PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

WOOD'S POWR-GRIP CO., INC.
MEDICAL BENEFIT PLAN

EFFECTIVE: JANUARY 1, 2003

RESTATED: JANUARY 1, 2023

COVID-19 Testing

COVID-19 Outbreak

OTC COVID-19 Testing Resolution

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INTRODUCTION

This document is a description of **Medical Benefit Plan of Wood's Powr-Grip Co., Inc.** (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

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.

Where a court order, administrative order, judgement, new or changed law or regulation applies to the provisions of this Plan, the Plan will be deemed to have been automatically amended (without further action on the part of the Plan Administrator), to ensure that the Plan conforms to such change. For example, where Plan provisions involve stated maximums, exclusions or limitations, and the change would cause the Plan Administrator to provide greater benefits than what would have been available prior to the change, payment of the greater benefit will be considered to have been made in accordance with the terms of this Plan. For the avoidance of doubt, it is the intent of the Plan Administrator that the Plan conform at all times to the requirements of any and all controlling law, including by way of example and not exclusion, the Employee Retirement Income Security Act (ERISA) of 1974, as amended.

Failure to follow the eligibility or enrollment requirements 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 cost management requirements, lack of Medical Necessity, lack of timely filing of claims, or lack of coverage.

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.

No action at law or in equity shall be brought to recover under 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.

A Plan Participant may not assign or transfer any benefits or rights that arise under the Plan or applicable law to any other person, including a healthcare provider, and any purported assignment or transfer is void. This includes (but is not limited to) an attempted assignment or transfer of claims for payment of benefits, breach of fiduciary duty, penalties or any other claim or remedy. For convenience, the Plan may pay any undisputed benefit directly to the healthcare provider, but this is not a waiver of this anti-assignment provision and does not make the healthcare provider an assignee or confer any other rights on the provider. Similarly, the Plan recognizes an authorized representative for purposes of the Plan's claims and appeal procedures, but the authorized representative is not an assignee and has no derivative rights with respect to the claim. However, this anti-assignment provision will not apply (1) to an assignment of a Plan Participant's rights to the Plan or the Plan Administrator, or (2) to the extent required under Medicaid laws.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures 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.

The Claims Administrator utilizes Aetna's Clinical Policy Bulletins (CPBs) to determine whether services and procedures are considered Medically Necessary and Experimental and/or Investigational under the Plan. The CPBs are based on peer-reviewed, published medical journals, a review of available studies on a particular topic, evidence-based consensus statements, expert opinions of health care professionals, and guidelines from nationally recognized health care organizations. These CPBs are reviewed on a regular basis based upon a review of currently available clinical information.

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.

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

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan, and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Medical Benefits. Explains when the benefit applies and the types of charges covered.

Care Management Services. Explains the methods used to curb unnecessary and excessive charges.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

How to Submit a Claim. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Plan Participant has a claim against another person because of Injuries sustained.

COBRA Continuation Coverage. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Plan Participants' rights under the Plan.

ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claims Administrator to obtain 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.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of the Employer.

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, Active Employee of the Employer. An Employee is considered to be full-time if he or she normally works at least **30 hours** per week and is on the regular payroll of the Employer for that work; or

If the Employee is not designated as a full-time Employee by the Employer, the Employer has elected to use the monthly measurement method for all Employees to determine full-time status. An Employee must average or be expected to average at least 30 hours of service each week to become eligible for coverage.

To remain eligible for coverage, the Employee must average at least 30 hours of service each week. For more information on benefit measurement periods, contact the Company's Human Resources Department.

(2) Is in a class eligible for coverage; and

(3) Completes the employment Waiting Period of 90 days as an Active Employee, with coverage beginning no later than the 91st day. 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.

Employee Status Changes

If a covered Employee changes from part-time to full-time status as defined by the Plan, credit will be given for any Waiting Period satisfied while employed as part-time. An enrollment form is required and must be submitted in a "timely" manner as stated in the Timely Enrollment provision under this Plan. Coverage will be effective the first day of the calendar month following the date the Employee satisfies the Waiting Period, if applicable, or changes to full-time status, whichever is later.

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

(1) **A covered Employee's Spouse.**

The term "**Spouse**" shall mean the person to whom the covered Employee is legally married. 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. This Plan does not allow coverage for domestic partnerships or civil unions.

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

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 the 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.

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.

(3) A **covered Dependent child who reaches the limiting age** and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance, and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: Other individuals living in the covered Employee's home, but who are not eligible as defined; the divorced former Spouse of the Employee; 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 parents are Employees, their children will be covered as Dependents of one of the parents, but not of both.

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.

FUNDING

Cost of the Plan. Wood's Powr-Grip Co., Inc. shares the cost of coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed, and returned with the enrollment application.

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.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage also, if Dependent coverage is desired.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee is automatically enrolled in this Plan for the first 31 days from the date of birth. In order to continue coverage beyond the first 31 days from the date of birth, the newborn child must be enrolled in the Plan as defined in the "Timely Enrollment" section. Otherwise, there will be no additional payment from the Plan and the parents will be responsible for any additional costs.

TIMELY, LATE, OR OPEN ENROLLMENT

(1) **Timely Enrollment** – The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (parents) 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.

(2) **Late Enrollment** – An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

Unless otherwise required by law, if an individual loses eligibility for coverage as a result of terminating employment, reduction of hours of employment, or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins as specified in the Open Enrollment provision.

(i) **Open Enrollment** – Every **December**, during the annual open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan. Benefit choices for Late Enrollees made during the open enrollment period will become effective **January 1**.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

(3) **Enrollment Following Benefit Measurement Period** – Employees who qualified as full-time Active Employees during the applicable measurement period (and their eligible Dependents) may enroll in the Plan the first day of the first full calendar month of the following stability period. Employees will be credited for time previously satisfied toward the employment Waiting Period.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their 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 31 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 31 days after the birth, marriage, adoption, or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was either (i) under COBRA and the COBRA coverage was exhausted or (ii) not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date of the qualifying event.

For purposes of these rules, a loss of eligibility occurs due to one of the following:

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a Dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

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.

(2) **Acquiring a newly eligible Dependent may create a Special Enrollment right.** If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption, or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption, or the date of Foster Child placement. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) In the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) In the case of a Dependent's birth, as of the date of birth; or

(c) In the case of a Dependent's adoption or placement for adoption or Foster Child placement, the date of the adoption or placement for adoption or Foster Child placement.

(3) Medicaid or Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Employees and their Dependents who are otherwise eligible for coverage under the Plan, but who are not enrolled, can enroll in the Plan provided that they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility:

(a) The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or

(b) The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan.

This Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. *The effective date of coverage will be the first day of the first calendar month following the date of loss of coverage or gain in eligibility.*

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer, and its Employees.

For more information regarding special enrollment rights, contact the Plan Administrator.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. **If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.** The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated;

(2) The date the covered Employee's Eligible Class is eliminated;

(3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods;

(4) 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;

(5) If the Employee commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or

(6) As otherwise specified in the Eligibility section of this Plan.

Note: Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

Continuation During Periods of Employer-Certified Disability. A person may remain eligible for a limited time if active, full-time work ceases due to disability. This continuance will end as follows:

For disability leave only: The date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

If the Employee's leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will run consecutive with FMLA.

Coverage under this provision will continue in accordance with the same terms and conditions of an Active Employee. If a COBRA qualifying event occurs, any period of continued coverage under this section will not reduce the maximum time for which the Employee may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor and amended from time to time, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations. This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired prior to the end of a 13 consecutive week period after the date of termination will have coverage reinstated the first day of the first calendar month following the date of rehire. Employees rehired after a break in service of 13 consecutive weeks or more will be treated as a new hire.

However, if the Employee is returning to work directly from COBRA coverage, this Employee will be credited with time met towards the employment Waiting Period as of the date the Employee elected COBRA Continuation Coverage.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 24-month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA Continuation Coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA Continuation Coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Montana National Guard Members. Participants performing State active duty as a Montana National Guard member may elect to continue Plan coverage subject to the terms of the Montana Military Service Employment Rights Act (MMSERA) under the following circumstances:

(1) The period of coverage of a person under such an election shall be the period of time beginning on the date on which the person's absence for State active duty begins, and ending:

(a) The next regularly scheduled day of employment following travel time plus eight hours, if State active duty is 30 days or less; or

(b) The next regularly scheduled day of employment following 14 days after termination of State active duty, if State active duty is not more than 180 days; or

(c) The next regularly scheduled day of employment following 90 days after termination of State active duty, if State active duty is more than 180 days.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except that a person on State active duty for less than 180 days may not be required to pay more than the regular Participant's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Montana Department of Military Affairs to have been caused by or aggravated during performance of State active duty.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

(1) The date the Plan or Dependent coverage under the Plan is terminated;

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage.);

(3) On the last day of the calendar month in which a covered Spouse loses coverage due to loss of dependency status. (See the section entitled COBRA Continuation Coverage);

(4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled COBRA Continuation Coverage.);

(5) 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;

(6) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or

(7) As otherwise specified in the Eligibility section of this Plan.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this section are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are reasonable and customary (as defined as an Allowable Charge); and services, supplies, and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all Covered Charges and/or exclusions with specificity. Please contact the Claims Administrator regarding questions about specific supplies, treatments, or procedures.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services, or supplies. A benefit determination on a claim will be made only after the claim has been submitted. A pre-notification of services by CareLink is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures.

PROVIDER INFORMATION

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, that Plan Participant 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.

To access a list of Network Providers, please refer to the Network Provider website and/or toll free number listed on the **Wood's Powr-Grip Co., Inc Medical Benefit Plan identification card**. Prior to receiving medical care services, the Plan Participant should confirm with the provider and the Participating Provider Organization (PPO) that the provider is a participant in this network.

Under the following circumstances, the higher Network payment will be made for certain Non-Network services:

- If a Plan Participant resides outside of the PPO service area.
- If a Plan Participant has no choice of Network Providers in the specialty that the Plan Participant is seeking within the PPO service area.
- If a Plan Participant is referred to a Non-Network Provider by a Network Provider.

Covered Charges will be reimbursed at the Network Provider benefit level based on the Allowable Charge. The Plan Participant may be balance billed by the Non-Network Provider for any amount over the Allowable Charge.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed. It should be noted that this directory is to be used as a reference only. Prior to receiving medical care services, the Plan Participant should confirm with the provider and the Network Provider PPO that the provider is a participant in this organization. A toll free number for the Network Provider PPO customer service desk can be found in the directory.

NO SURPRISES ACT (NSA)

For Non-Network Provider charges subject to the No Surprises Act (NSA) (part of the Consolidated Appropriations Act of 2021), the Plan Participant cost-sharing will be the Network benefit level which will be calculated as if the Allowable Charge was the Recognized Amount. Any such cost-sharing amounts will accrue toward the Network Provider deductible and maximum out-of-pocket amount. The NSA prohibits Non-Network Providers from pursuing payment from the Plan Participant for the difference between the Allowable Charge and the Non-Network Provider's billed charge for services, except for any applicable cost-sharing.

Non-Network Provider charges subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Network Facility:
  - Provided the Plan Participant has not provided Notice and Consent (as explained below) to waive the applicability of the NSA;
  - Including the furnishing of equipment/devices, labs, imaging, telehealth, pre-operative, and post-operative services regardless of being physically located at the Network Facility; and
- Covered Charges for air ambulance services.

Benefit determinations for Non-Network Provider claims subject to the NSA will be made within 30 days of the Claims Administrator's receipt of the claim and if applicable, reimbursement will be submitted directly to the Non-Network Provider.

Notice and Consent. Exceptions to the NSA balance billing protections may apply when the Plan Participant receives non-emergency services (other than ancillary services) from a Non-Network Provider and gives written consent to receive those services as Non-Network Provider benefits. Ancillary services include anesthesiology, pathology, radiology, neonatology, assistant surgeons, hospitalists, intensivists, and items and services related to emergency medicine.

PROVIDER DIRECTORIES

If a Plan Participant seeks care based on incorrect information indicating that the provider was a Network Provider at the time the treatment or service was received, the Plan Participant's cost share will be limited to the Network Provider benefit level if the Plan Participant can provide proof within 30 days that they sought care based on the incorrect information.

CONTINUING CARE PROVISION

In accordance with the Consolidated Appropriations Act of 2021, when a Plan Participant is a receiving treatment from a Network Provider, and that provider's relationship with the Plan is terminated, not renewed, or otherwise ends for any reason (other than the Provider's failure to meet applicable quality standards or for fraud), the Plan Participant has rights to elect Continuing Care from the former Network Provider.

The Plan shall notify the Plan Participant in a timely manner that the Network Provider's contractual relationship with the Plan has terminated. If the Plan Participant **elects in writing** to receive Continuing Care, benefits will apply under the same terms and conditions as would have applied had the termination not occurred. This Continuing Care Provision becomes available as of the date of the letter received by the Plan Participant that the former Network Provider is no longer associated with the Plan. The Continuing Care Provision will cease 90 days after that date or when the Plan Participant ceases to receive Continuing Care, whichever occurs first.

Under the Continuing Care Provision, the former Network Provider or former Network Facility must: (i) accept reimbursement from the Plan and any applicable cost sharing from the Plan Participant as payment in full; and (ii) continue to adhere to all policies, procedures, and standards of care imposed by the Plan in the same manner as if the Network Provider termination had not occurred.

For purposes of this provision, a "Continuing Care" Plan Participant is:

(1) undergoing a course of treatment for a serious and complex condition from a specific Network Provider;

(2) undergoing a course of institutional or inpatient care from a specific Network Provider;

(3) scheduled to undergo non-elective surgery from a specific Network Provider, including postoperative care;

(4) pregnant and undergoing a course of treatment for the Pregnancy from a specific Network Provider; or

(5) terminally ill and receiving treatment for such Illness from a specific Network Provider.

DEDUCTIBLES/COPAYMENTS/COINSURANCE PAYABLE BY PLAN PARTICIPANTS

Deductibles/Copayments are dollar amounts that the Plan Participant must pay before the Plan pays.

A **deductible** is an amount of money that is paid once a Calendar Year per Plan Participant. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges (except for Covered Charges that are not 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 Calendar Year as well as the current Calendar Year.

Deductibles will not apply toward the maximum out-of-pocket amount.

Family unit deductible. When the maximum amount has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that Calendar Year.

A **copayment** is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

Copayments (including Prescription Drug copayments) do not apply toward the deductible amount.

Copayments (including Prescription Drug copayments) will apply toward the maximum out-of-pocket amount.

Coinsurance is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Medical Benefits Schedule and is the Plan Participant's responsibility until the maximum out-of-pocket amount is reached. Coinsurance *does not* apply to the deductible and *does not* include copayment amounts. Coinsurance *will apply* to the maximum out-of-pocket amount.

Benefit payment made by the Plan will be at the percentage rate shown in the Medical Benefits Schedule. No benefits will be paid in excess of any listed limit of the Plan.

Once the Plan has made the applicable benefit payment, the remaining percentage owed is the Plan Participant's "coinsurance" responsibility. For example, if the Plan's reimbursement rate is 80%, the Plan Participant's responsibility (or coinsurance) is 20%.

MAXIMUM OUT-OF-POCKET AMOUNT

Covered Charges are payable by the Plan at the percentages shown each Calendar Year until the maximum out-of-pocket amount is reached. Then, Covered Charges incurred by a Plan Participant will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

When a Family Unit reaches the maximum out-of-pocket amount, Covered Charges for that Family Unit will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

MEDICAL BENEFITS SCHEDULE

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Claims must be received by the Claims Administrator within 365 days from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied. The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Plan Participant	$1,000	$2,000
Per Family Unit	$2,000	$4,000
The Network and Non-Network Deductibles will apply toward each other.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Plan Participant	$2,000	$4,000
Per Family Unit	$4,000	$8,000
The Network and Non-Network maximum out-of-pocket amounts will apply toward each other.		
The Plan will pay the designated percentage of Covered Charges until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the maximum out-of-pocket amount and are never paid at 100%. • Deductibles • Charges in excess of the Allowable Charge • Non-covered services • Prescription Drug Dispense as Written (DAW) penalties, and discounts and coupons provided through Prescription Drug assistance programs, drug manufacturers, or Pharmacies.		
COVERED CHARGES		
Note: *The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.*		
Hospital Facility		
Room and Board	80% after deductible	60% after deductible
	the semiprivate room rate	
Intensive Care Unit	80% after deductible	60% after deductible
	Hospital's ICU Charge	
Outpatient Services	80% after deductible	60% after deductible
Emergency Room Services	80% after deductible and $100 copayment per visit	
Note: *The emergency room copayment will be waived if admitted directly to the Hospital from the emergency room.*		
Urgent Care Services, Same Day Care, Walk-in Clinic	100%, no deductible spplies $75 copayment per visit	60% after deductible
Skilled Nursing Facility	80% after deductible	60% after deductible
	the Facility's semiprivate room rate 60 days per confinement maximum	
Physician Services		
Inpatient Visits	80% after deductible	60% after deductible
Office Visits	80% after deductible	60% after deductible
Surgery	80% after deductible	60% after deductible
Allergy Testing	80% after deductible	60% after deductible
Allergy Serum and Injections	80% after deductible	60% after deductible
Recuro Health Telehealth	$0	
Other Covered Charges		
Ambulance Service	80% after deductible	
Diagnostic Lab and X-ray	80% after deductible	60% after deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Durable Medical Equipment, Prosthetics and Orthotics	80% after deductible	60% after deductible
Home Infusion Therapy	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
	40 visits per Calendar Year maximum	
Hospice Care	80% after deductible	60% after deductible
Infertility *(diagnostic services only)*	80% after deductible	60% after deductible
Jaw Joint/TMJ	80% after deductible	60% after deductible
Mental Disorders and Substance Abuse		
Inpatient *(includes Partial Hospitalization)*	80% after deductible	60% after deductible
Outpatient Visits	80% after deductible	60% after deductible
Organ Transplants	80% after deductible	60% after deductible
	$5,000 travel and lodging maximum per transplant procedure, limited to $250 per day	
Pregnancy	80% after deductible	60% after deductible
Routine prenatal office visits	100%, no deductible applies *If global maternity fee:* 40% of Covered Charges will be payable at 100%, no deductible applies; thereafter 80% after deductible	100%, no deductible applies up to $500 per Calendar Year maximum; thereafter 60% after deductible
Note: *Refer to the Coverage of Pregnancy benefit listed in the Covered Charges section for more information regarding routine prenatal office visits.*		
Routine Well Newborn Care *(while Hospital confined)*	100%, no deductible applies	100%, no deductible applies
Preventive Care		
Routine Well Care *(Birth through adult)*	100%, no deductible applies	100%, no deductible applies up to $500 per Calendar Year maximum; thereafter 60% after deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Routine Well Care Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF), *unless otherwise specifically stated in this Medical Benefits Schedule*, and which can be located using the following website: https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results **Routine Well Care Services will include but will not be limited to, the following routine services:** Office visits, routine physical examinations, prostate screening, routine lab and X-ray services, all immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well child care examinations. This benefit also includes one routine eye exam per Calendar Year. **Note:** If applicable, this Plan may comply with a state vaccine assessment program. **Women's Preventive Services** will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), *unless otherwise specifically stated in this Medical Benefits Schedule*, and which can be located using the following websites: https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results; and https://www.hrsa.gov/womens-guidelines **Women's Preventive Services, will include, but will not be limited to, the following routine services:** Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), counseling and screening for interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.		
Diabetes Education	100%, no deductible applies	60% after deductible
Nutritional Education Counseling	100%, no deductible applies 4 visits per Calendar Year maximum	
Obesity Interventions *(for Plan Participants age 18 and older with a body mass index (BMI) of 30 kg/m^2 or higher)*	100%, no deductible applies 26 visits Calendar Year maximum	60%, no deductible applies 26 visits Calendar Year maximum
***Note:** Refer to the Covered Charges section for more information on Obesity Interventions.*		
Tobacco / Nicotine Cessation Counseling	100%, no deductible applies 4 visits per Calendar Year maximum	
Rehabilitation Therapy *(includes outpatient Physical, Occupational, Speech, Radiation and Chemotherapy)*	80% after deductible	60% after deductible
Renal Dialysis	80% after deductible	60% after deductible
Spinal Manipulation / Chiropractic services	80% after deductible	60% after deductible
	$2,000 per Calendar Year maximum	
***Note:** Diagnostic labs and X-rays will not apply to the Spinal Manipulation / Chiropractic benefits maximum.*		
Wig *(Hair Prosthesis)*	80% after deductible	
	$350 per Calendar Year maximum	
All Other Eligible Charges	80% after deductible	60% after deductible

*mi*Care HEALTH CENTER BENEFITS

*mi*Care Health Center benefits apply when care, treatment, or service is provided by a contracted *mi*Care provider to a Plan Participant for services that are recommended and approved by a Physician, Nurse Practitioner, Physician Assistant, or Medical Assistant (RNs or LPNs) at the Employer's onsite *mi*Care Health Center.

The Coordination of Benefits provision will not apply to services provided at the miCare Health Center.

*mi*Care Health Center Eligibility

A person's eligibility for *mi*Care Health Center benefits (including enrollment, termination, and COBRA Continuation Coverage rights) is subject to the terms and conditions as stated within the *Eligibility, Funding, Effective Date and Termination Provisions* of this Plan.

Benefit

Benefits for a Plan Participant will be as described in the following *mi*Care Health Center Benefits Schedule.

*mi*Care Health Center Charges

*mi*Care Health Center charges are the Allowable Charges for primary health care services for minor acute care, preventive care, wellness, and disease management payable up to any maximum benefit amounts shown in the *mi*Care Health Center Benefits Schedule.

Services provided at the *mi*Care Health Center are not subject to a deductible and will not be applied to the deductible or maximum out-of-pocket amounts that may be applicable under the medical benefits of this Plan.

*mi*Care HEALTH CENTER BENEFITS SCHEDULE

Maximum Benefit Amount Per Calendar Year	*Unlimited*
DEDUCTIBLE, PER CALENDAR YEAR	
Per Plan Participant	*none*
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	
Per Plan Participant	*none*
Covered Charges	**Plan Participant 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

PRESCRIPTION DRUG BENEFIT SCHEDULE

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.

Walmart Pharmacy, Stillwater Family Pharmacy and Mail Order * – Limited to a 34-day supply

Generic drugs
Copayment ..... $0 per prescription

Brand Name drugs (with no Generic equivalent available)
Copayment ..... $30 per prescription

Brand Name drugs (with Generic equivalent available)
Copayment ..... $60 per prescription

Walmart Pharmacy, Stillwater Family Pharmacy and Mail Order * – Available up to a 90-day supply

Generic drugs
Copayment ..... $0 per prescription

Brand Name drugs (with no Generic equivalent available)
Copayment ..... $60 per prescription

Brand Name drugs (with Generic equivalent available)
Copayment ..... $120 per prescription

* **Mail order processing is exclusively through Stillwater Pharmacy.**

Retail Pharmacy – Limited to a 34-day supply

Generic drugs
Copayment ..... $10 per prescription

Brand Name drugs (with no Generic equivalent available)
Copayment ..... $60 per prescription

Brand Name drugs (with Generic equivalent available)
Copayment ..... $120 per prescription

Retail Pharmacy – Available up to a 90-day supply

Generic drugs
Copayment ..... $0 per prescription

Brand Name drugs (with no Generic equivalent available)
Copayment ..... $120 per prescription

Brand Name drugs (with Generic equivalent available)
Copayment ..... $240 per prescription

Specialty Pharmacy Program – Limited to a 34-day supply

Specialty drugs
Copayment ..... $150 per prescription

It is required that specialty drugs be purchased through Stillwater Pharmacy. Only the first fill will be eligible through a Retail Pharmacy.

Plan Participants with prescriptions for specialty drugs should utilize True Rx's Prescription Drug advocate service, **True Assist**. True Assist will work with Plan Participants in order to maximize the co-pay structure for specialty drugs and assist them in obtaining the Prescription Drugs that they need. Please contact True Rx for more information regarding this service.

Note: If a Plan Participant requests a Brand Name drug when a Generic equivalent is available, then the Plan Participant will be responsible for the difference in cost between a Generic drug and applicable Brand Name drug in addition to the applicable copayment amount as stated above. The difference in cost will not apply to the maximum out-of-pocket amount shown in the Medical Benefits Schedule.

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

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Plan Participant for care of an Injury or Illness and while the Plan Participant is covered for these benefits under the Plan.

Claims must be received by the Claims Administrator within 365 days from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures 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.

COVERED CHARGES

Covered Charges are the Allowable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions, and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

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

Room charges made by a Hospital having only private rooms are payable at the average private room rate of that Facility.

Charges for an Intensive Care Unit stay are payable as shown in the Medical Benefits Schedule.

(2) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Illness, including elective or induced termination of Pregnancy.

See the "Maternity Management Program" in the Care Management Services section.

Note: Routine prenatal office visits are payable as shown under the Pregnancy benefit in the Medical Benefits Schedule.

The following services will continue to pay per normal Plan provisions:

Pregnancy-related ultrasounds, lab screenings (not otherwise specified), Complications of Pregnancy (as defined under this Plan), delivery, and post-partum care.

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

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

(a) The Plan Participant is confined as a bed patient in the Facility; and

(b) The confinement starts within 14 days of a Hospital confinement of at least 3 days; and

(c) The attending Physician certifies that the confinement is Medically Necessary; and

(d) The attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Plan Participant's care in these Facilities are payable as shown in the Medical Benefits Schedule.

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

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 the Allowable Charge for the primary procedure; 50% of the Allowable Charge will be allowed 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) Home Health Care Services and Supplies. Charges for Home Health Care 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.

Benefit payment for nursing, home health aide, and therapy services is subject to the Home Health Care limit shown in the Medical Benefits Schedule.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(6) Hospice Care Services and Supplies. Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Plan Participant's condition as being terminal, determined that the person is not expected to live more than six months, and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as shown in the Medical Benefits Schedule.

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

(a) Acupuncture. Care, treatment, and services related to acupuncture by a health care provider acting within the scope of his or her license.

(b) Allergy. Care, supplies, services, and treatment in connection with allergy testing, serum, and injections.

(c) **Ambulance.** Local Medically Necessary professional land or air 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 was Medically Necessary.

(d) **Anesthetic**; oxygen; intravenous injections and solutions. Administration of these items is included.

(e) **Blood and Blood Derivatives.** The charges for blood, blood plasma, and other blood products if not replaced by or for the Plan Participant, including charges incurred for self-donation of blood for anticipated surgery. Administration of these items is included.

(f) **Breast Pump, Breast Pump Supplies, Lactation Support and Counseling.**

Breast pump, breast pump supplies

A standard electric breast pump or a manual breast pump for initiation or continuation of breastfeeding may be bought rather than rented, with the cost to rent not to exceed the actual purchase price.

- Rental of a heavy duty/hospital grade breast pump may be considered Medically Necessary only for the period of time that a newborn remains inpatient in the Hospital. Purchase of a heavy duty/hospital grade breast pump is not considered Medically Necessary or a Covered Charge under this Plan.
- For female Plan Participants using a breast pump from a prior Pregnancy, a new set of breast pump supplies will be covered with each subsequent Pregnancy.
- Replacement of either a standard electric breast pump or a manual breast pump, but not both, will be covered every three Calendar Years following a subsequent Pregnancy.

Covered Charges for the purchase or rental of a breast pump and supplies will be payable subject to the Preventive Care benefits as shown in the Medical Benefits Schedule.

Note: *Breast pumps and breast pump supplies when purchased through a retail store (for example, through Target, Wal-Mart, Walgreens) will be considered payable at the Network benefit level only for the purposes of this benefit.*

The Claims Administrator will require the following documentation: claim form with proof of purchase to include purchase price and item description.

Lactation support and counseling

Covered Charges include inpatient and outpatient comprehensive prenatal and postnatal lactation support and counseling for female Plan Participants for the duration of the breastfeeding. Services must be rendered by a Physician acting within the scope of their license or certification under applicable State law.

Note: *Payment will be made for Covered Charges for lactation support and counseling under the Preventive Care benefits in the Medical Benefits Schedule at the higher Network payment for Non-Network services for the purposes of this benefit.*

(g) **Cardiac Rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion, coronary bypass surgery, or other cardiac condition; (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.

(h) **Chemotherapy or Radiation Treatment** with radioactive substances. The materials and services of technicians are included.

Pre-notification of services, by the Plan Participant, for cancer treatment services is strongly recommended. The pre-notification request should include the Plan Participant's Plan of Care and treatment protocol. Pre-notification of services should occur at least seven days prior to the initiation of treatment.

For pre-notification of services, call CareLink at the following numbers:

Toll-free in the United States:	(866) 894-1505
Local call in Billings, Montana:	(406) 245-3575

A pre-notification of services by CareLink is not a determination by the Plan that claims will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures.

(i) **Clinical Trials.** Covered Charges will include charges made for routine patient services associated with clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:

- The clinical trial is registered on the National Institute of Health (NIH) maintained website www.clinicaltrials.gov as a Phase I, II, III, or IV clinical trial.
- The Plan Participant meets all inclusion criteria for the clinical trial and is not treated "off-protocol."
- The Plan Participant has signed an Informed Consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed Informed Consent.
- The trial is approved by the Institutional Review Board of the institution administering the treatment.
- Routine patient services will not be considered Experimental or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and X-rays that a Plan Participant would receive whether or not he or she were participating in a clinical trial.

Routine patient services do not include, and reimbursement will not be provided for:

- The Investigational service, supply, or drug itself;
- Services or supplies listed herein as Plan Exclusions;
- Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Plan Participant (e.g., monthly CT scans for a condition usually requiring only a single scan); and
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item, or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

(j) Initial **Contact Lenses or Glasses** required following cataract surgery.

(k) **Contraceptives.** All Food and Drug Administration (FDA) approved contraceptive methods when prescribed by a Physician, including but not limited to intrauterine devices (IUDs) and implants (including insertion and removal when applicable), injections, and any related Physician and Facility charges including complications.

Refer to the separate Prescription Drug Benefit of this Plan regarding prescription coverage of oral contraceptive medications, devices, transdermals, vaginal contraceptives, implantables and injectables, including Physician-prescribed over-the-counter (OTC) contraceptives for female Plan Participants.

(l) **Detoxification.** Services, treatment, and care for detoxification.

(m) **Diabetes Education.** Inpatient and outpatient self-management training and education services for the treatment of diabetes, provided by a licensed health care professional with expertise in diabetes, are payable as shown in the Medical Benefits Schedule.

(n) **Durable Medical Equipment (DME).** Charges for Durable Medical Equipment and supplies necessary for the maintenance and operation of the Durable Medical Equipment that meet all of the following criteria:

- Medically Necessary;
- Prescribed by a Physician for outpatient use;
- Is NOT primarily for the comfort and convenience of the Plan Participant; and
- Does NOT have significant non-medical uses (i.e., air conditioners, air filters, humidifiers, environmental control devices).

If more than one item of Durable Medical Equipment can meet a Plan Participant's needs, Plan benefits are only available for the least cost alternative as determined by the Plan Administrator. Benefits are not available for certain convenience or luxury features that are considered non-standard.

Rental of a Durable Medical Equipment item will be a Covered Charge up to a maximum of the lesser of 24 months or the warranty period of the item, commencing on the date the item is first delivered to the Plan Participant.

A Durable Medical Equipment item may be purchased, rather than rented, with the cost not to exceed the actual acquisition cost of the item to the Plan Participant if the Plan Participant were to purchase the item directly. The acquisition cost of the item may be prorated over a six-month period, subject to prior approval by the Plan Administrator.

Replacement of a Durable Medical Equipment item, rented or purchased, will be a Covered Charge limited to once every four Calendar Years:

- Subject to prior approval of the Plan Administrator, replacement for a *purchased* Durable Medical Equipment item may be available for damage beyond repair with normal wear and tear, when repair costs exceed the acquisition cost, or when a change in the Plan Participant's medical condition occurs sooner than the four Calendar Year period.

- Subject to prior approval of the Plan Administrator, replacement for a *rented* Durable Medical Equipment item may be available when a change in the Plan Participant's medical condition occurs sooner than the four Calendar Year period.

Repair of a Durable Medical Equipment item including the replacement of essential accessories such as hoses, tubing, mouth pieces, etc., are Covered Charges only when necessary to make the item serviceable and the total estimated repair and replacement costs do not exceed the acquisition cost of the item. Rental charges for a temporary replacement Durable Medical Equipment item are Covered Charges up to a maximum of two consecutive months. Requests to repair a Durable Medical Equipment item are not subject to the four Calendar Year limit.

The Plan Administrator may require documentation, including but not limited to the make and model number of the Durable Medical Equipment item, the acquisition cost to the provider, and documentation to support Medical Necessity.

(o) **Emergency Medical Treatment** when traveling outside the United States on business or pleasure.

(p) **Foot Care.** Medically Necessary foot care, including devices such as custom molded orthotics and orthopedic shoes that are part of a brace or custom molded for foot support (limited to one pair per person per Calendar Year). This benefit also includes treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses, or toenails.

(q) **Growth Hormone.** Medically Necessary care treatment and services related to growth hormones.

(r) **Hair Prosthesis (Wig)** necessary due to the disease alopecia areata, radiation therapy, or chemotherapy, are payable as shown in the Medical Benefits Schedule.

(s) **Home Infusion Therapy.** The Plan will cover home infusion therapy services and supplies when provided by an accredited home infusion therapy agency, which is not a licensed Home Health Agency. These services must be Medically Necessary and required for the administration of a home infusion therapy regimen when ordered by and part of a formal written plan prescribed by a Physician. The benefit will include all Medically Necessary services and supplies including the nursing services associated with patient and/or alternative care giver training, visits to monitor intravenous therapy regimen, emergency care, Prescription Drugs, administration of therapy, and the collection, analysis, and reporting of the results of laboratory testing services required to monitor a response to therapy.

(t) **Infertility.** Care, supplies, and services for the diagnosis of Infertility.

(u) **Jaw Joint (TMJ).** Medically Necessary services for care and treatment of jaw joint conditions, including Temporomandibular Joint syndrome (TMJ).

(v) **Laboratory Studies.** Covered Charges for diagnostic lab testing and services.

(w) **Mental Disorders and Substance Abuse.** Covered Charges are payable for care, supplies, and treatment of Mental Disorders and Substance Abuse.

(x) Injury to or care of **Mouth, Teeth, and Gums.** Charges for Injury to or care of the mouth, teeth, gums, and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth.
- Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands, or ducts.
- Removal of impacted teeth.

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.

(y) **Nutritional Education Counseling.** Care, treatment, and services when provided by a health care provider acting within the scope of his or her license, are payable as shown in the Medical Benefits Schedule. This benefit **will not** include weight loss medications or nutritional supplements whether or not prescribed by a Physician.

(z) **Obesity Interventions.** This benefit is being provided consistent with the Affordable Care Act preventive services requirement. Covered Charges include Physician-directed intensive, multicomponent behavioral interventions for weight management for Plan Participants age 18 and older with a body mass index (BMI) of 30 kg/m^2 or higher.

Intensive, multicomponent behavioral interventions for weight management will include group and individual sessions of high intensity (up to 26 visits per Calendar Year) encompassing the following:

- Behavioral management activities such as setting weight loss goals
- Improving diet or nutrition and increasing physical activity
- Addressing barriers to change
- Self-monitoring
- Strategizing how to maintain lifestyle changes

Non-surgical care and treatment and Physician prescribed weight loss medications **will not** be a covered benefit except as may be specifically described as a benefit by this Plan.

This Plan **will not** cover nutritional supplements, gym memberships, or dues for participation in weight loss programs (e.g., Weight Watchers, Jenny Craig, etc.) whether or not prescribed by a Physician.

(a1) **Occupational Therapy** by a health care provider acting within the scope of his or her license, subject to Medical Necessity. Therapy must be ordered by a Physician, result from an Injury or Illness, and improve a body function. Covered Charges **will not** include recreational programs, maintenance therapy, or supplies used in occupational therapy.

(b1) **Organ Transplant.** Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant that is not considered Experimental or Investigational, are subject to the following criteria (payable as shown in the Medical Benefits Schedule):

- The transplant must be performed to replace an organ or tissue.

- **Organ transplant benefit period.** A period of 365 continuous days beginning five days immediately prior to an approved organ transplant procedure. In the case of a bone marrow transplant, the date the transplant begins will be defined as either the earlier of the date of the beginning of the preparatory regimen (marrow ablation therapy) or the date the marrow/stem cells is/are infused.

- **Organ procurement limits.** Charges for obtaining donor organs or tissues are Covered Charges under the Plan only when the recipient is a Plan Participant. When the donor has medical coverage, his or her plan will pay first. The donor benefits under this Plan will be reduced by those payable under the donor's plan.

  Donor charges include those for:

  (i) Evaluating the organ or tissue;
  (ii) Removing the organ or tissue from the donor; and
  (iii) Transportation of the organ or tissue from within the United States or Canada to the Facility where the transplant is to be performed.

Note: Expenses related to the purchase of any organ **will not** be covered.

As soon as reasonably possible, but in no event more than 10 days after a Plan Participant's attending Physician has indicated that the Plan Participant is a potential candidate for a transplant, the Plan Participant or his or her Physician must contact CareLink at (866) 894-1505.

- In the event a Network Provider transplant Facility is utilized, benefits will be payable at the Network Provider benefit level.

- In the event a Network Provider transplant Facility is unavailable and the providing transplant Facility is a Center of Excellence Facility, benefits will be payable at the Network Provider benefit level.

- In the event a Non-Network Provider transplant Facility is utilized and the providing transplant Facility is not a Center of Excellence Facility, benefits will be payable at the Non-Network Provider benefit level.

There is no obligation to the Plan Participant to use either a Network Provider or a Center of Excellence Facility; however, benefits for the transplant and related expenses will vary depending upon whether services are provided by a Network Provider or a Non-Network Provider and whether or not a Center of Excellence Facility is utilized.

A **Center of Excellence** is a licensed healthcare Facility that has entered into a participation agreement with a national transplant network to provide approved transplant services, at a negotiated rate, to which the Plan has access. A Plan Participant may contact CareLink to determine whether or not a Facility is considered a Center of Excellence.

Special Transplant Benefits

Under certain circumstances, there may be special transplant benefits available when the group health Plan and/or a Plan Participant participates in a special transplant program and/or contracts with a specific transplant network. Therefore, it is very important to contact CareLink as soon as reasonably possible so that the Plan can advise the Plan Participant or his or her Physician of the transplant benefits that may be available.

Travel and Lodging Expenses

If a transplant is performed at a Network Provider transplant Facility or a Center of Excellence Facility and the Plan Participant resides 50 miles or more from the transplant Facility, the Plan will pay for the following services incurred during the transplant benefit period (subject to the maximum benefit as shown in the Medical Benefits Schedule):

(A) Transportation expenses to and from the Network Provider transplant Facility or Center of Excellence Facility for the following individuals:

- The Plan Participant; and
  - One or both parents of the Plan Participant (only if the Plan Participant is a Dependent minor child); or
  - One adult to accompany the Plan Participant.
- Living donor (if applicable under the Plan).

Transportation expenses include commercial transportation (coach class only).

(B) Reasonable lodging and meal expenses incurred for the living donor, Plan Participant, and one or both parents of the Plan Participant (only if the Plan Participant is a Dependent minor child), or one adult companion who is accompanying the Plan Participant, only while the Plan Participant is receiving transplant-related services at a Network Provider transplant Facility or Center of Excellence Facility.

Lodging, for purposes of this Plan, will not include private residences.

Transplant Exclusions

Coverage for the following procedures, when Medically Necessary, may be provided under the regular medical benefits provision under this Plan, subject to all Plan provisions and applicable benefit limitations as shown in the Medical Benefits Schedule:

- Cornea transplantation
- Skin grafts
- Artery
- Vein
- Valve
- Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

(c1) **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints, or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Illness.

(d1) **Physical Therapy** by a health care provider acting within the scope of his or her license, subject to Medical Necessity. The therapy must be in accord with a Physician's exact orders as to type, frequency, and duration, and for conditions which are subject to significant improvement through short-term therapy.

(e1) **Prescription Drugs** (as defined)**.** Outpatient Prescription Drugs will be payable under the separate Prescription Drug Benefits section of this Plan.

(f1) **Preventive Care/Routine Well Care.** Covered Charges under Medical Benefits are payable for Preventive Care/Routine Well Care as described in the Medical Benefits Schedule. Additional preventive care shall be provided as required by applicable law.

Preventive Care/Routine Well Care is care by a Physician that is not for an Injury or Illness and will only apply in the absence of a diagnosis for a medical condition, including a recurring condition or for medication.

Consult with your Physician at the time services are rendered as to whether or not the services provided will be considered Preventive Care/Routine Well Care as mandated under the Affordable Care Act (ACA), U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations or the Women's Preventive Services as required by the Health Resources and Services Administration (HRSA).

Otherwise, services rendered which are not considered or billed by the Physician as Preventive Care/Routine Well Care (as stated above) will be subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.

(g1) **Prosthetic Devises.** The initial purchase, fitting, and repair of fitted prosthetic devices which replace body parts. Coverage includes prosthetic devices incidental to a Medically Necessary mastectomy including up to two bras per Calendar Year (see Reconstructive Surgery benefit), or a penile prosthesis for the correction of sexual dysfunction resulting from an Illness or surgery.

(h1) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

Mammoplasty coverage will include reimbursement for:

(i) Reconstruction of the breast on which a mastectomy has been performed,
(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
(iii) 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 Plan Participant.

(i1) Recuro Health Telehealth.

The Recuro Health Telehealth benefit offers Plan Participants telephone access to experienced board-certified licensed Physicians as a convenient alternative to receive immediate health care for common medical issues. Recuro Health Telehealth Physicians are available 24 hours a day, including weekends and holidays and are able to provide diagnoses, medical advice, and treatment recommendations, including prescription medications.

Covered Charges are payable as shown in the Medical Benefits Schedule.

To contact a Recuro Health Physician, call the Recuro Health Patient Care Center toll-free at (877) 872-0370, or access their website at www.member.recurohealth.com for additional information.

Telehealth services not incurred through Recuro Health Telehealth will be a Covered Charge subject to the same deductible, copayment, or coinsurance requirements that apply to comparable health services provided in person.

(j1) Rehabilitation Therapy (Inpatient). Charges for inpatient rehabilitation services are payable as shown in the Medical Benefits Schedule. Services must be Medically Necessary to restore and/or improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental Injury, Illness, or surgery.

Services must be furnished in a specialized rehabilitative unit of a Hospital and billed by the Hospital or be furnished and billed by a rehabilitation facility approved by the Plan. This benefit only covers care the Plan Participant received within 24 months from the onset of the Injury or Illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a Physician specializing in rehabilitative medicine).

(k1) Renal Dialysis. Renal dialysis services include dialysis, Facility services, supplies, and medications provided during treatment. Laboratory testing and Physician visits will be payable per normal Plan provisions.

(l1) Speech Therapy by a health care provider acting within the scope of his or her license, subject to Medical Necessity. Therapy must be ordered by a Physician and follow either:

(i) Surgery for correction of a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy) of a Plan Participant; or
(ii) An Injury; or
(iii) An Illness.

(m1) Spinal Manipulation/Chiropractic Services by a health care provider acting within the scope of his or her license, subject to Medical Necessity and non-maintenance care, are payable as shown in the Medical Benefits Schedule.

(n1) Sterilization Procedures. Sterilization procedures for female Plan Participants are payable under the Preventive Care benefit as shown in the Medical Benefits Schedule.

The following charges will be payable per normal Plan provisions:

- Hysterectomies; and
- Sterilization procedures for male Plan Participants.

(o1) Surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations.

(p1) Tobacco/Nicotine Cessation Counseling. Care and treatment for tobacco/nicotine cessation counseling is payable as shown in the Medical Benefits Schedule. Refer to the Prescription Drug Benefits section regarding coverage of tobacco/nicotine cessation medications and products.

(q1) Well Newborn Nursery/Physician Care.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board, and other normal care, including circumcision, for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent who is neither injured nor ill and a parent (1) is a Plan Participant who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to the Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Covered Charges for routine nursery care will be applied toward the Plan of the newborn child.

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

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Covered Charges for routine Physician care will be applied toward the Plan of the newborn child.

(r1) X-rays. Charges for diagnostic X-rays and imaging services.

CARE MANAGEMENT SERVICES

UTILIZATION MANAGEMENT

Utilization Management is a program designed to assist Plan Participants in understanding and becoming involved with their diagnosis and medical Plan of Care, and advocates patient involvement in choosing a medical Plan of Care. Utilization Management begins with the pre-notification process.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services, and/or supplies. A benefit determination on a claim will be made only after the claim has been submitted. A pre-notification of services by CareLink is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in this section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures.

Examples of when the Physician and Plan Participant should contact CareLink prior to treatment include:

- Inpatient admissions to a Hospital or Skilled Nursing Facility;
- Inpatient admissions to free-standing chemical dependency, mental health, and rehabilitation facilities;
- Cancer treatment Plan of Care, administered on an inpatient or outpatient basis;
- Hysterectomies;
- Back surgery; and
- Outpatient services as follows:
    - Dialysis
    - Durable Medical Equipment (DME) over $2,000
    - Genetic testing
    - Home Health Care
    - Hospice Care
    - Injectables (administered under the Medical Benefits Plan, not those received through the Prescription Drug Benefits of this Plan

All claims are subject to the terms and conditions, limitations, and exclusions of the Plan in effect at the time charges are incurred.

The Physician or Plan Participant should notify CareLink at least seven days before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee;
- The name, Employee identification number, and address of the Plan Participant;
- The name of the Employer;
- The name and telephone number of the attending Physician;
- The name of the Hospital, proposed date of admission, and proposed length of stay;
- The diagnosis and/or type of surgery; and
- The Plan of Care, treatment protocol and/or informed consent, if applicable.

If there is an emergency admission to the Hospital, the Plan Participant, Plan Participant's family member, Hospital, or attending Physician should notify CareLink within two business days after the admission.

Hospital observation room stays in excess of 23 hours are considered an admission for purposes of this program, therefore CareLink should be notified.

Contact the Care Management administrator at: CareLink (406) 245-3575 or (866) 894-1505

PRE-ADMISSION AND POST DISCHARGE CARE CALLS

A CareLink nurse will contact the Plan Participant to provide health education, pre-surgical counseling, inpatient care coordination, facilitation of discharge plan, and post-discharge follow-up.

PRE-NOTIFICATION DETERMINATION AND REVIEW PROCESS

The Plan Administrator or its designee, on the Plan's behalf, will review the submitted information and make a determination on a pre-notification request within 15 days of receipt of the pre-notification request and all supporting documentation. If additional records are necessary to process the pre-notification request, the Plan Administrator or its designee will notify the Plan Participant or the Physician. The time for making a determination on the request will be deferred from the date that the additional information is requested until the date that the information is received.

The Physician and Plan Participant will be provided notice of the Plan's determination. If the pre-notification request is denied, written notice will provide the reason for the adverse pre-notification determination.

As a reminder, a pre-notification of services by CareLink is not a determination by the Plan that a claim will be paid.

The Plan offers a one-level review procedure for adverse pre-notification determinations. The request for reconsideration must be submitted in writing within 30 days of the receipt of the adverse pre-notification determination and include a statement as to why the Plan Participant disagrees with the adverse pre-notification determination. The Plan Participant may include any additional documentation, medical records, and/or letters from the Plan Participant's treating Physician(s). The request for reconsideration should be addressed to:

CareLink
Attn: Appeals
7400 West Campus Rd.
New Albany, OH 43054

The Plan Administrator or its designee will perform the reconsideration review. The Plan Administrator or its designee will review the information initially received and any additional information provided by the Plan Participant and determine if the pre-notification determination was appropriate. If the adverse pre-notification determination was based upon the Medical Necessity, the Experimental/Investigational nature of the treatment, service, or supply or an equivalent exclusion, the Plan may consult with a health care professional who has the appropriate training and experience in the applicable field of medicine. Written or electronic notice of the determination upon reconsideration will be provided within 30 days of the receipt of the request for reconsideration.

CASE MANAGEMENT

If a Plan Participant has an ongoing medical condition or catastrophic Illness, a Case Manager may be assigned to monitor this Plan Participant, and to work with the attending Physician and Plan Participant to design a treatment plan and coordinate appropriate Medically Necessary care. The Case Manager will consult with the Plan Participant, the family, and the attending Physician in order to assist in coordinating the Plan of Care approved by the Plan Participant's attending Physician and the Plan Participant.

This Plan of Care may include some or all of the following:

- Individualized support to the patient;
- Contacting the family to offer assistance for coordination of medical care needs;
- Monitoring response to treatment;
- Evaluating outcomes; and
- Assisting in obtaining any necessary equipment and services.

Case Management is not a requirement of the Plan. There are no reductions of benefits or penalties if the Plan Participant and family choose not to participate.

Each treatment plan is individualized to a specific Plan Participant and is not appropriate or recommended for any other patient, even one with the same diagnosis. All treatment and care decisions will be the sole determination of the Plan Participant and the attending Physician.

MATERNITY MANAGEMENT PROGRAM

The Maternity Management Program is an educational and empowerment program for eligible female Employees and Dependents. This program provides a means to positively affect a Pregnancy and the health of the baby.

A CareLink nurse will set up a confidential, personal telephone interview to identify medical history and lifestyles that could have an impact on the outcome of the Pregnancy.

A CareLink nurse is available to assist and coordinate high risk aspects of maternity care. This includes providing information such as access to educational programs and community resources designed to meet the needs identified by the Plan Participant or Physician.

Notification Requirements: The Plan Participant needs to notify CareLink during the first trimester of their Pregnancy.

DEFINED TERMS

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

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis for not less than 30 hours per week, and not on a temporary basis.

Allowable Charge. Allowable Charge means the amount for a treatment, service or supply that is the negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement.

For Covered Charges rendered by a Physician, Hospital, or ancillary provider in a geographic area where applicable law or a governmental authority directs the amount to be paid, the Allowable Charge will mean the amount established by applicable law or governmental authority for the Covered Charge.

In the absence of such network arrangement, negotiated arrangement, controlling law or governmental directive that establishes the amount to be paid, the Allowable Charge will mean: (i) an amount that does not exceed billed charges for the same treatment, service or supply furnished in the same geographic area by a provider of like services; and (ii) a reasonable amount established solely and exclusively by the Plan Administrator or its designee; and (iii) (except in circumstances where a provider network arrangement, other discounting or negotiated arrangement is established), an amount that does not exceed 200% of the Medicare allowed amount, if any.

In the event the Non-Network Provider disputes the Plan's Allowable Charge for any claim subject to the No Surprises Act (NSA) through the Independent Dispute Resolution (IDR) process, the Allowable Charge may be determined by a Certified IDR Entity.

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

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

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

Brand Name means a trade name medication.

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

Certified Independent Dispute Resolution (IDR) Entity means an entity responsible for conducting determinations under the No Surprises Act (NSA) that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

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

Common Law Marriage means a marriage recognized by the state in which the Plan Participant resides as common-law and files both federal and state taxes as married, provides the evidence of cohabitation as husband and wife, and by general reputation of the two individuals are living as husband and wife and claiming to be such, and submits a notarized affidavit verifying Common-Law Marriage status. "By general reputation" is meant to be the understanding among the neighbors and acquaintances with whom the parties associate in their daily lives, that they are living together as husband and wife, and not that they are merely living together.

Complications of Pregnancy are determined as follows:

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions **are not** considered a Complication of Pregnancy: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as Complications of Pregnancy.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this 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 which could normally be self-administered.

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

Emergency Services means the following:

(1) An appropriate medical screening examination (as required under section 1867 of the Social Security Act 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency; and

(2) Within the capabilities of the staff and facilities available at the Hospital (including Hospital outpatient department that provides Emergency Services) or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment (as are required under section 1867 of the Social Security Act 42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

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

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Wood's Powr-Grip Co., Inc.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

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

Experimental and/or Investigational means services, supplies, care, and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the Experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

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

(2) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure was reviewed and approved by the treating Facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) Except as provided under the Clinical Trial benefit in the Medical Benefits section of the Covered Charges section, if Reliable Evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same drug, service, medical treatment, or procedure; or the written informed consent used by the treating Facility or by another Facility studying substantially the same drug, device, medical treatment, or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Facility means a healthcare institution which meets all applicable state or local licensure requirements.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

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

Foster Child means a child who meets the eligibility requirements shown in the Dependent Eligibility section of this Plan for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county, or private foster care agency.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

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

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

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

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational, and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

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

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

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

Hospice Unit is a Facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

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

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

- A Facility operating legally as a psychiatric Hospital or residential treatment Facility for mental health and licensed as such by the state in which the Facility operates.
- A Facility operating primarily for the treatment of Substance Abuse if it has received accreditation from Commission of Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC), or if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness, or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage, or Complications of Pregnancy.

Independent Freestanding Emergency Department means a health care Facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services. Independent Freestanding Emergency Departments do not include Urgent Care Centers or Clinics.

Infertility means incapable of producing offspring.

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

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

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Plan Participant.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, or other such acute medical conditions.

Medically Necessary (Medical Necessity) care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

Network Provider/Network Facility means a healthcare institution or healthcare provider who has by contract agreed to provide services at discounted reimbursement rates. A single direct contract or case agreement between a health care Facility and a Plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

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

Non-Network Provider/Non-Network Facility means a healthcare institution or healthcare provider who does not have a contractual relationship with the Plan or issuer, respectively, regarding reimbursement of items or services they provide.

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

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse 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 psychiatric facility which 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 lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

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

Physician means a Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Certified Nurse Midwife (CNM) or Certified Midwife (CM), Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (PhD), Speech Language Pathologist, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Medical Benefit Plan of Wood's Powr-Grip Co., Inc., which is a benefits plan for certain Employees of Wood's Powr-Grip Co., Inc. and is described in this document.

Plan of Care is a written plan that describes the services being provided and any applicable short-term and long-term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or treatment protocol for the Plan Participant's specific condition. The Plan of Care must be written or approved by a Physician and updated as the Plan Participant's condition changes.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician.

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

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

Skilled Nursing Facility is a Facility that fully meets all of these tests:

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

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

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

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

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, Custodial Care, or educational care.

(7) It is approved and licensed by Medicare.

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

Specialty Drugs mean certain pharmaceuticals and/or biotech or biological drugs that are high-cost/high technology and are used in the management of chronic, complex or genetic disease, including, but not limited to, injectable, infused or oral medications, or that otherwise require special handling, dispensing conditions or monitoring, delivered by any means including by purchase at a Pharmacy and processed for payment by the Pharmacy Benefit Manager or an outpatient basis from a provider or Facility or purchased directly by the Plan Participant. For this purpose, the term "Specialty Drug" means any injectable or non-injectable drug that is on the Pharmacy Benefit Manager's list of Specialty Drugs as it determines such list from time to time.

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

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco/nicotine and ordinary caffeine-containing drinks.

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

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

Urgent Care Services means care and treatment for an Illness, Injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Benefits section.

The following are not covered under this Plan:

(1) **Coding guidelines.** Charges for inappropriate coding in accordance to the industry standard guidelines in effect at the time services are received.

(2) **Complications of non-covered treatments.** Care, services, or treatment required as a result of complications from a treatment not covered under the Plan.

(3) **Cosmetic procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by Injury, disease, trauma, congenital/developmental anomalies, or previously covered therapeutic processes.

(4) **Counseling.** Care and treatment for marital or pre-marital counseling.

(5) **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, or Custodial Care, except as specifically stated as a benefit of this Plan.

(6) **Educational or vocational testing.** Services for educational or vocational testing or training, except as specifically stated as a benefit of this Plan.

(7) **Excess charges.** The part of an expense for care and treatment of an Injury or Illness that is in excess of the Allowable Charge.

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

(9) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(10) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandage, or as may be covered under the Routine Well Care benefits of this Plan.

(11) **Foreign travel.** Care, treatment, or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(12) **Government coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(13) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician, except as stated as a specific benefit of this Plan.

(14) **Health club memberships.**

(15) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting.

(16) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or Facility for the service.

(17) **Hypnosis.**

(18) **Illegal acts.** Charges for services received as a result of an Illness or Injury occurring directly, or indirectly as a result of a serious criminal act, or a riot or public disturbance, or regardless of causation, if such Illness or Injury occurs in connection with, or while engaged in, or attempting to engage in, a serious criminal act, or a riot or public disturbance. For the purposes of this exclusion, the term "serious criminal act" shall mean any act or series of acts by the Plan Participant, or by the Plan Participant in concert with another or others, for which, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. For this exclusion to apply, it is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed.

Charges for services, supplies, care, or treatment to a Plan Participant for an Injury or Illness which occurred as a result of that Plan Participant operating a motor vehicle while under the influence of alcohol or drugs or a combination thereof or operating a motor vehicle with a blood or breath alcohol content (BAC) above the legal limit. The arresting officer's determination of inebriation will be sufficient for this exclusion to apply. It is not necessary that criminal charges be filed, or if filed, that a conviction result. Expenses will be covered for injured Plan Participants other than the person operating the vehicle while under the influence or a BAC above the legal limit, and expenses may be covered for chemical dependency treatment as specified in this Plan.

This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(19) **Impotence.** Care, treatment, services, supplies, or medication in connection with treatment for impotence, except as specifically stated as a benefit of this Plan.

(20) **Incarcerated.** Care, treatment, services, and supplies incurred and/or provided to a Plan Participant by a government entity while housed in a governmental institution.

(21) **Infertility.** Care, supplies, services, and treatment for Infertility, except for diagnostic services rendered for Infertility evaluation.

(22) **Learning disabilities**, behavioral modifications, or developmental delay services or treatment, except when provided as treatment for an autism spectrum disorder.

(23) **Mailing or sales tax.** Charges for mailing, shipping, handling, conveyance, and sales tax.

(24) **Massage therapy or rolfing.**

(25) ***mi*Care Health Center.** The following services are not available at the *mi*Care Health Center:

(a) **Before covered.** Care, treatment, or supplies incurred before a person was covered under this Plan.

(b) **Chronic pain management services**, for pain that lasts beyond the term of an Injury or painful stimulus including but not limited to pain from a chronic or degenerative disease, and pain from an unidentified cause.

(c) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.

(d) **Excluded under Medical.** Services that are excluded under medical Plan Exclusions.

(e) **Immunizations and allergy injections** except for influenza, whooping cough, and tetanus.

(f) **Obstetrics**, to include all services typically provided during Pregnancy (prenatal period), childbirth, and the postnatal period.

(g) **Occupational Illness or Injury.** Services related to the management of work related Injuries or conditions, including an independent medical evaluation, a return to work status determination, or a determination of whether an Injury or condition relates to or arose from the individual's employment. This exclusion will not apply to the initial treatment for minor Injuries or occupational diseases that may have occurred or arisen in the workplace.

(h) **Radiology procedures.**

(i) **Services outside the scope of the license** for a family practice Physician, general practitioner, or mid-level provider, as determined by the laws of the state in which the services are provided.

(26) **Missed Appointment.** Charges for failure to keep a scheduled visit or appointment.

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

(28) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(29) **No Physician recommendation.** 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 which is appropriate care for the Injury or Illness.

(30) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-medical emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(31) **Not specified as covered.** Non-traditional medical services, treatments, and supplies which are not specified as covered under this Plan.

(32) **Obesity.** Care and treatment of obesity, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness, except as specifically stated as a benefit of this Plan. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap-band surgery, including reversals. Nutritional or dietary education is a covered benefit.

(33) **Occupational Injury.** Care and treatment of an Injury or Illness that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applies even though the Plan Participant:

(a) Has waived his/her rights to Workers' Compensation benefits;

(b) Was eligible for Workers' Compensation benefits and failed to properly file a claim for such benefits; or

(c) Is permitted to elect not to be covered under Workers' Compensation and has affirmatively made that election.

(34) **Personal comfort items.** Personal comfort items, patient convenience items, or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines, girdles, corsets, abdominal binders and belts, first-aid supplies, and non-hospital adjustable beds.

(35) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document or that exceed the limits as shown under this Plan.

(36) **Private duty nursing.** Charges in connection with care, treatment, or services of a private duty nurse.

(37) **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.

(38) **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.

(39) **Second surgical opinions.** Charges for second and third opinions for elective surgery.

(40) **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

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

(42) **Sex changes.** Care, services, or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

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

(44) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(45) **Surrogate parenting expenses.**

(46) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as stated as a specific benefit of this Plan.

(47) **War.** Any loss that is due to a declared or undeclared act of war.

Claims must be received by the Claims Administrator within 365 days from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures 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.

PRESCRIPTION DRUG BENEFITS

The Coordination of Benefits provisions will not apply to prescriptions purchased at a participating Pharmacy.

PHARMACY DRUG CHARGE

Participating Pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. **True Rx** is the administrator of the Pharmacy drug plan.

The copayment is applied to each covered Pharmacy drug charge as shown in the Prescription Drug Benefit Schedule and is limited to the supply amount as shown.

If a drug is purchased from a non-participating Pharmacy, or a participating Pharmacy when the Plan Participant's ID card is not used, the Plan Participant will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Plan Participant will be required to submit the prescription receipt to **True Rx** for reimbursement (minus any applicable copayment as shown in the Prescription Drug Benefit Schedule).

MAIL ORDER DRUG BENEFIT OPTION THROUGH STILLWATER PHARMACY

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.

Mail order processing is provided exclusively through Stillwater Pharmacy. Please contact **True Rx** for more information concerning the mail order Pharmacy.

The copayment is applied to each covered mail order drug charge as shown in the Prescription Drug Benefit Schedule and is limited to the supply amount as shown.

SPECIALTY PHARMACY PROGRAM

The Specialty Pharmacy Program is a program that has been determined by the administrator of the Pharmacy drug plan to **require reimbursement only through Stillwater Pharmacy** for medications determined to be part of the Specialty Pharmacy Program. The Pharmacy benefit administrator will review and modify the list of products included in the Specialty Pharmacy Program periodically as new information becomes available.

With some exceptions, the first prescription will be allowed through the regular Pharmacy option under this Plan; any subsequent refill for specialty medications **must** be filled through the Special Pharmacy Program.

Prescriptions under the Specialty Pharmacy Program will be limited to a 34-day fill and will be payable at the Specialty Pharmacy Program copayment level as shown in the Prescription Drug Benefit Schedule.

For more information regarding the Specialty Pharmacy Program, please contact **True Rx** toll-free at (866) 921-4047 or visit https://truerx.com/.

Plan Participants with prescriptions for specialty drugs should utilize True Rx's Prescription Drug advocate service, **True Assist**. True Assist will work with Plan Participants in order to maximize the co-pay structure for specialty drugs and assist them in obtaining the Prescription Drugs that they need. Please contact True Rx for more information regarding this service.

STEP THERAPY PROGRAM

Step Therapy is a process that requires the use of one or more first line agents before a medication which is part of a step therapy protocol can be utilized.

The goal of step therapy is to ensure that safe and cost effective medications are used, based on recognized treatment guidelines and well documented clinical studies. This means that in some instances the Plan Participant will need to try one or more medications which are considered first line before he/she is able to receive a "second step" medication through his/her Pharmacy benefit plan.

What happens when a medication is Medically Necessary but it is a part of a Step Therapy protocol? If it is Medically Necessary for the Plan Participant to receive a "second step" medication before any "first step" medications have been tried, the Plan Participant's Physician may request coverage of the medication as a medical exception.

For a complete list of medications that are subject to Step Therapy protocols, contact **True Rx**.

COVERED PRESCRIPTION DRUGS

Note: Some quantity limitations and prior authorization may be required.

(1) Drugs prescribed by a Physician that require a prescription either by federal or state law excluding any drugs stated as not covered under this Plan.

(2) Compound prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic medications; diabetic supplies including blood glucose monitors, lancet devices, insulin syringes/needles, test strips, lancets, swabs, control solutions, when prescribed by a Physician.

(4) Acne medications; oral or topical (prior authorization is required for Plan Participants 35 and older).

(5) ADD/ADHD medications.

(6) Anabolic steroids.

(7) Anti-infectives: antiparasitic agents, influenza agents, oral anti-fungals, and tuberculosis agents.

(8) Emergency injectables (e.g., Epi-Pen, Glucagon)

(9) Inhaler spacers.

(10) Migraine medications; *quantity limits apply*.

(11) Sex transformation medications.

(12) Specialty medications on True Rx's Specialty Drug List, including growth hormones.

(13) Substance Abuse: prescribed medication for Substance Abuse treatment.

(14) Prescribed vitamins: e.g., vitamin D, B12 injection, vitamin K.

The following will be covered at 100%, no copayment required for Formulary drugs.

Benefits may be subject to prescription Formulary and/or quantity limitations. Non-formulary prescriptions may be payable subject to the applicable prescription copayment as shown in the Prescription Drug Benefit Schedule. Contact ***True Rx*** *toll-free at* ***(866) 921-4047*** *or visit* ***https://truerx.com/*** *to request coverage of the medication as a non-formulary medical exception.*

(1) Physician-prescribed contraceptive methods (Food and Drug Administration (FDA) approved) including but not limited to oral contraceptive medications, transdermals, devices (diaphragms, cervical caps, and intra-uterine devices (IUDs)), vaginal contraceptives, implantables, injectables, female condoms, spermicides, and sponges for all female Plan Participants with reproductive capacity.

Refer to the Medical Benefits section of this Plan regarding additional coverage for intrauterine devices (IUDs), implantables, and injectables.

(2) Physician-prescribed tobacco/nicotine cessation medications or products. Physician-prescribed tobacco/ nicotine replacement products (i.e., nicotine patch, gum, lozenges) and Physician-prescribed medications (such as Zyban, Chantix (and subject to change)).

(3) Certain vaccinations/immunizations as recommended by applicable federal law will be covered only when rendered through a Participating Pharmacy. **Note:** Not all Participating Pharmacies may be providing vaccinations/immunizations or may vary in what they offer. It is important to check with the Participating Pharmacy to determine availability, age restrictions, any prescription requirements, or hours of service.

(4) Additional Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription copayment, coinsurance, or deductible will be required, and will only be available when utilizing a Participating Pharmacy.

Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available following the one year anniversary date of the adoption of the USPSTF grade A and B recommendation.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact **True Rx** for more information regarding which medications are available. **Note:** Age and/or quantity limitations may apply:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results

Limits To This Benefit

This benefit applies only when a Plan Participant incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

EXPENSES NOT COVERED

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

(1) **Abortifacients.** Any drug or medicine that ends a Pregnancy early.

(2) **Administration.** Any charge for the administration of a covered Prescription Drug.

(3) **Allergy sera.** Allergy sera may be covered through the Medical Plan.

(4) **Appetite suppressants/anti-obesity.** A charge for appetite suppressants, dietary supplements, or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride or as otherwise stated as a benefit under the Plan.

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

(6) **Devices.** Devices of any type, even though such devices may require a prescription, except inhaler spacers. These include (but are not limited to) therapeutic devices, insulin pumps and pump supplies, artificial appliances, braces, support garments, or any similar device. *These may be considered Covered Charges under the Medical Benefits section of this Plan when deemed Medically Necessary.*

(7) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A, or medications for hair growth, hair removal, or wrinkles. This exclusion does not include acne medications.

(8) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Plan Participant. This exclusion shall not apply to the extent that charges are for routine patient care associated with an approved clinical trial. (See "Clinical Trials" within the Covered Charges section of this Plan.)

(9) **FDA.** Any drug not approved by the Food and Drug Administration.

(10) **Gene Therapy.** Medications that introduce or are related to the introduction of genetic material. *These may be considered Covered Charges under the Medical Benefits section of this Plan.*

(11) **Immunization.** Immunization agents or biological sera, except as specifically stated as a benefit under this Plan.

(12) **Impotence.** A charge for impotence medication or medication to increase libido.

(13) **Infertility.** A charge for Infertility medication.

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

(15) **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.

(16) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".

(17) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(18) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state, or federal programs.

(19) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or diabetic supplies and as specifically stated as a Covered Charge under the Prescription Drug Benefits section of this Plan.

(20) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(21) **Orphan drugs.** A pharmaceutical agent being used to treat a rare medical condition referred to as an orphan disease.

(22) **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.

(23) **Repackaged products.** Drugs repackaged by distributors and sold at a higher cost.

(24) **Specialty drugs.**

HOW TO SUBMIT PHARMACY CLAIMS

When you obtain a prescription, show your **EBMS/Wood's Powr-Grip Inc.** identification card to the pharmacist. Most Pharmacy providers should submit claims on your behalf.

If the Pharmacy provider is unable to submit the claim for you, request a receipt.

To assist **True Rx** in processing a claim, the following information must be provided when submitting the claim for processing:

- A copy of the receipt
- Group name and number (**Wood's Powr-Grip Inc., Group #0000147**)
- Employee's name and Identification Number
- Provider Billing Identification Number
- Name of patient
- The prescribing Physician
- The prescription name
- An itemization for each separate prescription
- The date of purchase

For Prescription Drug questions or to obtain a claim form contact:

True Rx toll-free at: (866) 921-4047
or access their website through: https://truerx.com/

True Rx Management Services
7 Williams Bros. Dr.
Washington, IN 47501
Fax: (812) 254-7426

HOW TO SUBMIT A CLAIM

When services are received from a health care provider, a Plan Participant should show their **EBMS/Wood's Powr-Grip Inc.** identification card to the provider. Most providers should submit claims on the Plan Participant's behalf.

If it is necessary for a Plan Participant to submit a claim, they should request an itemized bill **which includes procedure (CPT) and diagnostic (ICD) codes** from their health care provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number (**Wood's Powr-Grip Inc., Group #0000147**)
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

Note: *A Plan Participant may obtain a claim form from or the Claims Administrator. Medical claim forms are also available at www.ebms.com.*

WHERE TO SUBMIT CLAIMS

Claims for expenses should be submitted to the Claims Administrator at the address below:

Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within 365 days from the date charges for the service were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

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 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. Under the No Surprises Act, the Plan will have up to 30 calendar days to send a notice of denial of payment or an initial payment to the Non-Network Provider from the time the Claim is resubmitted with 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 the 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 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.

Note: When the dispute of a Claim payment or denial only involves payment amounts due from the Plan to the Non-Network Provider, and the provider has no recourse against the Plan Participant under the No Surprises Act, the payment dispute may only be resolved through open negotiation, or the Independent Dispute Resolution (IDR) process as outlined in the NSA. There may be instances when a Plan Participant may appeal a Claim through this section concurrently with a Non-Network Provider's payment dispute through the IDR process.

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)
Attn: Claims Appeals
P.O. Box 21367
Billings, MT 59104

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 Internal 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)
Attn: Claims Appeals
P.O. Box 21367
Billings, MT 59104

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 Internal 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.

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 four months from the date of receipt of the notice of the final internal Adverse Benefit Determination or the first day 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.
- Violation of cost-sharing and surprise billing protections as identified within the NSA.
- 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 six business days as to whether the Claimant's request is eligible for external review and if additional information is necessary to process the Claimant's request. If the 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 the Claimant's request, the Claimant may submit the additional information within the four month filing period, or 48 hours, whichever occurs later.

The Claimant should receive written notice from the assigned IRO of the 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 the 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.

COORDINATION OF BENEFITS

Coordination of the benefit plans. The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. 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 under two or more plans the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or non-group insurance contracts and subscriber contracts;

(2) Uninsured arrangements of group or group-type coverage;

(3) Group and non-group coverage through closed panel plans;

(4) Group-type contracts;

(5) The medical components of long-term care contracts, such as skilled nursing care;

(6) Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;

(7) The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts;

(8) Any third-party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident, or non-medical long-term care coverage.

Allowable Charge(s). For a charge to be allowable it must be a usual, customary, and reasonable charge and at least part of it must be covered under this Plan. (See "Allowable Charge" in the Defined Terms section.)

In the case of Health Maintenance Organization (HMO) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or Network Provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Plan Participant does not use an HMO or Network Provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Plan Participant used the services of an HMO or Network Provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge. The first rule that describes which plan is primary is the rule that applies:

(a) The benefits of the plan which covers the person directly (that is, as an Employee or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B"). For Qualified Beneficiaries, coordination is determined based on the person's status prior to the Qualifying Event.

Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay first.

(b) Unless there is a court decree stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

- 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;
- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

When a child's parents are divorced, legally separated, or not living together, whether or not they have ever been married, these rules will apply:

- 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. If the financially responsible parent has no health care coverage for the Dependent child, but that parent's Spouse does, the plan of that parent's Spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree.
- A court decree may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);
- 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 married or living together.

If there is no court decree allocating responsibility for the Dependent child's health care expenses, the order of benefits are as follows:

1st The plan covering the custodial parent,
2nd The plan covering the Spouse of the custodial parent,
3rd The plan covering the non-custodial parent, and
4th The plan covering the Spouse of the non-custodial parent.

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, court order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a Dependent under a Spouse's plan, Rule (e) applies. If the Dependent child's coverage under the Spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's Spouse.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or as a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid-off or retired Employee. This rule does not apply if Rule (a) can be used to determine the order of benefits. 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.

(d) The benefits of a benefit 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. This rule does not apply if Rule (a) can be used to determine the order of benefits.

(e) 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 Allowable Charges when paying secondary.

(3) 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. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

(4) 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.

(5) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Schedule of Benefits section. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Plan Participant will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Plan Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Plan Participant under the Plan.

THIRD PARTY RECOVERY PROVISION

By enrollment in the Plan, a Plan Participant agrees to the provisions of this section as a condition precedent to receiving benefits under this Plan. If the Plan Participant fails to comply with the requirements of this Section, the Plan may reduce or deny benefits otherwise available under the Plan.

Defined Terms

"Plan Participant" means anyone covered under the Plan, including but not limited to minor dependents and deceased Plan Participants. Plan Participant shall include the parents, trustee, guardian, heir, personal representative, or other representative of a Plan Participant, regardless of applicable law and whether or not such representative has access or control of the Recovery.

"Recover," "Recovered," "Recovery" means all monies recovered by way of judgment, settlement, reimbursement, or otherwise to compensate for any loss related to any Injury, Illness, condition, and/or accident where a Third Party is or may be responsible. "Recovery" includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, wages, and/or any other recovery of any form of damages or compensation whatsoever.

"Subrogation" means the Plan's right to exercise the Plan Participant's rights to Recover or pursue Recovery from a Third Party who is liable to the Plan Participant for expenses for which the Plan has paid or may agree to pay benefits.

"Third Party" means any third party including but not limited to another person, any business entity, insurance policy or any other policy or plan, including but not limited to uninsured or underinsured coverage, self-insured coverage, no-fault coverage, automobile coverage, premises liability (homeowners or business), umbrella policy.

Right to Reimbursement

This provision applies when the Plan Participant incurs medical or dental expenses due to an Injury, Illness, condition, and/or accident which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Plan Participant may have a claim against a Third Party for payment of such expenses. To the extent the Plan paid benefits on the Plan Participant's behalf, the Plan Participant agrees that the Plan has an equitable lien on any Recovery whether or not such Recovery(s) is designated as payment for such expenses. This lien shall remain in effect until the Plan is repaid in full.

The Plan Participant, and/or anyone on his or her behalf, agrees to hold in trust for the benefit of the Plan, that portion of any Recovery received or that may be received from a Third Party and to which the Plan is entitled for reimbursement of benefits paid by the Plan on the Plan Participant's behalf. The Plan Participant shall promptly reimburse the Plan out of such Recovery, in first priority for the full amount of the Plan's lien. The Plan Participant will reimburse the Plan first, even if the Plan Participant has not been fully compensated or "made whole" and/or the Recovery is called something other than a Recovery for healthcare, medical and/or dental expenses.

The Plan will not pay or be responsible for attorney fees and/or costs of recovery associated with a Plan Participant pursuing a claim against a Third Party, unless the Plan agrees in writing to such a reduction in its equitable lien, or subject to the terms of a court order.

Right to Subrogation

This provision applies when the Plan Participant incurs medical or dental expenses due to an Injury, Illness, condition, and/or accident which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Plan Participant may have a claim against a Third Party for payment of such expenses.

The Plan Participant agrees that the Plan is subrogated to any and all claims, causes of action or rights that the Plan Participant may have now or in the future against a Third Party who has or may have caused, contributed aggravated, and or be responsible for the Plan Participant's Injury, Illness, condition, and/or accident to the extent the Plan has paid benefits or has agreed to pay benefits.

The Plan Participant further agrees that the Plan is subrogated to any and all claims or rights that the Plan Participant may have against any Recovery, including the Plan Participant's rights under the Plan to bring an action to clarify his rights under the Plan. The Plan may assert this Right of Subrogation independently of the Plan Participant. The Plan is not obligated to pursue this right independently or on behalf of the Plan Participant, but may choose to exercise this right, in its sole discretion.

Provisions Applicable to Both the Right to Reimbursement and Right to Subrogation

The Plan Participant automatically assigns to the Plan any and all rights he or she has or may have against any Third Party to the full extent of the Plan's equitable lien. The Plan Participant agrees to:

(1) Cooperate fully with the Plan and its agents, regarding the Plan's rights under this section;

(2) Advise the Plan of any right or potential right to reimbursement and/or subrogation on the Plan's behalf;

(3) Provide to the Plan in a timely manner any and all facts, documents, papers, information, or other data reasonably related to the Plan Participant's Injury, Illness, condition, and/or accident, including any efforts by another individual to Recover on the Plan Participant's behalf;

(4) Execute all assignments, liens, or other documents that the Plan or its agents may request to protect the Plan's rights under this section;

(5) Obtain the Plan's consent before releasing a Third Party from liability for payment of expenses related to the Plan Participant's Injury, Illness, condition, and/or accident;

(6) Hold in trust that portion of any Recovery received by the Plan Participant or on the Plan Participant's behalf equal to the Plan's equitable lien until such time as the Plan is repaid in full;

(7) Agree not to impair, impede, or prejudice in any way, the rights of the Plan under this section; and

(8) Do whatever else the Plan deems reasonably necessary to secure the Plan's rights under this section.

The Plan may take one or more of the following actions to enforce its rights under this section:

(1) The Plan may require the Plan Participant as a condition of paying benefits for the Plan Participant's Injury, Illness, condition, or accident, to execute documentation acknowledging the Plan's rights under this section;

(2) The Plan may withhold payment of benefits to the extent of any Recovery received by or on behalf of a Plan Participant;

(3) The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Reimbursement against any Recovery received, or that will be received, by or on behalf of Plan Participant;

(4) The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Subrogation directly against a Third Party who is or may be responsible; or

(5) The Plan may, to the extent of any benefits paid by the Plan which have not otherwise been reimbursed to the Plan, offset any future benefits otherwise payable under the Plan to the Plan Participant or on the Plan Participant's behalf.

The Plan Administrator is vested with full discretionary authority to interpret and apply the provisions of this section. In addition, the Plan Administrator is vested with the discretionary authority to waive or compromise any of the Plan's rights under this section. Any decision of the Plan Administrator made in good faith will be final and binding. The Plan Administrator is authorized to adopt such procedure as deemed necessary and appropriate to administrate the Plan's rights under this section.

Right to Recover Benefits Paid in Error

The Plan has the right to recover any benefits the Plan paid in error to the Plan Participant or on behalf of a Plan Participant to which the Plan Participant is not entitled, for services which were not covered under the Plan, or for benefits paid in excess of the Plan's Allowable Charges. The Plan may recover benefits paid in error from the Plan Participant, the provider who received a payment from the Plan on the Plan Participant's behalf, or from any person who may have benefited. The Plan may also offset any future benefits otherwise payable to or on the Plan Participant's behalf, or from any other Plan Participant enrolled through the same covered Employee.

COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept Late Enrollees.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA. A domestic partner is not a Qualified Beneficiary.

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee's hours of employment are reduced;
- The parent – covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the Plan as a "Dependent child."

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

Plan Administrator
Wood's Powr-Grip Co., Inc.
908 West Main, P.O. Box 368
Laurel, MT 59044
(406) 628-8231

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the 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 Qualified Beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

Medicare extension of COBRA Continuation Coverage

If you (as the covered Employee) become entitled to Medicare benefits, your Spouse and Dependents may be entitled to an extension of the 18-month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination of employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Dependent children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18-month period.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
Wood's Powr-Grip Co., Inc.
908 West Main, P.O. Box 368
Laurel, MT 59044
(406) 628-8231

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
Wood's Powr-Grip Co., Inc.
908 West Main, P.O. Box 368
Laurel, MT 59044
(406) 628-8231

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage will end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.HealthCare.gov.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Administrator:

Plan Administrator
Wood's Powr-Grip Co., Inc.
908 West Main, P.O. Box 368
Laurel, MT 59044
(406) 628-8231

COBRA Administrator
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Medical Benefit Plan of Wood's Powr-Grip Co., Inc. is the benefit plan of Wood's Powr-Grip Co., Inc., the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Wood's Powr-Grip Co., Inc. to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies, or is otherwise removed from the position, Wood's Powr-Grip Co., Inc. shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator has the authority to, and does so allocate limited fiduciary duties to American Health Holdings, Inc. Those duties are limited to a review of and determination on a Plan Participant's request (or a request by the Plan Participant's treating provider) for a pre-determination of benefits prior to the occurrence of treatment or services. As part of those limited duties, American Health Holdings shall have the discretionary authority and ultimate decision-making authority to review the request and any submitted documentation, make a decision, respond to an appeal if the decision is to deny the request, and to maintain records related to its activities related to this decision. See the Care Management Services section for additional information.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s) and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) With care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) In accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary, or continuing either the appointment or the procedures; or

(2) The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

For Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions may be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend, or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

DISTRIBUTION OF ASSETS

Subject to the requirements of ERISA §402, in the event of a termination or partial termination of the Plan or Trust (if applicable), Wood's Powr-Grip Co, Inc. by action of its Board of Directors, shall direct the disposition of Plan assets, including assets held in a Trust, if any, which may include transfer of such assets to another employee benefit plan or trust maintained by an Employer.

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending, or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

"Protected Health Information" (PHI) means individually identifiable health information, created, or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

(2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

(7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

(8) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

(a) The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

President/CEO
Vice President/CFO
Vice President of Operations/Production Manager
Human Resources Manager
Human Resource Professional
Finance Director
Staff Accountant

(b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

(c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "SECURITY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

(4) Report to the Plan any security incident of which it becomes aware.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Continue health care coverage for a Plan Participant, Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or Dependents may have to pay for such coverage.

- Review this Summary Plan Description and the documents governing the Plan or the rules governing COBRA Continuation Coverage rights.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

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

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her 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 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 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/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA website.)

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. The Plan is not insured.

PLAN NAME: Medical Benefit Plan of Wood's Powr-Grip Co., Inc.

PLAN NUMBER: 503

TAX ID NUMBER: 81-0294758

PLAN EFFECTIVE DATE: January 1, 2003

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

Wood's Powr-Grip Co., Inc.
908 West Main, P.O. Box 368
Laurel, MT 59044
(406) 628-8231

PLAN ADMINISTRATOR

Wood's Powr-Grip Co., Inc.
908 West Main, P.O. Box 368
Laurel, MT 59044
(406) 628-8231

NAMED FIDUCIARY

Wood's Powr-Grip Co., Inc.
908 West Main, P.O. Box 368
Laurel, MT 59044

AGENT FOR SERVICE OF LEGAL PROCESS

Wood's Powr-Grip Co., Inc.
908 West Main, P.O. Box 368
Laurel, MT 59044

Service of process may also be made on the Plan Administrator.

CLAIMS ADMINISTRATOR

Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, MT 59104
(800) 777-3575 or (406) 245-3575

Plan Name: **Medical Benefit Plan of Wood's Powr-Grip Co., Inc.**

Effective Date: **January 1, 2003**

Restatement Date: **January 1, 2023**