humidifiers; handrails, ramps, elevators and stair guides; telephones; adjustments made to vehicles; changes made to a home or place of business; and other equipment that has both non-therapeutic and therapeutic use.

Charges for durable medical equipment are covered if its rental (or, at the Plan's option, purchase) is required for therapeutic use, and prescribed by a doctor. However, in no event will rental allowances ever exceed the actual purchase price of the equipment. Only the least expensive item required by the patient's medical condition is covered.

Emergency Medical Condition means 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 that may place the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part. Examples include, but are not limited to, heart attacks, poisonings, loss of consciousness, convulsions, and serious falls.

Emergency Services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Employee is any person who is rendering personal services on a permanent basis to the Company for compensation. Such work may occur either at the usual place of business of the Company or at a location to which the business of the Company requires the Employee to travel.

Employer is Maryfield, Inc. dba Pennybyrn,

Enrollment Date is the first day an eligible Employee may apply for coverage. If there is a Waiting Period, the first day of the Waiting Period is the enrollment date. If there is no Waiting Period, the date of hire is the enrollment date.

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

Experimental, Investigational or not Medically Necessary. Experimental or Investigational or not Medically Necessary means any supply, medicine, facility, equipment, service, or treatment that is not currently or at the time the charges were incurred recognized as an acceptable, safe, effective, and necessary medical practice for the medical condition for which the supply, medicine, facility, equipment, service, or treatment was provided or is proposed. See Medical Benefits Exclusions.

Foster Child is a minor in the primary sole custody of the covered Employee as assigned by order of a court.

Generic drug means a pharmaceutical product manufactured and sold under its chemical, common or official name, and is approved by the Food and Drug Administration (FDA).

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Genetic Information means information about:
- An Employee's genetic tests
- Genetic tests of an Employee's family members (up to and including fourth-degree relatives and a fetus or embryo)
- Any manifestation of a disease or disorder in a family member
- Participation of an Employee or family member in research that includes genetic testing, counseling, or education.

Home Health Care Agency means a Hospital, a public or private agency or other service that is certified (or licensed if licensing is required) by the state in which it is located to provide medical care and treatment in the home. The agency must meet all of the following conditions:
- It has a full-time administrator;
- It is primarily engaged in and licensed by the Community Health Accreditation Program (CHAP) to provide skilled nursing services and other therapeutical services;
- The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan; and
- It maintains a complete medical record on each individual.

Home Health Care Plan means a written program for care and treatment which
- Is required as a result of an Illness or Injury; and
- Is established and approved by the Plan Participant's attending Physician; and
- is in lieu of continued confinement as a Hospital inpatient;

Hospice means a facility, agency or service that arranges, coordinates and provides special physical, psychological and spiritual needs for dying individuals and their families. A Hospice Care program furnishes palliative or supportive care focused on comfort and not cure.

A Hospice facility provides services and supplies under a Hospice Care program and admits at least 2 unrelated patients.

Hospital is an institution that:
- is operating in accordance with the law of the jurisdiction in which it is located, pertaining to institutions identified as Hospitals;
- is primarily engaged in providing, for compensation from its patients and on an inpatient basis, diagnosis, treatment and care of Injured or sick persons by or under the supervision of a staff of Physicians or Surgeons;
- continuously provides 24-hour nursing services by graduate registered nurses (RNs);
- maintains facilities on the premises for major operative surgery;
- is not an institution established primarily for the Custodial Care of patients such as a rest home or nursing home but rather renders recognized medical services for the treatment of medical or psychiatric conditions;
- is a Hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or is recognized by the American Hospital Association (AHA).

The definition of "Hospital" may also include:
- a facility operating legally as a psychiatric Hospital for Mental Health and licensed as such by the state in which the facility operates.
- a facility operating primarily for the treatment of Substance Use Disorders (alcohol and/or drugs) that maintains permanent and full-time facilities for bed care, has a Physician in regular attendance, continuously provides 24-hour day nursing service by a registered nurse, has a full-time psychiatrist or psychologist on the staff and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Use Disorders.

A qualified provider of psychiatric rehabilitative treatment:
- Must be under the direction of a board-eligible or certified psychiatrist or general psychiatrist. The Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation must accredit the program as a residential treatment facility.
- Hospital licensure is required if the treatment is Hospital based.

See also Psychiatric Rehabilitative Treatment Center under Defined Terms.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder or pregnancy of a Plan Participant. A recurrent Illness will be considered one illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated or separated by at least six (6) weeks. All such disorders existing simultaneously that are due to the same or related causes shall be considered one Illness.

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Infertility means the medical inability of a male and female couple to conceive by natural means, or the inability to sustain a pregnancy to term.

Injury means a condition caused by accidental means that results in damage to the Plan Participant's body from an external force. Benefits are payable only for Injuries incurred while not engaged in work-related activities.

A qualified **Institutional Review Board (IRB)** is one that meets all the federal requirements for the operation of an IRB as specified in the Code of Federal Regulations, and has not been disqualified to oversee clinical research by the NIH or FDA and has taken corrective action to rectify any noncompliance issue raised by the NIH or FDA within the past three years and has passed all subsequent NIH or FDA inspections.

Intensive Care Unit / Coronary Care Unit / Acute Care Unit are Hospital areas maintained specifically for critically ill patients. These specialized units have readily available life saving equipment; provide specialty nursing care; contain at least 2 beds; and no less than one registered nurse (R.N.) on duty at all times.

Intensive Outpatient (or Intensive Outpatient Program). An Intensive Outpatient Program (IOP) is a kind of treatment, service and support program used primarily to treat eating disorders, depression, self-harm and chemical dependency that does not rely on detoxification, and is group-based and non-residential. A typical IOP consists of 3 hours of care 3 times per week, where the patient lives at home or another environment; however, the frequency and length of treatment sessions may vary.

Life-threatening Condition. A Life-threatening Condition is a disease or condition likely to result in death unless the disease or condition is interrupted, as defined under the Public Health Service Act § 2709(e). See also Schedule of Benefits, Medical Benefit Exclusions and the remainder of the Plan's Defined Terms for more information regarding coverage of Routine Patient Costs associated with an Approved Clinical Trial.

Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Plan Participant. If a Plan Participant is covered by this Plan on more than one occasion, payments on all occasions shall be counted.

Marketplace. Under PPACA, the Health Insurance Marketplace, sometimes known as the Marketplace or health insurance "exchange" helps uninsured people enroll in health coverage. See the website at **https://www.healthcare.gov/quick-guide/** for more information.

Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) shall be calculated by the Plan Administrator taking into account and after having analyzed at least one of the following:

1. The Usual, Customary and Reasonable amount.
2. The allowable charge under the terms of the Plan.
3. The negotiated rate established in a contractual arrangement with a provider.
4. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual, Customary and Reasonable amount. The Plan has the discretionary authority to decide if a charge is Usual, Customary and Reasonable and for a Medically Necessary service. (Refer to Covered Medical Expenses.)

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, upcoding, duplicate charges, and charges for services not performed.

Measurement Period means the defined period during which the Plan measures each Employee's average hours of service per week. If the hours average at least 30 hours of service per week, the Employee will be treated as a full-time Employee and will be eligible for Employee coverage for the subsequent defined Stability Period. The Initial Measurement Period for a new Employee will be the 12–month period beginning on the date of hire. If such Employee is deemed to average at least 30 hours of service per week during the Initial Measurement Period, the Employee will be treated as a full-time Employee and will be eligible for Employee coverage beginning at the end of the administrative period following the Initial Measurement Period.

MedCost Benefit Services, LLC is the third party administrator contracted by the Plan to perform third party administration services for the Plan and to process claims for the Employer.

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Medical Care Facility refers to an institution, place, building or agency that furnishes, conducts, and operates health services for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity, or physical or mental health condition (including but not limited to Hospitals and Skilled Nursing Facilities).

MedCost PPO is a preferred provider organization (PPO). This is a network of medical care providers who agree to participate in a special cost containment program. Under this program, Plan Participants who use the services of a PPO (Network) Provider receive greater levels of benefits than those who use a Non-PPO (Non-Network) provider.

Medically Necessary means health care services, supplies or treatment which us appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

The fact that a Provider may have prescribed, ordered, recommended or approved certain services or supplies to the Plan Participant does not necessarily mean that such services or supplies satisfy the above criteria. The Plan Administrator has the authority to determine Medical Necessity.

Medicare is the insurance program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is recognized by the general psychiatric community.

Morbid Obesity (synonymous with "clinically severe obesity") is a condition that is characterized by excessive accumulation and storage of fat in the body and that in an adult is typically indicated by a body mass index (BMI) 40 kg/m^2 or with being 100 pounds overweight.

Network Hospital, Physician or Provider means a Hospital, Physician or other provider that has an agreement with a Preferred Provider Organization to make covered services available to a Plan Participant at reduced rates.

No Surprises Act is the No Surprises Act, Pub. L. No. 116-260, as amended.

Non-Ancillary Services are health care services other than Ancillary Services as defined herein.

Non-Network Hospital, Physician or Provider means a Hospital, Physician or other provider that does not have an agreement with a Preferred Provider Organization to make covered services available to a Plan Participant at reduced rates.

Non-Traditional Medical Service or Services means any practice or therapy that is perceived by its users to have the healing effects of medicine, but does not originate from evidence gathered using the scientific method, is not part of biomedicine, or is contradicted by scientific evidence or established science. Examples include, but are not limited to, homeopathy, naturopathy, and energy medicine.

Observation means services furnished by a Hospital on the Hospital's premises, including use of a bed and periodic monitoring by the Hospital's nursing or other staff, which is reasonable and necessary to evaluate an outpatient's condition, or to determine the need for a possible admission to the Hospital as an inpatient. This is normally less than a 24-hour period but can extend to 48 hours if Medically Necessary. Observations extending longer than 48 hours will be considered as an inpatient confinement and will require precertification

Outpatient Care and/or Services means treatment or services not requiring confinement in a Hospital.

Partial Hospitalization for the treatment of Mental Health and Substance Use Disorders means an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Use Disorders when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse. This program shall be administered in a facility that is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide Partial Hospitalization services, if required, by the state in which the facility is providing these services. Treatment typically consists of 3 to 6 hours per day for 5 days per week, however the frequency and length of treatment sessions may vary. Partial Hospitalization does not include a charge for room and board since the patient lives at home or in another environment.

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Physician is a provider that is licensed by the state medical board in the jurisdiction in which the services are provided, such as a medical or dental doctor or surgeon, audiologist, chiropodist, chiropractor, licensed professional counselor, masters level social worker, midwife, nurse practitioner, optometrist, osteopath, Physician's assistant, physical or occupational therapist, podiatrist, psychiatrist, psychologist, and speech therapist, to the extent that such persons, within the scope of their license, are permitted to perform services covered by the Plan. A Physician shall not be a Plan Participant or any close relative of the Plan Participant.

Plan. Maryfield, Inc. dba Pennybyrn has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA) for certain employees of Maryfield, Inc. dba Pennybyrn. The benefits described in this booklet constitute benefits available under the Plan and are referred to collectively in this booklet as "the Plan".

Plan Administrator. The person appointed by the Plan Sponsor to be responsible for the management of the Plan in accordance with its terms and for the establishment of its policies, interpretations, practices and procedures. The Plan Administrator may employ persons or firms to process claims and perform other services on behalf of the Plan; however, the decisions of the Plan Administrator will be final and binding on all interested parties.

Plan Participant is any Employee, Spouse or Dependent who is covered under the Plan.

Plan Sponsor. The term "Plan Sponsor" means the entity as defined at section 3(16)(B) of ERISA, 29. U.S.C. § 1002(16)(B).

Plan Year means the 12-month Plan Year that is disclosed in the Summary Plan Description and in the Form 5500 Filing, if applicable.

Pregnancy means that physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

Prenatal Care. Care related to Pregnancy before birth, excluding labor, birth/delivery and post-delivery.

Prescription Drugs means injectable insulin and drugs that have been recognized in the United States Pharmacopoeia, the National Formulary, or New and Non-Official Remedies for the preceding year. These are drugs that under Federal Law may only be dispensed by written order of a doctor and which are approved for general use by the Food and Drug Administration. The drugs must be dispensed on or after the covered person's effective date of coverage under the Plan.

Psychiatric Rehabilitative Treatment Facility. A qualified provider of psychiatric rehabilitative treatment:

- Must be under the direction of a board-eligible or certified psychiatrist or general psychiatrist. The Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation must accredit the program as a residential treatment facility.
- Hospital licensure is required if the treatment is Hospital based.

See also Hospital under Defined Terms.

Qualified Health Plan (QHP). Under PPACA an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like Deductibles, Copayments, and out-of-pocket maximum amounts), and meets other requirements. A Qualified Health Plan will have a certification by each Marketplace in which it is sold.

Qualified Individual. A Qualified Individual means a Plan Participant who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-threatening Condition and a) either the individual's doctor has concluded that participation is appropriate, or b) the covered person provides medical and scientific information establishing that his or her participation is appropriate. See also Schedule of Benefits, Medical Benefit Exclusions and the remainder of the Plan's Defined Terms for more information regarding coverage of Routine Patient Costs associated with an Approved Clinical Trial.

Qualified Medical Child Support Order (or QMCSO) means any judgment, decree or order (including approval or settlement agreement) issued by a court of competent jurisdiction that creates or recognizes the right of a Covered Person's child (called an alternate recipient in the law) to receive benefits under the Plan.

Qualifying Payment Amount is a payment amount calculated pursuant to Section 102 of the No Surprises Act for applicable claims.

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Rescission means a cancellation or discontinuance of coverage that has a retroactive effect.

Residential Treatment. Residential Treatment for Mental Disorders and Substance Use Disorders is a rehabilitation program where services are provided in a temporary living arrangement similar to a Skilled Nursing Facility but in which 24-hour nursing services are provided to a patient who is not an immediate danger to self or others, and who needs this structure to maintain his or her current recovery level as determined by a qualified provider of psychiatric rehabilitative treatment.

Residential Treatment Facility. See definition of Hospital.

Routine Patient Costs are defined as health care items or services that are furnished to an individual enrolled in an Approved Clinical Trial, which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the Approved Clinical Trial, and would be covered if the patient did not participate in the Approved Clinical Trial. Routine Patient Costs for items and services to diagnose or treat complications or adverse events arising from participation in an Approved Clinical Trial are items and services furnished in connection with participation in an Approved Clinical Trial, and accordingly, are required to be covered in accordance with Federal law if the plan typically covers such items or services for a Qualified Individual who is not enrolled in an Approved Clinical Trial.

Routine Patient Costs do not include any of the following:

- An FDA approved drug or device shall be a Routine Patient Cost only to the extent that the drug or device is not paid for by the manufacturer, the distributor or the provider of the drug or device, or
- The investigational item, device or service, itself; or
- Items and services that are provided solely to satisfy clinical trial data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- Non-health care services that a patient may be required to receive as a result of being enrolled in the Approved Clinical Trial, or
- Costs associated with managing the research associated with the Approved Clinical Trial, or
- Costs that would not be covered for non-investigational treatments, or
- Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Approved Clinical Trial, or
- The costs of services, which are not provided as part of the Approved Clinical Trial's stated protocol or other similarly, intended guidelines.

See also Schedule of Benefits, Medical Benefit Exclusions and the remainder of the Plan's Defined Terms for more information regarding coverage of Routine Patient Costs associated with an Approved Clinical Trial.

Skilled Nursing Facility means an institutional provider that meets the following requirements:

- it is approved as a Skilled Nursing Facility by the Medicare Program or the Joint Commission on Accreditation of Hospitals;
- it has a Physician available at all times;
- it has a Registered Nurse (RN) or Physician on full-time duty in charge of patient care;
- it has one or more RN's or LPN's or LVN's on duty at all times;
- it keeps a daily medical record for each patient; and
- is primarily engaged in providing skilled nursing care and related services for convalescent and rehabilitative care and it is not, other than incidentally, a place that provides minimal care, custodial care, ambulatory care, or care for treatment of mental illness.

The term shall also apply to expenses incurred in an institution referring to itself as a Convalescent Nursing Facility or Extended Care Facility or any other similar designation.

Specialty Pharmacy is a program provided through the pharmacy benefit manager, or a preferred pricing arrangement with a Network provider. See Prescription Drug Benefits, Limitations and Exclusions.

Stability Period means the defined period during which an Employee who was deemed full-time during the Measurement Period will be eligible for Employee coverage under the Plan. The Initial Stability Period for a new Employee will be the 12-month period following the Initial Measurement Period (plus an administrative period) during which the new Employee was deemed to be a full-time Employee.

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Substance Use Disorder / Chemical Dependency is the physiological and psychological addiction to a controlled drug, substance or alcohol. Dependency on tobacco, nicotine and/or caffeine are not included in this definition.

Telemedicine is the practice of medicine using electronic communications, information technology or other means between a Physician in one location and a patient in another physical location. Telemedicine typically involves secure videoconferencing or store-and-forward technology that replicates the traditional Physician-patient interaction.

Temporomandibular Joint (TMJ) is a condition resulting from disease of or Injury to the temporomandibular joint. This joint is a hinge joint that controls the movement of the lower jaw. The joint is controlled by:

- Muscles on each side of the face and those in the back of the head and neck. These muscles open and close the jaw; and
- The position of the teeth in the upper and lower jaw. The teeth determine how far the hinge will close.

Total Disability (Totally Disabled) means:

- In the case of an Employee, an actual or perceived impairment that substantially limits one or more major life activities of the Employee. Total Disability is determined by the employer.
- In the case of a Dependent, an actual or perceived impairment that substantially limits one or more major life activities of the Dependent.

Usual, Customary and Reasonable (UCR). See section entitled *Coverage of Medical Expenses.*

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NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how Medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of your Group Health Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your Employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

1) your past, present, or future physical or mental health or condition;
2) the provision of health care to you; or
3) the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the Plan Administrator, as designated in your Summary Plan Description.

Effective Date
This Notice is effective August 15, 2013.

Our Responsibilities
We are required by law to:
- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

How We May Use and Disclose Your Protected Health Information
Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other Hospital personnel who are involved in taking care of you. For example, we may share your protected health information with a utilization review or precertification service provider.

- **For Payment.** We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or Medically Necessary, or to determine whether the Plan will cover the treatment. Likewise, we may share your

protected health information with another entity to assist with the adjudication or subrogation of health Claims or to another health plan to coordinate benefit payments.

- **For Health Care Operations.** We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting Claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your Genetic Information for underwriting purposes.

- **Treatment Alternatives or Health-Related Benefits and Services.** We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

- **To Business Associates**. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your Claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

- **As Required by Law.** We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a Physician.

- **To Plan Sponsors.** For the purpose of administering the Plan, we may disclose to certain Employees of the Plan Sponsor protected health information. However, those Employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Organ and Tissue Donation.** If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military.** If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or Illness.

- **Public Health Risks.** We may disclose your protected health information for public health activities. These activities generally include the following:
  - to prevent or control disease, Injury, or disability;

- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

- **Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

- **Law Enforcement.** We may disclose your protected health information if asked to do so by a law- enforcement official in response to a court order, subpoena, warrant, summons, or similar process:
  - to identify or locate a suspect, fugitive, material witness, or missing person;
  - about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
  - about a death that we believe may be the result of criminal conduct; and
  - about criminal conduct.

- **Coroners, Medical Examiners, and Funeral Directors.** We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

- **National Security and Intelligence Activities.** We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Inmates.** If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- **Research.** We may disclose your protected health information to researchers when: (1) the individual identifiers have been removed; or (2) when an Institutional Review Board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures
The following is a description of disclosures of your protected health information we are required to make.

- **Government Audits.** We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

- **Disclosures to You.** When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

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Other Disclosures

- **Personal Representatives.** We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice / authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

- **Spouses and Other Family Members.** In most situations, we send mail to the Employee / member. This includes mail relating to the Employee's Spouse and other Family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the Employee's Spouse and other Family members and information on the denial of any Plan benefits to the Employee's Spouse and other Family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

- **Authorizations.** Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

- **Right to Inspect and Copy.** You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

  To inspect and copy your protected health information, you must submit your request in writing to the Plan Administrator. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Plan Administrator.

- **Right to Amend.** If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

  To request an amendment, your request must be made in writing and submitted to the Plan Administrator. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - is not part of the medical information kept by or for the Plan;
  - was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - is not part of the information that you would be permitted to inspect and copy; or
  - is already accurate and complete.

  If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

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- **Right to an Accounting of Disclosures.** You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or Family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

  To request this list or accounting of disclosures, you must submit your request in writing to the Plan Administrator. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a Family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

  Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

  We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, you must make your request in writing to the Plan Administrator. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply -- for example, disclosures to your Spouse.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing to the Plan Administrator. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to Be Notified of a Breach.** You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at the following website: **http://www.medcost.com/**. To obtain a paper copy of this notice, contact the Plan Administrator.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Plan Administrator. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Potential Impact of State Laws
The HIPAA Privacy Regulations generally do not ‘preempt’ (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV, or AIDS, Mental Disorders, Substance Use Disorders / Chemical Dependency, genetic testing, and reproductive rights.

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YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

1. Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

2. Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is the plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in the plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). The plan will pay out-of-network providers and facilities directly.
- Under the No Surprises Act, health plans generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

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If you believe you've been wrongly billed, you may contact the Department of Health and Human Services' (HHS) No Surprises Helpdesk at 1-800-985-3059 or visit the HHS No Surprises website at www.cms.gov/nosurprises/consumers.

Visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

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GENERAL PLAN INFORMATION

Type of Administration: The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees.

Plan Name: Maryfield, Inc. dba Pennybyrn Employee Group Health & Welfare Plan

ERISA Plan Number: 501

Group Number: 1275

Tax Id Number: 58-1363950

Plan Effective Date: March 1, 1996
Revised and Restated October 1, 2007; Amended October 1, 2008; Amended October 1, 2009; Amended December 1, 2009; Amended January 1, 2010; Amended and Updated April 1, 2010; Amended May 1, 2010; Amended and Restated October 1, 2010; Amended August 1, 2011; Amended and Restated October 1, 2011; Amended October 1, 2012; Amended August 15, 2013; Amended October 1, 2013; Amended December 1, 2013; Amended January 1, 2014; Amended and Restated October 1, 2014; Amended and Restated October 1, 2015; Amended and Restated October 1, 2016; Amended May 1, 2017; Amended and Restated October 1, 2017; Amended and Restated October 1, 2018; Amended January 1, 2019; Amended and Restated October 1, 2019; Amended January 1, 2020; Amended April 1, 2020; Amended March 18, 2020; Amended and Restated October 1, 2020; Amended October 1, 2020; Amended January 1, 2020; Amended January 1, 2021; Amended and Restated October 1, 2021; Amended and Restated October 1, 2022;Amended October 1, 2022; Amended and Restated January 1, 2024.

Plan Year Ends: Last day of February

Plan Year: March 1st through last day of February

Benefit Year: January 1st through December 31st

Employer Information:
Maryfield, Inc. dba Pennybyrn
1315 Greensboro Road
High Point, North Carolina 27260
336-886-2444

Plan Administrator
Maryfield, Inc. dba Pennybyrn
1315 Greensboro Road
High Point, North Carolina 27260
336-886-2444

Named Fiduciary
Maryfield, Inc. dba Pennybyrn
1315 Greensboro Road
High Point, North Carolina 27260

Agent for Service of Legal Process
Maryfield, Inc. dba Pennybyrn
1315 Greensboro Road
High Point, North Carolina 27260

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Additional Providers
5 Stone Therapy LLC
2036 Quill Ct.
Kannapolis, NC 28083
85-2889571

Anderson Therapy Services
3891 Arnold Rd
Lexington, NC
83-1516642

Third Party Administrator
MedCost Benefit Services, LLC
165 Kimel Park Drive
Winston-Salem, North Carolina 27103
336-774-4400

Claims Administrator:
MedCost Benefit Services *
PO Box 25987
Winston-Salem, North Carolina 27114-5987
800-795-1023

**In compliance with California law, MedCost Benefit Services operates in the state of California as "MedCost Benefit Services d/b/a MBS Third Party Administrators."*

Discretionary Authority
The Plan Administrator 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 Plan Participant's rights; and to determine all questions of fact and law arising under the Plan.

Health Claims
Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, applicable law, and with ERISA. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Claims Administrator. The Plan Administrator may delegate to the Claims Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Claims Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.