Employee Benefit Plan Summary of Material Modifications

Benefits Summary: What's New for 2023

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

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

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

Summary of Changes:

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

1. Section 5. Schedule of Benefits. **Change in the Maximum Out-Of-Pocket Limit Per Calendar Year:** The Out-Of-Pocket will increase to $7,100 for Employee Only coverage and $14,200 for the Family coverage as follows:

MAXIMUM OUT-OF-POCKET LIMIT PER CALENDAR YEAR			
	NETWORK PROVIDERS		NON-NETWORK PROVIDERS*
	Medical	Pharmacy	
Per Covered Person	$5,775	$1,325	No Limit**
Per Covered Family Unit	$11,550	$2,650	No Limit**
The Plan will pay the percentage of covered charges designated below until the maximum Out-of-Pocket payments are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the Calendar Year unless stated otherwise. When calculating the family out-of-pocket maximum, each family member may contribute up to the individual out-of-pocket maximum amount, after which the Plan will pay 100% of the Maximum Allowable Charge for that family member's covered services for the remainder of the Calendar Year.			
Expenses incurred for the following are included in the Out-of-Pocket Maximum: 1. Deductible(s) 2. Co-Payment(s) 3. Coinsurance Expenses incurred for the following are not included in the Out-of-Pocket Maximum: 1. Additional Deductibles/Penalties			

2. Section 10. Defined Terms**. The following definition was amended as follows:**
Gastric Sleeve Surgery. Helps obese patients lose weight by making them feel full more quickly, which reduces the intake of food. In gastric sleeve surgery, 80 percent of the patient's stomach is removed, and what remains resembles a "sleeve," hence the name. The procedure and the weight loss program associated with the procedure must be approved in advance by the Utilization Management. Patient adherence with recommended pre-surgery diet and lifestyle changes for a minimum of three (3) months is essential to the approval process. The Plan requires patients have scheduled consultations with a dietician, an exercise therapist, or the surgeon at least once a month for a minimum of three (3) consecutive months prior to the procedure.
You may be a candidate for weight loss surgery if you meet the following criteria:
• BMI of 40 or greater with or without coexisting medical problems,
• BMI of 35 or greater with one or more obesity-related co-morbidities, including type II diabetes, hypertension, obstructive sleep apnea (OSA), and hyperlipidemia,
• Inability to achieve sustainable weight loss with prior weight loss efforts.

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

A panniculectomy may be considered medically necessary when all of the following criteria are met:
• The pannus hangs at or below the level of the pubic symphysis; AND
• The pannus causes cellulitis, skin ulcerations or persistent dermatitis that has failed to respond to at least 3 months of non-surgical treatment (such as antibiotics, antifungals, good hygiene or dressing changes); OR
• There is a documented functional impairment and the panniculectomy is expected to improve the impairment. Functional impairment is defined as complete or partial loss of function of a body part.

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

• If individual has not had bariatric surgery, the member must have maintained a stable weight for a minimum of 6 months; OR

• If individual has had bariatric surgery and experienced significant weight loss, a panniculectomy should not be performed until at least 18 months after surgery and only after weight has been stable for the most recent 6 months.

4. Section 10. Defined Terms**. The following definition was amended as follows:**
Sterilization shall mean voluntary sterilization for women (tubal ligation or tubal occlusion/tubal blocking procedures, partial or total salpingectomy only) and voluntary sterilization for men (vasectomy only).

5. Section 11. Plan Exclusions. **The following exclusion was modified:**
Fatty Tissue Removal. Procedure or surgery to remove fatty tissue such as abdominoplasty, thighplasty or brachioplasty. Breast reduction may be considered if criteria are met and deemed medically necessary through the precertification process but is excluded for cosmetic purposes or to make one feel better about their appearance. Panniculectomy is covered under the Plan unless it is considered not medically necessary as defined in Section 10. Defined Terms.