AMENDMENT 18
TO THE
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
FOR
MEDICAL BENEFIT PLAN OF WOOD'S POWR-GRIP CO., INC.

EFFECTIVE: MARCH 1, 2018

1. AMEND the ELIGIBLE CLASSES OF DEPENDENTS, Section (1) provision listed in the ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS section as follows:

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

(1) A covered Employee's **Spouse** and **children** from birth to the limiting age of 26 years. When the child reaches limiting age, coverage will end on the last day of the child's birthday month.

The term "**Spouse**" shall mean an individual of the opposite or same sex recognized as the covered Employee's husband or wife by the laws of the state in which the marriage was formalized. Documentation proving a legal marital relationship will be required by the Plan Administrator. Any "Spouse" covered under the Plan with a Common Law Marriage agreement before March 1, 2018, will be grandfathered in and remains a covered Spouse. After March 1, 2018, Common Law Marriage is not an eligible class.

The term "**children**" shall include natural children, adopted children or children placed with a covered Employee in anticipation of adoption, and Foster Children. Step-children may also be included as long as a natural parent remains married to the Employee and resides in the Employee's household. Other children are covered if they are the natural child of a covered Dependent and the Employee pays 100% of their support and the child(ren) resides with the covered Employee or is a Full-Time student as described above.

If a covered Employee is the **Legal Guardian** of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "**child placed with a covered Employee in anticipation of adoption**" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, 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.

Any child of a Plan Participant who is an alternate recipient under a **Qualified Medical Child Support Order** (QMCSO) shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

AMENDMENT #19
TO THE
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
FOR
WOOD'S POWR-GRIP CO., INC.
MEDICAL BENEFIT PLAN

Effective Date: January 1, 2020

1. **AMEND the SCHEDULE OF BENEFITS section to add the WELLVIA TELEHEALTH BENEFIT under the PHYSICIAN SERVICES subsection, as follows:**

***WellVia* Telehealth benefit**	$0

2. **AMEND the MICARE HEALTH CENTER BENEFITS BENEFITS section, THE MICARE HEALTH CENTER BENEFITS SCHEDULE subsection, as follows:**

***mi*Care HEALTH CENTER BENEFITS SCHEDULE**

Maximum Benefit Amount Per Calendar Year	*Unlimited*
DEDUCTIBLE, PER CALENDAR YEAR	
Per Covered Person	*none*
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	
Per Covered Person	*none*
Covered Charges	**Covered Person Pays**
Routine Well Care	$0
Office visits / minor office visit procedures	$0
Laboratory Services	$0
***Select* Prescription Drugs**	$0
Note: *miCare can provide an initial 30-day supply for select prescription drugs. These drugs may include but are not limited to; antibiotic medicines, maintenance supply medications, and women's contraceptives.*	
All Other Covered *mi*Care Services	$0

3. **AMEND to REPLACE the PRESCRIPTION DRUG BENEFIT subsection of the SCHEDULE OF BENEFITS section, as follows:**

PRESCRIPTION DRUG BENEFIT

If applicable, this Plan will make a retroactive adjustment to a claim based on a discount, coupon, Pharmacy discount program or similar arrangement provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs.

m*i*Rx Pharmacy Option – Limited to a 34-day supply

Generic drugs
Copayment $5
Copayment ..... $0 with MiCare

Brand Name drugs (with no generic equivalent available)
Copayment $30

Brand Name drugs (with generic equivalent available)
Copayment $60

m*i*Rx Mail Order Prescription Drug Option – Limited to a 90-day supply

Generic drugs
Copayment $10

Brand Name drugs (with no generic equivalent available)
Copayment $60

Brand Name drugs (with generic equivalent available)
Copayment $120

Retail Pharmacy Option – Limited to a 34-day supply

Generic drugs

Copayment $10

Brand Name drugs (with no generic equivalent available)

Copayment $60

Brand Name drugs (with generic equivalent available)

Copayment $120

Specialty Prescriptions-Retail and MiRx Pharmacy Options

Copayment $150

It is required that specialty prescriptions be purchased through miRx.

Additional information on Prescription Drugs may be found in the Prescription Drug Benefit section of this document.

4. AMEND the following PHYSICIAN CARE language under the COVERED CHARGES portion of the MEDICAL BENEFITS section as follows:

Physician Care. The professional services of a Physician for surgical or medical services.

~~Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:~~ Charges for multiple surgical procedures are subject to the following provisions in the absence of a negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement:

(a) If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on Allowable Charge for the primary procedures; 50% of the Allowable Charge for each additional procedure performed through the same incision or during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowable Charge percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Allowable Charge.

5. REPLACE the CLAIMS REVIEW PROCEDURE privison with the following:

INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

A **Claim** means a request for a Plan benefit, made by a Claimant (Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims). A Claim does not include an inquiry on a Claimant's eligibility for benefits, or a request by a Claimant or his Physician for a pre-notification of benefits on a medical treatment. Pre-notification of certain services is strongly recommended, but not required by the Plan. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification is not required as a condition precedent to paying benefits, and cannot be appealed under this section. Please refer to the Care Management Services section.

A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply by virtue of an assignment of benefits. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives.

There are two types of claims.

Concurrent Care Determination

A **Concurrent Care Determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If Case Management is appropriate for a Plan Participant, Case Management is not considered a Concurrent Care Determination. Please refer to the Care Management Services section.*

Post-Service Claim

A **Post-Service Claim** is a Claim for medical care, treatment, or services that a Claimant has already received.

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims involving specialized medical knowledge or judgment.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

Initial Benefit Determination

The initial benefit determination on a Claim will be made within 30 days of the Claim Administrator's receipt of the Claim (or 15 days if the Claim is a Concurrent Care Determination). If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits**. If additional information is requested, the Plan's time period for making a determination is suspended until such time as the Claimant provides the information, or the end of the 45 day period, whichever occurs earlier. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

Notice of Adverse Benefit Determination

If a Claim is denied in whole or in part, the Plan shall provide written or electronic notice of the determination that will include the following:

(1) Information to identify the claim involved.

(2) Specific reason(s) for the denial, including the denial code and its meaning.

(3) Reference to the specific Plan provisions on which the denial was based.

(4) Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

(5) Description of the Plan's Internal Appeal Procedures and External Review Procedure and the applicable time limits. This will include a statement of the Claimant's right to bring a civil action once Claimant has exhausted all available internal and external review procedures.

(6) Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

(7) Any internal rule, **guideline, protocol, or other similar criterion that was relied upon in making the** determination on the Claim.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim.

(9) Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Plan participant's failure to timely pay required premiums.

Claims Review Procedure - General

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level internal review procedure and an external review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by an individual who is neither the individual who made the determination on a prior level of review, nor a subordinate of that individual. Additionally, if an External Review is requested, that review will be conducted by an Independent Review Organization that was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.

- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.

Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's Adverse Benefit Determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

Internal Appeal Procedure

First Level of Internal Review

The written request for review must be submitted within 180 days of the Claimant's receipt of a Notice of the Initial Benefit Determination (or 15 days for an appeal of a Concurrent Care Determination). The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The appeal should be addressed to:

Plan Administrator
℅ Employee Benefit Management Services, LLC (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Claims Administrator. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt

of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

Second Level of Internal Review

If the Claimant does not agree with the Claims Administrator's determination from the first Level of Internal Review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the First Level of Internal Review (or 15 days for an appeal of a Concurrent Care Determination),
along with any additional supporting information to:

Plan Administrator
℅ Employee Benefit Management Services, LLC (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The Second Level of Internal Review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

If the Claimant is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Claimant may request an External Review. The claimant must exhaust both levels of the Internal Review Procedure before requesting an External Review, unless the Plan Administrator did not comply fully with the Plan's Internal Review Procedure for the first level of review. In certain circumstances, the Claimant may also request an expedited External Review.

External Review Procedure

This Plan has an External Review Procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within 4 months from the date of receipt of the notice of the final internal Adverse Benefit Determination or the 1st of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a Claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or services is not Medically Necessary.
- Determination that a treatment is Experimental or Investigational.
- Rescission of coverage, whether or not the rescission involved a Claim.
- Application of treatment limits to a Claim for a Mental Disorder

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an External Review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within 6 business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If

Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for External Review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law. Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

6. AMEND every reference to the CLAIMS REVIEW PROCEDURE or CLAIMS PROCEDURE with INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURE throughout.

7. REPLACE the following TIMELY FILING language found in the INTRODUCTION, MEDICAL BENEFITS and Plan EXCLUSIONS sections as follows:

~~A Plan Participant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in the Claims Procedure section. If a lawsuit is brought, it must be filed within one year after the final determination of an Appeal.~~

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedure section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.