Employee Benefit Plan

Plan Document/
Summary Plan Description

Plan 572

Amended and Restated
effective January 1, 2014

This SPD supersedes any previous printed or electronic SPD for this Plan.

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1. INTRODUCTION

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

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

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

How to Use This Document

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

- who is eligible;
- services that are covered;
- services that are not covered;
- how benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements under federal law. Please take the time to read and understand how the benefits of the Plan affect you. As you read this document, please keep in mind that the written terms will govern whatever benefits you receive under the Plan. No oral interpretations can change this Plan.

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

Not an Employment Contract

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

2. ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS

A. ELIGIBILITY

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

Individuals who are shareholders of the Langdale Company and its subsidiaries.

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

(1) Is in an Eligible Class of Employees.

(2) Completes the employment Waiting Period as a member of an Eligible Class of Employees.

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

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

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

(3) An unmarried Child age 26 or over who is or becomes Totally Disabled and dependent upon you. The Plan Administrator may require at reasonable intervals during the two years following the Child's reaching the limiting age, subsequent proof of Total Disability and continuing to meet the definition of Child and other terms of this coverage. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Child examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of Total Disability.

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

Excluded from Eligible Classes of Dependents.

These persons are excluded as Dependents: other individuals living in the covered ~~Employee's~~Participant's' s home, but who are not eligible as defined; the legally separated or divorced former Spouse of ~~the Employee~~the Participant; any Child born to a Dependent Child; any person who is on active duty in any military service of any country; any person who is a resident of another country outside the United States; or any person who is covered under the Plan as an ~~Employee~~Particiapnt.

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

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

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

Additional Requirements for Spousal Eligibility. A Spouse who is eligible for his or her own employer's group health plan is encouraged to become covered under that plan. If such coverage is available to the Spouse, the Spouse is not eligible for coverage under this Plan.

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

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

Administrator may retroactively terminate the coverage of the ~~Employee~~ Participant and his or her Dependents.

B. ENROLLMENT

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

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

Enrollment Rules if Spouse is Also Employed by a Participating Employer.

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

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

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

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

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

newborn child will not be eligible for mid-year enrollment unless a HIPAA Enrollment Event applies, as described below.

HIPAA Special Enrollment Events. The Plan will allow eligible ~~Employees~~ Participants and Dependents, who previously declined Plan coverage, to enroll in the Plan mid-year upon experiencing one of the following special enrollment events listed below. Enrollment is requested by filling out, signing, and returning the enrollment application to the Plan Administrator.

1. **Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program)**.

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

2. **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If enrollment is timely requested, coverage will become retroactively effective as of the date of the birth, adoption, or placement for adoption (as applicable). In the case of marriage, coverage will become effective as of the 1st day of the month following the date the completed request for enrollment is received.

3. **Loss of Coverage for Medicaid or a State Children's Health Insurance Program.**

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

the 1st day of the month following the date the completed request for enrollment is received.

4. **Eligibility for Medicaid or a State Children's Health Insurance Program.** If you or your Dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan, you may be able to enroll yourself and your Dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. Coverage will become effective as of the 1st day of the month following the date the completed request for enrollment is received.

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

Mid-year enrollment and election changes under this Plan must be timely requested within 31 days of the authorized Flexible Benefits Plan event by filling out, signing, and returning an enrollment application to the Plan Administrator. If such changes are timely requested, coverage will become effective under this Plan as of the 1st day of the month following the day the completed request for enrollment is received, unless otherwise provided by law.

C. EFFECTIVE DATE

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

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

D. TERMINATION OF COVERAGE

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

Employee Coverage will end on the earliest of:

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

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

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

Other Events Ending Your Coverage. The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent.

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

Employees on Military Leave. An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). Please see *Section 19: Other Federal Laws That Apply* in this SPD or ask your Plan Administrator for details.

Continuation During Employer-Approved Leaves of Absence (Non-FMLA).

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

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

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

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

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

Reinstatement of Coverage Following a Leave of Absence. If coverage terminates under the Plan due to (a) exhaustion of the limited continuation of coverage during leaves of absence, with termination of employment or (b) termination of employment, coverage may be resumed under the following terms and circumstances:

(1) If an Employee's coverage terminates due to (a) or (b) above and the Employee is either rehired by the same Participating Employer into an

Eligible Class of Employees or resumes satisfaction of all applicable Eligibility requirements with the same Participating Employer, within six (6) months of the prior loss of coverage, coverage may be reinstated provided the Employee elected and maintained COBRA continuation coverage under this Plan for himself/herself during the entire six-month period. If this requirement is met and the Employee timely re-enrolls, the effective date of coverage shall be the date of rehire or resumption of satisfaction of all applicable Eligibility requirements. Re-enrollment must occur within 31 days of rehire or resumption of satisfaction of the Eligibility requirements.

Dependents who were immediately covered prior to the loss of coverage will also be eligible to timely re-enroll as of the Employee's effective date, provided that COBRA coverage was maintained for the Dependent and provided that the Dependent is still eligible for coverage under the terms of the Plan. Dependents who were not covered as of the prior loss of coverage will not be eligible to enroll until the Waiting Period applicable to the Employee has been met. This is true even though the Employee is not required to again satisfy the Waiting Period for his or her own coverage to again become effective.

(2) If an Employee's coverage terminates due to (a) or (b) above and the Employee is either rehired by the same Participating Employer into an Eligible Class of Employees or resumes satisfaction of all applicable Eligibility requirements with the same Participating Employer, within six (6) months of the prior loss of coverage, yet the Employee did not elect and maintain COBRA coverage for himself/herself during the entire six-month period, the effective date of coverage after rehire or resumption will be the first day of the next month following the date of rehire or the date the Employee resumes satisfaction of all applicable Eligibility requirements, provided the Employee timely enrolls. Re-enrollment must occur within 31 days of rehire or resumption of satisfaction of the Eligibility requirements.

Dependents who were covered immediately prior to the loss of coverage will also be eligible to timely re-enroll as of the Employee's effective date, provided that the Dependent is still eligible for coverage under the terms of the Plan. Dependents who were not covered immediately prior to the loss of coverage will not be eligible to enroll until the Waiting Period applicable to the Employee has been met.

(3) In all other cases of rehire or resumption of the Eligibility requirements, all Eligibility and Enrollment requirements must be met as though a new Employee.

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

3. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

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

A QMCSO is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

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

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

4. PRIMARY CARE PROVIDER (PCP)

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

Plan Benefits Relating to Certain PCP-Provided Services

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

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

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

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

Solstas is the only Network Preferred Laboratory for this Plan.

Selection of a Primary Care Provider

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

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

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the Plan or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a PPO participating health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with

certain procedures, including but not limited to obtaining prior authorization for certain services. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator at (229) 249-0940 or toll free (877) 949-0940, or go to TLC's website: www.tlcbenefitsolutions.net.

5. SCHEDULE OF BENEFITS

6. ADDITIONAL COVERAGE DETAILS

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

DEDUCTIBLE

Deductible Amount. This is amounts of covered charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the Deductibles shown in the Schedule of Benefits. This amount will accrue toward the maximum Out-of- Pocket payment. For some services, the Deductible is waived.

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

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

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

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

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

BENEFIT PAYMENT

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

CALENDAR YEAR AND LIFETIME MAXIMUM AMOUNTS

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

COVERED CHARGES

The Plan pays benefits for the covered charges listed below. Covered charges are the Usual and Reasonable 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 or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at the Usual and Reasonable Charge of the average private room rate. If a private room is Medically Necessary due to contagious disease, the Hospital's Usual and Reasonable Charge for such room will be a covered charge.

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

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

(a) The patient is confined as a bed patient in the facility;

(b) The attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) The attending Physician completes a treatment Plan that includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing/Extended Care Facility.

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

(a) Charges for multiple **Surgical Procedures** will be a covered charge subject to the following provisions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) External incision and drainage of cellulitis.

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

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

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

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

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

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

Effective Treatment of Substance Abuse means a program of Substance Abuse therapy that meets all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) **Coverage of Pregnancy.** The Allowable Amount for Procedures for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse. ~~There is no coverage of Pregnancy for a Dependent Child.~~ The Plan will provide coverage of Pregnancy for a Dependent Child in accordance with Section 2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services.

(13) **Routine Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Routine Preventive Care includes care by a Primary Care Physician or Gynecologist that is not for an Injury or Sickness for Covered Persons. Preventive Care includes one pap smear, mammogram (as detailed in *Section 5: Schedule of Benefits*), one prostrate screening, one gynecological exam, and one physical examination per Calendar Year. Eligible charges also include immunizations, x-rays and laboratory tests completed within four (4) weeks before or after the date of the examination.

(14) **Pediatric Care.** Pediatric Care includes routine pediatric care and immunizations by a Physician that is not for an Injury or Sickness for Covered Persons to age 18.

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

(15) **Routine Patient Care Costs in Approved Clinical Trials.** An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

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

Routine patient care costs exclude:

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

Utilization Management and other Plan limitations apply.

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

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

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

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

(i) Under the supervision of a Physician;

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

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

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

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

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

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

(g) **Diabetes Self-Management Training (DSMT)** is allowed for patients that have an eligible diabetes diagnosis, is ordered by the physician treating

the patient's diabetes and is furnished by a qualified practitioner, as defined in the Plan. One hour of individual training is allowed and up to nine hours in a group setting. The initial training should not exceed 10 hours.

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

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

(j) **Laboratory studies**.

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

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

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

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

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

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

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

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

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

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

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

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

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

CATASTROPHIC CLAIMS

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

7. TRANSPLANT PROGRAM

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

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

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

Eligibility for Transplant Policy Benefits

Employees and Dependents are eligible for benefits under the Transplant Policy if:

a.) the Employee and Dependent(s) are eligible and enrolled for medical benefits under The Langdale Company Employee Benefit Plan;

b.) the Employee and Dependent(s) meet all the terms and conditions outlined in the Transplant Policy plan documents.

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

All transplant services must be rendered at a transplant facility in the Network, as specified by National Union Fire Insurance Co. of Pittsburgh, PA.

Claims and Appeals Under the Transplant Policy

Claims and appeals for benefits under the Transplant Policy are governed by the terms of the Transplant Policy plan documents, and administered by National Union Fire Insurance Co. of Pittsburgh, PA.

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

8. UTILIZATION MANAGEMENT PROGRAM

The Plan Administrator has delegated the administration of the Plan's Utilization Management ("UM") program to Doctors Direct Healthcare.

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

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

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

1. **Hospital Admissions Authorization.** A Covered Person's physician must obtain hospital admission Prior Authorization from Doctors Direct Healthcare, as appropriate, before a scheduled hospital admission. If an Emergency results in a hospital admission, Covered Persons must notify Doctors Direct Healthcare of continued treatment for services to be covered after the Emergency Medical Condition is Stabilized. If the Covered Person's Medical Condition is determined not to be an Emergency, Covered Persons must notify Doctors Direct Healthcare of the post-screening services they receive for services to be covered. Notification should take place as soon as reasonably practical, given the Covered Person's Medical Condition. If notification is not received, the services may not be covered.

2. **Length of Stay.** Doctors Direct Healthcare will assign the initial covered hospital length of stay. This will be based on the diagnosis and other clinical data provided by the Physician. Covered Persons, admitting Physicians and facilities will receive written notice of the number of covered days that are approved.

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

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

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

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

6. **Retroactive Authorizations.** For Emergency inpatient and outpatient admissions, notification must be received within 2 business days of admission, or claims will be denied. **PRIOR AUTHORIZATION SERVICES WILL NOT HAVE THE 2-DAY WINDOW.**

Covered Person's Rights With Respect to Utilization Management.

1. A Covered Person or his or her representative or provider has the right to appeal any Non-Authorization. The Plan Administrator determines appeals from Covered Persons and their representatives. Doctor's Direct Healthcare determines appeals submitted by healthcare providers.

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

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

4. The right to have the Covered Person's attending physician speak with the Doctors Direct Healthcare Medical Director before the decision to non-authorize or disapprove a request for service is made.

Doctors Direct Healthcare Responsibilities with Respect to Utilization Management.

Doctors Direct Healthcare is responsible for the following:

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

2. Providing Covered Persons and providers with toll-free telephone access (877) 503-0388 to UM staff at least 40 hours per week Monday-Friday during normal business hours;

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

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

5. Doctors Direct Healthcare will notify providers of Authorizations; and

6. Doctors Direct Healthcare will notify Covered Persons and providers of Non-Authorizations with written or electronic confirmation.

Noncompliance

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

Participant Audit Bonus

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

Second and/or Third Surgical Opinion Program

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

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

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

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty. While any

surgical treatment is allowed a second opinion, the following procedures are ones for which Surgery is often performed when other treatments are available.

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

Case Management

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

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

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

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

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

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

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

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

DOCTORS DIRECT HEALTHCARE
Telephone 1-877-503-0388 or (910) 485-0510
Fax 1-866-252-8232 or (910) 485-8662

PRE-AUTHORIZATION REQUIREMENTS
EFFECTIVE JANUARY 1, 2014
(1 of 2)

BENEFITS & SERVICES UM REQUIREMENTS (When Medically Necessary)	**PPO Plan**
INPATIENT ADMISSIONS (Non-emergency) ***Includes Medical, Mental Health, Chemical Dependency and Rehabilitation**	**Prior Authorization Required.** (If not obtained, benefits will be reduced or denied per SPD pending medical necessity approval)
INPATIENT ADMISSIONS (Emergency) ***Includes Medical, Mental Health and Chemical Dependency**	**Notification Required within 2 business days of admission.** (If not notified, benefits will be reduced or denied per SPD pending medical necessity approval.)
SURGERY--OUTPATIENT (performed outside of the provider's office - including ambulatory surgery centers)	**Prior Authorization Required** (If not obtained, benefits will be reduced or denied per SPD pending medical necessity approval.)
SKILLED NURSING FACILITY CARE	**Prior Authorization Required** (If not obtained within the first 48 hours of admission, benefits will be reduced or denied per SPD pending medical necessity approval.)
PRIVATE DUTY NURSING	**Prior Authorization Required** (If not obtained within the first 48 hours, benefits will be reduced or denied per SPD pending medical necessity approval.)

TRANSPLANTS	**Prior Authorization Required**
OTHER SERVICES: **Genetic Testing** **Home Health, Hospice** **Home Infusion Therapy** **Intensive Outpatient Programs or Partial Hospitalizations for treatment of mental health or substance abuse** **Physical Therapy (after initial evaluation)** **Procedures for treatment of varicose veins in the office or surgical suite** **Occupational Therapy (after initial evaluation)** **Speech Therapy (after initial evaluation)** **Cardiac Rehab (after initial evaluation)** **Pulmonary Rehab (after initial evaluation)** **Adult MRI's (age17 and older)** **PET ScanSonorex/OssaTron/ESWT Therapy** **Reconstructive/Plastic Surgery** **Oral Surgery/Medical Dental** **Durable Medical Equipment (DME)** **Orthotics & Prosthetics**	**Prior Authorization Required** (If not obtained, benefits will be reduced or denied per SPD pending medical necessity approval.) (DME/Medical Supplies/Orthotics & Prosthetics: Prior Authorization is required for all rentals. Purchases greater than $500 will also require Prior Authorization.) ****Please note-Nebulizers, Diabetic Supplies (except for Insulin Pump) and CPAP supplies do not require Prior Authorization.**

*Please contact Doctors Direct Healthcare's Medical Management Office at 1-877-503-0388 ext 1 for questions regarding pre-authorization requirements. Claims requiring Prior Authorization will not be paid unless and until Prior Authorization is obtained.

9. DISEASE MANAGEMENT PROGRAM

The Participating Employers want to provide Covered Persons with every possible opportunity to stay healthy. The Plan has partnered with Doctors Direct Healthcare and Lowndes County Partnership for Health to provide a Disease Management Program as an innovative approach to health care. The goals of the program are to assist Covered Persons with managing chronic illnesses and promote a healthier lifestyle.

The Disease Management Program is an "opt out" management care program for the following chronic diseases: diabetes, hypertension (high blood pressure), hyperlipidemia (high cholesterol), asthma, and cardiovascular disease.

Throughout the year, members of a multi-disciplinary care team will maintain contact and provide needed educational information and support to help Covered Persons in the program meet mutually agreed upon goals. They will also work with the Covered Person's Physician to help achieve the most successful treatment options in a timely manner.

Participation in these programs is completely voluntary and without extra charge. A Covered Person may elect to opt out of the program by notifying the Plan Administrator in writing.

The program does not provide any coverage for medical or pharmaceutical expenses. This program does not change or modify any other condition, limitation or exclusion of this Plan.

10. DEFINED TERMS

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

Acute is the sudden onset of symptoms that are short duration.

Adjudication is defined as processing claims according to contract.

AHA shall mean the American Hospital Association.

Allowable Claim Limits means the charges for services and supplies, listed and included as covered medical expenses under the Plan, which are Medically Necessary for the care and treatment of illness or injury, but only to the extent that such fees are within the Allowable Claim Limits. See *Section 13: Claim Review and Audit* for examples.

Allowable Expense is the maximum dollar amount assigned for a procedure based on various pricing mechanisms or contracts.

AMA shall mean the American Medical Association.

Ambulance Service is defined as a professional Ambulance Service.

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

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

Appeal means a formal review process when a service is denied.

Assignment of Benefits shall mean an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

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

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 Drugs means a drug that is manufactured and marketed under a trademark or name by a specific drug manufacturer..

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

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

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

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

"Child(ren)" is defined as:

Child(ren) shall mean a covered Employee's or covered Spouse's natural child, stepchild, a legally adopted child, a child placed for adoption, a foster child, a

child for whom the covered Employee or covered Spouse is the legal guardian, or a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order. .

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

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

(1) Nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; and

(2) Cesarean section, termination of ectopic Pregnancy and spontaneous termination of Pregnancy occurring during a period of gestation in which a viable birth is not possible.

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

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

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

Covered Expense means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or participant's health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

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

Creditable Coverage means coverage under a group health Plan, health insurance coverage. Medicaid, Medicare, and public health Plans, as well as other types of coverage set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This definition is not intended to enlarge or otherwise modify the definition of Creditable Coverage as set forth in HIPAA and shall be interpreted the same as the statutory definition.

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.

Deductible is the amount a Covered Person must pay each calendar year under the Plan, before benefits become payable. There are separate Network and Non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

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

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 Treatment means treatment or services for an Injury or Sickness that is of serious, life-threatening nature, developing suddenly and unexpectedly, and demanding immediate treatment.

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

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

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

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

Essential Health Benefits shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the care and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental.

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

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
   a) maximum tolerated dose;
   b) toxicity;
   c) safety;

d) efficacy; and
e) efficacy as compared with the standard means of treatment or diagnosis; or

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

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

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

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

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

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

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

1. Such Child normally lives with the Employee in a parent-child relationship; and
2. The Employee has a legal right to claim such Child as a Dependent on his Federal income tax return if the Child resides with the Employee for a period of six (6) months or longer.

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

Generic Drug 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 pharmacists as being generic.

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

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

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

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of the registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping service); 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 people who are expected to die within six (6) months.

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

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

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

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

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

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

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

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

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special 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.

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

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

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes, but is not limited to, such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness, shortness of breath, convulsions or other such acute medical conditions.

Medical Care Necessity, Medically Necessary, Medical Necessity and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent

therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's Sickness or Injury without adversely affecting the Plan Participant's medical condition.

1. It must not be maintenance therapy or maintenance treatment;
2. Its purpose must be to restore health;
3. It must not be primarily custodial in nature;
4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and
5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

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

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. 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.

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

or diabetes.

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

Out-of-Pocket is the cost borne directly by Covered Person without the benefit of insurance or additional out-of-pocket expenses, Deductibles, Co-payments, and Co-insurance.

Outpatient Care 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 patient's home.

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.

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

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

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

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

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

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

Pregnancy is childbirth and conditions associated therewith.

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

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

PPO Charge/Allowance is the discounted amount a participating provider will charge for a medical expense per agreement with the PPO Network. For PPO participating providers, the Plan will reimburse covered expenses at the PPO discounted rate or, for non-PPO providers, the actual charge billed if it is less than the Usual and Customary (U&C) Charge; however, the Plan will not, in any case, reimburse any amounts that are in excess of the Allowable Claim Limits as described in the section, "Claim Review and Audit". Reimbursement of all covered charges will be made in accordance with the Schedule of Benefits.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and
Customary, and whether the charge is within Allowable Claim Limits.

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

Reasonable and/or Reasonableness shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and

assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the maximum Allowable Expense), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

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

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

Sickness is illness, disease or Pregnancy. There are no benefits for Pregnancy of covered Dependent Children.

Skilled Nursing/Extended Care 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 Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

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

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

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

(5) It has an effective utilization review Plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addiction, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

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

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

Spinal Manipulation/Chiropractic Care 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.

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

Sterilization means voluntary sterilization for women (tubal ligation or tubal occlusion/tubal blocking procedures only) and voluntary sterilization for men (vasectomy only).

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

Substance Abuse shall mean any use of alcohol, any Drug (whether obtained

legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Surgical Procedures (or Surgery) is any of the following:

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

Temporomandibular Joint Syndrome (TMJ) is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull

and the complex muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to the orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

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

Usual and Customary (U&C) shall mean covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently accepts or charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made or accepted by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

For claim determinations under the Claim Review and Audit, the Usual and Customary charge is the Allowable Claim Limits. Please refer to *the Section 13: Claim Review and Audit* for the definition of "Allowable Claim Limits."

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Waiting Period means that period of time that an Employee must be employed in an Eligible Class of Employees prior to initial eligibility for coverage under the Plan. Each Participating Employer may establish their own separate Waiting Period for Eligible Class(es) of Employees and notify them accordingly.

11. PLAN EXCLUSIONS

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

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

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

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

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

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

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

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

(7) **Cosmetic Services.** Services or supplies that are cosmetic, or to improve appearance or self perception which does not restore a bodily function, including but not limited to cosmetic or plastic Surgery, hair loss or treatment for skin wrinkling, unless Medically Necessary.

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

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

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

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

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

(12) **Excess Charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Customary Charge, or, for claims audited under the Claim Review and Audit Program, excess charges are the amount which is found to be in excess of the Allowable Claim Limits. Please refer to *Section 13: Claim Review and Audit* for additional information regarding Allowable Claim Limits.

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

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

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

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

(17) **Fatty Tissue Removal.** Procedure or surgery to remove fatty tissue such a panniculectomy, 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.

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

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

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

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

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

(21) **Hazardous Pursuit, Hobby or Activity**. This Plan does not cover any charge for care, supplies, treatment, and/or services that of an Injury or sickness that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Plan Participant's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm including but not limited to: hang gliding, skydiving, bungee jumping, parasailing, use of all terrain vehicles, rock climbing, use of explosives, automobile, motorcycle, aircraft, or speed boat racing, reckless operation of a vehicle or other machinery, and travel to countries with advisory warnings.

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

(23) **Hearing Aids and Exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting unless required due to an accidental Injury to the ear.

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

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

(26) **Illegal Acts.** Services received as a result of, in connection with, or related to: engaging in an illegal act, illegal occupation, or behavior that in the discretion of the Plan Administrator is reckless; committing or attempting to commit any crime, criminal act, assault, or felonious behavior; or participating in a riot or public disturbance. For purposes of applying this exclusion, it is not necessary that the act or behavior result in a citation, charge, or complaint, or that there be a conviction or determination of liability in response to any citation, charge, or complaint.

This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

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

(28) **Injectable Drugs.** Certain self-administered injectable drugs (i.e., B-12) when administered by a physician.

(29) **Marriage Counseling.** Marriage and/or family counseling is not covered. Expenses for treatment of an individual diagnosed with a Mental and Nervous disorder will be payable under Mental and Nervous Benefits as described in the Schedule of Benefits. Screening and counseling for interpersonal and domestic violence, when part of Preventive/Wellness exam, are covered under the Plan.

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

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

(32) **Mental Disorders.** Charges for treatment of Mental Disorders, except as otherwise stated in Plan.

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

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

(35) **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.

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

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

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

(39) **Obesity.** Care and treatment of obesity, including but not limited to gastric by-pass surgery and gastric banding, weight loss or dietary control whether or not it is, in any case, a part of the treatment Plan for another Sickness. Obesity screening and counseling, when part of Preventive/Wellness exam, are covered under the Plan.

(40) **Occupational.** For any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit; If you are covered as a Dependent under this Plan and you are self-employed or employed by an employer that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers compensation insurance will cover your costs, but if you do not have such coverage you may end up with no coverage at all.

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

(42) **Penile Implant.** Charges incurred for a penile implant.

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

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

(45) **Pregnancy of Child.** Care and treatment of Pregnancy and Complications of Pregnancy for a Dependent Child.

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

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

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

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

(50) **Residential Treatment.** A residential program or live-in facility to treat substance abuse, mental illness, or behavioral problems is not covered under the Plan.

(51) **Robotic Charges.** Robotic charges are not eligible under the Plan.

(52) **Routine Care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury. Sickness or Pregnancy related condition which is known or reasonably suspected, unless such is specifically covered in the Schedule of Benefits.

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

(54) **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.

(55) **Sex Changes.** Care, service 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.

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

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

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

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

(60) **Surrogate Pregnancy.** Maternity services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement

are excluded. This exclusion applies to all expenses for prenatal, intra-partal, and post-partal Maternity/OB Care, and Health Care Services rendered to the Covered Person acting as a Gestational Surrogate.

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

(62) **War.** Any loss that is due to a declared or undeclared act of war, invasion, hostilities, riot, rebellion, insurrection or aggression, unless otherwise required by Federal law. Charges for Sickness or Injury caused by or arising out of atomic explosions or nuclear energy, whether or not the result of war, unless otherwise required by Federal law.

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

12. PRESCRIPTION DRUG BENEFITS

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

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

USING THE PRESCRIPTION DRUG CARD

With the pharmacy benefit program you will:

(1) receive a prescription drug card to be used at a network of pharmacies, including most major drugstore chains; and

(2) pay a set, predictable amount -- called a co-payment -- for each covered prescription.

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

The network of pharmacies has been designed to be as responsive as possible to your needs. To verify whether the pharmacy you use is part of the network, please ask your pharmacist or call Envision at 1-800-361-4542.

CO-PAYMENT, SUPPLY, AND MAIL ORDER REQUIREMENTS

The co-payment is applied to each covered Prescription Drug charge and is shown in the *Section 5: Schedule of Benefits.* The Prescription Drug co-payment amount is not a covered charge under the Medical Plan.

If a drug is purchased from a non-network Pharmacy or a network Pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the co-payment will be limited to the ingredient cost and dispensing fee.

Maintenance medications may be obtained through a retail pharmacy (31 days supply) or through mail-order/home delivery program (90 days supply).

USING THE MAIL ORDER FEATURE

Booklets pertaining to mail order are available from the Plan Administrator or Envision.

To place your order:

Complete the mail order form and enclose:

(1) your prescription; and

(2) the appropriate co-payment

Your medication will be mailed to your home about two weeks after your order is received.

You can also call Envision with your request(s) to:

(1) order refills

(2) check the status of a mail order

(3) check participating pharmacy listing

(4) speak with a pharmacist about a medication you are taking.

COVERED PRESCRIPTION DRUGS

(1) All Drugs prescribed by a Physician that require a prescription either by federal or state law, except injectables (other than insulin) and except for the Drugs excluded in this Plan.

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

(3) Insulin when prescribed by a Physician, insulin needles/syringes, glucose testing strips, ketone testing strips and ketone tablets.

(4) Prenatal and Prescription Vitamins.

(5) Contraceptives or contraceptive minerals.

(6) Preventive Medicines, as described in *Section 5: Schedule of Benefits*.

FORMULARY - PREFERRED BRAND NAME DRUGS

Your plan has a formulary, which is a preferred listing of medications. Prescription drug coverage includes a preferred list of commonly prescribed

medications selected for their medical effectiveness and savings potential. Envision will send you a list of Preferred Drugs with your ID card. During the year, Envision reviews and updates the list regularly based on continual evaluation of available drugs. Based on this evaluation, a new drug or a generic for an existing brand name drug may be added to the list. To find out if a drug has been added to the list, please contact Envision. If you choose to use a preferred formulary medication your financial responsibility will be lower than if you choose the non-preferred medication.

GENERIC DRUGS

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

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

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

COVERAGE FOR OVER-THE-COUNTER MEDICATIONS

Prescription drug coverage includes certain Proton Pump Inhibitors (PPI) drugs and certain Non-sedating Antihistamine drugs which are available over the counter without a prescription, when you follow the steps described here:

(1) Ask your doctor to write a prescription for this medication, even though it is available over the counter.

(2) Present your prescription to the pharmacist at a network pharmacy along with your prescription drug card. You will pay the $10.00 drug co-payment (after prescription deductible has been met for the year) for

- The following Proton Pump Inhibitor (PPI) drugs: Lansoprazole Cap 15 mg, Omeprazole Cap 20.6 mg, Omeprazole Tab 20 mg, Prevacid 24H Cap 15 mg, and Prilosec OTC Tab 20 mg.
- The following Non-sedating Antihistamine drugs: Zyrtec, Zyrtec D, Allegra 30 mg tablets, Allegra 60 mg tablets, Allegra Susp. 30 mg/5ml, Allegra-D 12 Hour, Allegra-D 24 Hour, Claritin, Claritin D, and Fexofenadine HCI Tab 180 mg.

The pharmacy benefit program does not cover over-the-counter medications other than those listed above.

COVERAGE FOR VACCINES

The pharmacy benefit program covers the following immunizations with a prescription, except for flu shots, when provided by a Network Pharmacy and administered in compliance with applicable state law and pharmacy certification requirements. The following vaccines are covered at 100 percent by the Plan.

- Hepatitis B
- Herpes Zoster (shingles) – age 60 and older
- Influenza (flu)
- Influenza (flu) high dose – age 65 and older
- Pneumococcal (pneumonia)

STEP THERAPY & COVERAGE LIMITATIONS FOR SOME PRESCRIPTION DRUGS

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

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

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

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

The pharmacy benefit program has the following exclusions:

- Cosmetic medications require 100 percent co-payment (hair growth agents, photo-aged skin products, Botox for cosmetic purposes, dermatological bleaching agents)

- Tretinoin agents used in the treatment of acne and/or for cosmetic purposes (Retin-A) except through age 17 years, with prior authorization required

- Fertility agents oral or injectable require 100 percent co-payment.

- Contraceptives are covered under the medical plan (see *Section 5: Schedule of Benefits*)

- Impotence & Erectile Dysfunction products – six (6) tablets per calendar month are allowed. Additional medication during that calendar month require 100 percent co-payment

- Weight management agents used to suppress appetite and control fat absorption require 100 percent co-payment

- Injectable medications, except with prior authorization

- Serum, toxoids and vaccine agents

- All Durable medical equipment including, but not limited to ostomy supplies, peak flow meters

- Non-legend medications - nonprescription drugs and vitamins, except certain Proton Pump Inhibitor (PPI) drugs and certain Non-sedating Antihistamine drugs (See section *Coverage for Over-the-Counter Medications*, above). This does not apply to injectable insulin.

- Drugs dispensed while in a hospital or similar facility - these drugs may be covered as a hospital expense by the medical plan

- More refills than your doctor approves

- Refills more than one year after the original prescription date
- Experimental drugs or those limited by federal law to investigational use
- Allergy serums
- Immunizing agents, sera, blood or blood plasma
- Drugs for an injury or illness covered under Worker's Compensation
- Any charge for the administration of a covered Prescription Drug
- Any drug or medicine that is consumed or administered at the place where it is dispensed
- Devices of any type, even though such devices may require a prescription. All Durable medical equipment including, (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, ostomy supplies, peak flow meters or any similar device.
- Any drug not approved by the Food and Drug Administration
- A charge excluded under Plan Exclusions for Medical Benefits
- A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs
- A drug or medicine that can legally be bought without a written prescription
- Any over-the-counter durable medical equipment

13. CLAIM REVIEW AND AUDIT

The Plan has arranged with ELAP, Inc., the "Designated Decision Maker" ("DDM"), for a program of claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically appropriate. Benefits for claims which are selected for review and auditing will be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a Usual and Reasonable Charge determination.

Medical care providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits, and allowed the rights and privileges to file an appeal of the determination in accordance with the same rights and privileges accorded to Plan Participants in exchange for the provider's agreement not to bill the Plan Participant for charges which were not covered as a result of the claim review and audit Plan.

Any Covered Person who continues to receive billings from the medical care provider for these charges should contact the DDM or the Plan Administrator right away for assistance.

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

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of covered medical expense that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the provider of service and the Covered Person. In the event that the Plan Administrator does not receive information adequate for the claim review and audit within the time limits required under ERISA, it will be necessary to deny the claim. Should such a denial be necessary, the Covered Person and/or the provider of service may appeal the denial in accordance with the provisions which may be found in the *Section 14: Claims and Appeals* in this Summary Plan Description.

Allowable Claim Limits

"Allowable Claim Limits" means the charges for services and supplies, listed and included as covered medical expenses under the Plan, which are Medically Necessary for the care and treatment of illness or injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the

determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

1. Hospital. The Allowable Claim Limit for charges by a Hospital facility and for charges by facilities which are owned and operated by a Hospital may be based upon 112% of the Hospital's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or may be based upon the Medicare allowed amount as determined considering the provider, service and geographic area, plus an additional 20%.

2. Pharmaceuticals. The Allowable Claim Limit for pharmacy charges may be determined by applying the Average Wholesale Price (AWP) as defined by REDBOOK at the rate of 112% of AWP.

3. Medical and Surgical Supplies, Implants, Devices. The Allowable Claim Limit for charges for medical and surgical supplies may be based upon the invoice price (cost) to the provider, plus an additional 12%. The documentation used as the resource for this determination may include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the DDM.

4. Physician Medical and Surgical Care, Laboratory, X-ray, and Therapy. The Allowable Claim Limit for these services may be determined based upon the fees for comparable services in the geographic region at the 90th percentile of the Physician Fee Reference ("PFR"), which is the highest percentile reflected in the PFR.

5. Ambulatory Health Care Centers. The Allowable Claim Limit for ambulatory health care centers, including Ambulatory Surgery Centers, which are independent facilities may be based upon the Medicare allowable expenses for the services in the geographic region, and/or the Medicare Outpatient Prospective Payment System (OPPS), plus an additional 20%.

6. General Medical and/or Surgical Services. The Allowable Claim Limit for any covered services may be calculated based upon industry-standard resources including, but not limited to, CMS Cost Ratios, Medicare allowed fees (by geographic region), Medicare OPPS allowed fees, published and publicly available fee and cost lists and comparisons, any resources listed in the categories above, or any combination of such resources that results in the determination of a reasonable expense under the Plan, in the opinion of the DDM. The Allowable Claim Limit for these services will be calculated using one or more of the industry-standard resources, plus an additional 12%.

7. Unbundling. The Allowable Claim Limit will not include charges for any items billed separately that are customarily included in a global billing procedure code

in accordance with American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

8. Errors. The Allowable Claim Limits will not include any identifiable billing mistakes including, but not limited to, upcoding, duplicate charges, and charges for services not performed. Allowable Claim Limits also will not include charges that are required to treat injuries sustained or illnesses contracted, including infections and complications, which, in the opinion of the DDM and based upon the medical records of the treatment, can be attributed to a medical error by the provider.

9. Medical Record Review. In the event that the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the DDM may determine the Allowable Claim Limit according to the medical record review and audit results.

10. Not Able to Identify or Understand. The Allowable Claim Limits will not include any charges for which the DDM cannot identify or understand the item(s) being billed.

In the event that the DDM determines that insufficient information is available to identify the Allowable Claim Limit for a specific service or supply using the listed guidelines above, consideration will be given to such fees for the geographic location, the most comparable services or supplies and based upon comparative severity. The DDM reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

Notwithstanding any conflicting contracts or agreements, the Plan may consider the Allowable Claim Limits as the maximum amount of Covered Medical Expense that may be considered for reimbursement under the Plan, and may apply this determination in lieu of any PPO network provider hospitals' per diem, DRG rates or PPO discounted rates as the amount considered for reimbursement under the Plan. Additionally, in the event that a determination of an Allowable Claim Limit exceeds the actual charge billed for the service or supply, the Plan will consider for coverage the lesser of the actual billed charge or the Allowable Claim Limit determination.

14. CLAIMS AND APPEALS

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

CLAIMS FOR BENEFITS

Three Claim Types

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

Under the Plan, there are three types of claims:

- Pre-service Non-urgent
- Concurrent Care
- Post-service

Pre-service Non-urgent Care Claims

A "Pre-Service Non-urgent Care Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on receiving approval of the benefit in advance of obtaining medical care. This claim does not involve urgent care because there is not a serious jeopardy to the life or health of the claimant, and severe pain is not involved. (See definition of "’Urgent Care Claim" below.

An “Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. **It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his/her life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.**

Further, since the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment in an urgent care situation, there are no Pre-service Urgent Care Claims under the Plan. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Concurrent Claims

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

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

Post-service Claims

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

How To File A Claim

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

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

For Plan reimbursements, submit bills for service rendered.

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

ALL BILLS AND CLAIMS MUST SHOW:

- Name of Plan
- Group number of Plan

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

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

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

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

Incorrectly Filed Claims

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that (a) in the case of an incorrectly filed Pre-service Non-urgent Claim, the claimant shall be notified as soon as possible but no later than 5 days following receipt by the Plan of the incorrectly filed claim. The notice will describe the proper procedures for filing a claim. This notice may be given verbally unless written notice is specifically requested by the claimant.

Appointment of Authorized Representative

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

Timing of Claim Decisions

Pre-service Non-urgent Care Claims

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

Concurrent Claims

- Plan Notice of Reduction or Termination. If the Plan has determined that an initially approved course of treatment should be reduced or terminated (other than by Plan amendment or Plan termination), this will be treated as an adverse benefit determination, and the claimant will be notified sufficiently in advance to allow the claimant to appeal the decision before the care is reduced or terminated.

- Request by Claimant Involving Non-urgent Care. If the claimant has requested that the Plan extend an initially approved course of treatment beyond the period of time or number of treatments that has been approved, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims

- A determination will be made within a reasonable period of time, but not later than 30 days after receipt of the claim.

Extensions of Time

Despite the specified timeframes, nothing prevents the claimant from voluntarily agreeing to extend the above timeframes.

In addition, if the Plan is not able to decide a pre-service or post-service claim within the above timeframes due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the Claim. The extension notice shall include a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected.

If an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be given 45 days from receipt of the notice within which to provide the information requested. The

period of time for deciding the claim will be tolled from the date on which the notification of the extension is sent to the claimant, until the date on which the claimant timely responds to the request for information. If the requested information is not provided, the claim may be decided without that information.

Calculating Time Periods

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

Adverse Benefit Determination

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

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

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

Notification of an Adverse Benefit Determination

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

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

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

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

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

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

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

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

INTERNAL APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Full and Fair Review of All Claims

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

First Internal Appeal Level

Requirements for First Appeal

The claimant must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. (The 180-day period is reduced to 30 days if appealing the Plan's decision to reduce or terminate a previously approved ongoing course of treatment before the end of the approved period of

time or number of treatments.) To file an appeal in writing, the claimant's appeal must be addressed to the Plan Administrator and mailed as follows:

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

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

1. The name of the claimant;

2. The claimant's address and telephone number

3. The group name or group identification number;

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

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

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

Review of Adverse Benefit Determination on First Appeal

The first appeal of an adverse benefit determination will be reviewed and decided by the Plan Administrator. The person who reviews and decides an appeal will be a different individual than the person who made the initial benefit decision and will not be a subordinate of the person who made the initial benefit decision. The review by the Plan Administrator will take into account all information submitted by the claimant, whether or not presented or available at the initial benefit decision. The Plan Administrator will give no deference to the initial benefit decision.

Consultation With Expert

In the case of a claim denied on the grounds of a medical judgment, the Plan Administrator will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be

the same individual who was consulted, if any, regarding the initial benefit decision or a subordinate of that individual.

Access to Relevant Information and Rationale

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

Timing of Notification of Benefit Determination on First Appeal

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECOND AND FINAL INTERNAL APPEAL LEVEL

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

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

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

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

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

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

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

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

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

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

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

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

The Plan must include a discussion of the reason(s) for the final internal adverse benefit determination.

Furnishing Documents in the Event of an Adverse Determination

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

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

Decision on Second and Final Internal Appeal

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

Exhaustion of Internal Appeals Process

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

EXTERNAL REVIEW PROCESS

This Plan is subject to the Federal external review process. The claimant can request in writing the external review only and if the Plan’s internal appeals processes are exhausted, as described in the “Exhaustion of Internal Appeals Process” section and the request is made within four (4) months following receipt of a final internal adverse benefit determination (or in some cases, adverse benefit determination).

Once the Plan receives the claimant’s request for external review, the Plan has five (5) business days to determine whether the claim is eligible for external review. The Plan will notify the claimant of its decision within 1 business day. If the claim is eligible for external review, the Plan will provide appropriate information within five (5) business days to one of three Independent Review Organizations (or IROs) assigned based on a rotation schedule. The claimant may submit any additional information to the assigned IRO within 10 business days. The IRO must make its final decision within 45 days of receiving the

request from the Plan. The IRO will notify both the claimant and the Plan of the final external review decision in writing.

Scope of External Review

The Federal external review process applies only to:

1. An adverse benefit determination (including a final internal adverse benefit determination) by the Plan that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and

2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Furthermore, a Claim is not eligible for external review if:

- the claimant is (or was) not covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, the claimant was not covered under the Plan at the time the health care item or service was provided;

- the adverse benefit determination is based on the fact that the claimant was not eligible for coverage under the Plan (except where the claim relates to a rescission of coverage);

- the claimant has not exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); or

- the claimant has not provided all the information and forms required to process an external review.

Independent Review Organizations

For purposes of compliance with this section, the Plan contracted with three (3) Independent Review Organizations (or IROs), who are independent third party organizations and make binding decisions to uphold or reverse the claims denial. All IROs the Plan contracts with must be accredited by URAC.

External Review is Final and Binding

Both the claimant and the Plan are bound by the final decision of the IRO, except to the extent that other remedies are available under State or Federal law. The Plan must provide benefits pursuant to the final decision of the external reviewer without delay, regardless of whether the Plan intends to seek judicial review of

the decision. The Plan may choose to pay a claim voluntarily at any time during or after the external review process.

CONTINUED COVERAGE PENDING APPEAL

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

PROVIDER OF SERVICE APPEAL RIGHTS

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

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

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

LIMITATION OF ACTION

You must exhaust the appeals process before bringing a lawsuit for judicial review. Further, any legal action for judicial review must be brought within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action.

15. COORDINATION OF BENEFITS

Coordination of benefits sets out rules for the order of payment of Allowable Expenses when two or more plans – including Medicare – cover an individual. When a Covered Person is covered by this Plan and one or more other plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will coordinate coverage (i.e. may be entitled to reduce benefits payable under the secondary/subsequent plans by the amount paid by the primary plan(s)).

WHEN THIS PLAN IS SECONDARY COVERAGE

Covered Persons for whom the Plan is secondary coverage under these rules, not primary coverage, must file all medical and pharmacy expenses with the primary payer initially, and then provide an Explanation of Benefits (EOB) to the Plan Administrator. The Plan Administrator will then coordinate coverage up to the Allowable Expense payable under this Plan in the absence of Coordination of Benefits, as set forth in the Schedule of Benefits, provided that Plan benefits will be reduced so that Plan benefits and the benefits payable under Other Plans do not total more than this Plan's Allowable Expense.

Covered Persons for whom the Plan is not primary coverage are not eligible to participate in the Disease Management Program.

BENEFIT PLAN

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

(1) Group or group-type plans, including franchise or blanket benefit plans, whether or not insured.

(2) Blue Cross and Blue Shield group plans.

(3) Group or group-type coverage through HMOs, and other prepayment, group practice and individual practice plans.

(4) Federal government plans or programs. This includes Medicare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan that, by its terms, does not allow coordination.

(6) The medical benefits coverage in group, group-type, and individual no fault auto insurance, uninsured coverage, and underinsured motorist coverage, by whatever names they are called.

EXCESS INSURANCE

If at the time of injury, sickness, disease or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

a) any primary payer besides the Plan;

b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

c) any policy of insurance from any insurance company or guarantor of a third party;

d) worker's compensation or other liability insurance company; or

e) any other source, including but not limited to any crime victim restitution funds, medical, disability or other benefit payments, and school insurance coverage.

VEHICLE LIMITATION

When medical payments are available under any vehicle insurance (including no-fault automobile insurance, uninsured motorist coverage, or underinsured motorist coverage), the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

ALLOWABLE EXPENSES

Allowable Expenses shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under

any Other Plan include the benefits that would have been payable had claim been duly made therefore.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Further, when an HMO is primary and the Participant does not use an HMO Provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Participant used the services of an HMO Provider.

BENEFIT PLAN PAYMENT ORDER

When two or more plans provide benefits for the same Allowable Expense, benefit payment will follow these rules:

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

(2) Plans with a coordination provision will pay their benefits by the following rules, up to the Allowable Expense:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member, subscriber, or retiree) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

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

(b) The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan providing non-continuation coverage is primary and the plan providing continuation coverage is secondary.

(d) When a child is covered as a dependent and the parents are not separated (whether or not they have ever been married) or divorced, these rules will apply:

(i) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

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

(e) When a child's parents are divorced, not married, or legally separated (whether or not they were ever married), these rules will apply:

(i) The plan of the parent with custody will be considered first

(ii) The plan of the spouse of the parent with the custody of the child will be considered second.

(iii) The plan of the parent not having custody of the child will be considered third.

(iv) The plan of the spouse of the parent without custody will be considered next.

(v) This rule will be in place of items (i) through (iv) above when it applies. A court decree may state which parent is primarily responsible for medical benefits of the child. In this case, and if the plan of that parent has knowledge of the terms of the decree, the plan of that parent will be determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period during which any benefits are actually paid or provided before the entity has that actual knowledge.

(vi) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated and divorced.

(f) If none of the above rules determines the order of benefits, the benefits of the plan which covered the person for the longer period of time is primary.

(3) Medicare will pay primary, secondary or last to the extent stated in Federal law. When Medicare is 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. The Plan Administrator will make this determination based on information available through CMS.

This Plan will be primary to Medicare as may be required, if the Medicare eligibility is based solely upon the diagnosis of End Stage Renal Disease (ESRD). Afterwards, Medicare will become the primary payer of benefits.

This Plan will pay primary to Medicare only as required by the Medicare Secondary Payer rules. Nothing herein shall be construed as providing for a longer period during which this Plan will be primary.

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

CLAIMS DETERMINATION PERIOD

Benefits will be coordinated on a Plan year basis (i.e. January 1 through December 31). This is called the claim determination period.

RIGHT TO RECEIVE OR RELEASE NECESSARY INFORMATION

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

FACILITY OF PAYMENT

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan, and the Plan will not pay that amount again.

RIGHT OF RECOVERY

In accordance with the “Recovery of Payments” section of this SPD, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess. Please see *Section 16: Recovery of Payments* for more details.

MEDICAID COVERAGE

A Covered Person’s eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the State Medicaid program; and the Plan will honor any subrogation rights the State may have with respect to benefits which are payable under the Plan.

16. RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan ("Erroneous Payments"). As a result, the Plan may pay benefits that are later found to be greater than the Maximum Allowed Amount.

In such cases, the Plan has the right to recover the amount of any Erroneous Payment directly from the person or entity who received such payment, from other payers, and/or from the Employee or Dependent on whose behalf such payment was made.

The Plan has the right to recover benefits it has paid on an Employee's or Dependent's behalf that were:

- made in error;
- due to a mistake or misstatement in fact;
- due to fraud or misrepresentation;
- in anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions;
- pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

Recipients of Erroneous Payments shall return or refund the amount of such Erroneous Payment to the Plan within 30 days of discovery or demand. Recipients include a covered Employee, Dependent, medical provider, another benefit plan, insurer or any other person or entity who receives an Erroneous Payment exceeding the amount of benefits payable under the terms of the Plan. The person or entity receiving an Erroneous Payment may not apply such payment to another expense. The Plan Administrator shall have no obligation to secure payment for the expense for which the Erroneous Payment was made or to which it was applied.

The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an Erroneous Payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the

authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor, to the extent permitted by law. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand. Any Erroneous Payments not repaid within 30 days of discovery or demand shall incur prejudgment interest of 1.5% per month.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

Further, Employees, Dependents, and/or their beneficiaries, estate, heirs, guardian, personal representative, or assigns shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

If the Plan must bring an action against an Employee, Dependent, Provider or other person or entity to enforce the provisions of this section, then that , Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

17. THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PAYMENT CONDITION

This section explains how your benefits are impacted if you suffer a Sickness or Injury that is caused by and/or payable by a third party other than the Plan.

For example, if a third party is responsible for payment for a Sickness or Injury for which you receive a settlement, judgment, insurance proceeds, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that Sickness or Injury. You must reimburse the Plan even if you have not been "made whole" for your Sickness or Injury.

Please contact the Plan Administrator if you have any questions regarding this section.

A. CONDITIONAL PAYMENT OF BENEFITS

1. The Plan shall be deemed to have conditionally advanced payment of benefits in those situations where a Covered Person's Sickness or Injury is caused in whole or in part by, or results from, the acts or omissions of the Covered Person or a third party, whereby any party besides the Plan may be responsible for and/or other funds are available for expenses associated with the Sickness or Injury, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Other Coverage").

2. A Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated Covered Person agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or his or her attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Covered Person settles, recovers, or is reimbursed by any Other Coverage, the Covered Person agrees to reimburse

the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (including attorneys' fees and costs) associated with the Plan's attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is only one of a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

B. SUBROGATION

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to pursue payment from any Other Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

2. If a Covered Person receives or becomes entitled to receive benefits from Other Coverage and/or a party other than the Plan, an automatic equitable lien attaches in favor of the Plan to any claim for such benefits, which any Covered Person may have against any Other Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable attorneys' fees and costs of collection.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Person commence a proceeding or pursue a claim against any party or Other Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Covered Person fails to file a claim or pursue damages against:

   a) the responsible party, its insurer, or any other source on behalf of that party;

b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

c) any policy of insurance from any insurance company or guarantor of a third party;

d) worker's compensation or other liability insurance company; or

e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

C. RIGHT OF REIMBURSEMENT

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar

doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness or Injury.

D. EXCESS INSURANCE

If at the time of Sickness or Injury there is available, or potentially available any Other Coverage (including but not limited to Other Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Other Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

1. the responsible party, its insurer, or any other source on behalf of that party;

2. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

3. any policy of insurance from any insurance company or guarantor of a third party;

4. worker's compensation or other liability insurance company; or

5. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

E. SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person, or filing of bankruptcy by the Covered Person, will not affect the Plan's

equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

F. WRONGFUL DEATH

In the event that the Covered Person dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Other Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person and all others that benefit from such payment.

G. OBLIGATIONS

1. It is the Covered Person' obligation at all times, both prior to and after payment of medical benefits by the Plan:

    a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

    b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;

    c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

    d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

    e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

    f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Other Coverage.

2. If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses

(whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person' cooperation or adherence to these terms.

H. OFFSET

Failure by the Covered Person and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Covered Person may be withheld until the Covered Person satisfies his or her obligation.

I. MINOR STATUS

1. In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

J. LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

K. SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

18. COBRA CONTINUATION OPTIONS

INTRODUCTION

If you lose your Plan coverage, you may have the right to temporarily extend it under the federal law Consolidated Budget Reconciliation Act of 1985 (COBRA).

This section generally explains COBRA continuation coverage, when COBRA coverage may become available to you and your family, and what you need to do to protect the right to receive it. Please read this information carefully. The Plan offers no greater COBRA rights than what the COBRA statute requires. You should contact your Plan Administrator if you have questions about your right to continue coverage.

WHAT IS COBRA COVERAGE?

COBRA coverage is a continuation of Plan coverage when that coverage would otherwise end because of certain events called "qualifying events." Specific qualifying events are listed below. After a qualifying event occurs and any required notice of that event is properly given, COBRA coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

The word "you" below generally refers to each person covered by the Plan who is or may become a qualified beneficiary.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

WHAT ARE QUALIFYING EVENTS?

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because of one of the following qualifying events:

(1) Your hours of employment are reduced; or

(2) Your employment ends for any reason (other than your gross misconduct).

If you are the spouse of an employee, you will become a qualified beneficiary if you lose coverage under the Plan because of any of the following qualifying events:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason (other than for gross misconduct); or

(4) You become divorced or legally separated from your spouse; or

(5) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

If you are the dependent child of an employee, you will become a qualified beneficiary if you lose coverage under the Plan because of any of the following qualifying events:

(1) Your parent-employee dies;

(2) Your parent-employee's hours of employment are reduced;

(3) Your parent-employee's employment ends for any reason (other than for gross misconduct);

(4) Your parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);

(5) Your parents become divorced or legally separated; or

(6) You no longer meet the Plan's definition of a dependent child and are therefore no longer eligible.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has received proper notice that a qualifying event has occurred. When the qualifying event is the end of employment , the reduction of hours of employment, the death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your employer will give the required notice to the Plan Administrator.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator **in writing within 60 days** after the later of the qualifying event at the following address:

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

Tel: (229) 249-0940
Toll Free: (877) 949-0940

You will need to provide a copy of court orders or any other paperwork that is needed in order to determine COBRA eligibility.

Notice can be given by the covered employee, by a qualified beneficiary, or by a representative of either.

If you send a notice through the mail, the notice must be post-marked within the 60-day period described above. **If your notice is not properly and timely given , you will lose your right to elect COBRA.**

ELECTING COBRA COVERAGE

Once the Plan Administrator receives notice and satisfactory proof that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary. At that time, you will receive information about the cost of COBRA coverage, and how to elect and pay for COBRA. **To elect COBRA, you must complete the election form that will be provided to you and timely return the form within a 60-day election period.**

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

ELECTING COBRA AFTER LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact the Plan Administrator for more information about these special rules.

SPECIAL RULES FOR FEDERAL TRADE ADJUSTMENT ASSISTANCE

The Trade Adjustment Assistance Act of 2002 amended COBRA to provide certain trade affected workers with a second opportunity to elect COBRA continuation coverage. Individuals who are eligible for trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) and who did not elect COBRA during the general election period may get a second election period. This additional, second election period is measured 60 days from the first day of the month in which an individual is determined TAA-eligible.

For example, if an individual's general election period runs out and he or she is determined TAA-eligible 61 days after separating from employment, at the beginning of the month, he or she would have approximately 60 more days to elect COBRA. However, if this same individual is not determined TAA-eligible until the end of the month, the 60 days are still measured from the first of the month, in effect giving the individual about 30 days.

Additionally, the Trade Act of 2002 added another limit on the second election period. A COBRA election must be made not later than 6 months after the date of the TAA-related loss of coverage. COBRA coverage chosen during the second election period typically begins on the first day of that period.

More information about the Trade Act is available at www.doleta.gov/tradeact.

COST OF COBRA COVERAGE

Each qualified beneficiary is required to pay for the entire cost of COBRA coverage, plus an administrative fee. The amount may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to disability, 150 percent) of the cost of the Plan (including both employer and employee contributions) for coverage of a similarly situated Plan participant or beneficiary who is not receiving COBRA coverage. You will be notified of the cost in your COBRA election materials. The amount of your COBRA premiums may change from time to time as the law allows and will most likely increase over time.

PAYING FOR COBRA COVERAGE

You must make your first payment for COBRA coverage no later than 45 days after the date you elect COBRA. Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated through the time you make the first payment. **If you do not make your first payment for COBRA coverage in full within 45 days after the date of your COBRA election, you will lose all COBRA rights under the Plan.**

Monthly payments for each subsequent month of coverage are due on the first day of the month for that month's COBRA coverage, subject to a 30-day grace period. **If you do not make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage.**

If you have questions regarding paying for COBRA coverage, please contact the Plan Administrator.

HOW LONG DOES COBRA COVERAGE LAST?

As explained above, COBRA coverage is a temporary continuation of Plan coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended. Please contact the Plan Administrator for Plan procedures and applicable deadlines governing requests for COBRA extensions.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you provide timely written notice to the Plan Administrator, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if you provide timely written notice to the Plan Administrator within 60 days of the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation

coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

OTHER INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

A child who is born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary if the covered employee has elected COBRA coverage for himself or herself. Continuation coverage may be elected for the child, provided the child satisfies the otherwise applicable plan eligibility and enrollment requirements, and provided that timely notice of the birth or adoption is given under the applicable terms of the Plan. If timely notice is not given, the child cannot be added to COBRA continuation coverage. The child's COBRA coverage begins when the child begins participation in the Plan, and it lasts for as long as COBRA lasts for other similarly situated qualified beneficiaries in the family.

TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

The coverage periods described above are maximum coverage periods. COBRA coverage will terminate before the end of the maximum coverage if:

(1) Any required premium is not paid in full and on time;

(2) The qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both), after electing COBRA (you should provide notice if Medicare entitlement occurs);

(3) The employer ceases to provide any group health plan for its employees; or

(4) In the case of a disability extension, the disabled qualified beneficiary is deter- mined by the Social Security Administration to no longer be disabled (you should provide notice if the Social Security Administration makes this determination). See the explanation above under the heading, "Notice If the Disability Ends."

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

COVERAGE OPTIONS OTHER THAN COBRA

There may be coverage options other than COBRA for you and your family. Under PPACA, health coverage is available through the Health Insurance Marketplace. In the Marketplace, you may be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace.

IF YOU HAVE QUESTIONS

Questions about your rights under COBRA, and other questions about the Plan, can be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

In order to protect your and your family's rights, you should update any changes in your address and the addresses of family members. Updates should be provided to the Plan Administrator. You should also keep for your records a copy of any notices and other communications you send to the Plan Administrator regarding COBRA.

19. OTHER FEDERAL LAWS THAT APPLY

The Plan is a welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The Plan is also a non-grandfathered health plan subject to the requirements of the Patient Protection and Affordable Care Act (PPACA). Other federal laws also govern the Plan, which are briefly summarized below. For more information, please contact the Plan Administrator.

HIPAA Privacy & Security

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your protected health information.

The Langdale Company Employee Benefit Plan (the "Plan") will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, Plan administration, or as required or permitted by law.

A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Plan's Notice of Privacy Practices ("Privacy Notice"), which is furnished to all Plan participants at the time of enrollment, is available upon written request, and can also be accessed on the Plan's internet site at: www.tlcbenefitsolutions.net

Privacy Officer And Contact Person

The HIPAA Privacy and Security Officer for the Plan, whose responsibility is the development and implementation of policies and procedures to ensure compliance with HIPAA, shall be the individual whose job title is "Compliance Officer." The contact person or office responsible for receiving complaints regarding health information privacy, and who is able to give further information concerning matters covered by the Privacy Notice, is the Compliance Officer.

Issuance Of HIPAA Certificate of Creditable Coverage

The Plan Administrator will issue you a HIPAA certificate of Creditable Coverage under the following circumstances:

- when you lose coverage under the Plan;
- when you become entitled to elect COBRA;
- when your COBRA coverage ends;
- if you request a certificate of creditable coverage before losing coverage; or

- if you request a certificate of creditable coverage up to 24 months after losing coverage.

Beginning January 1, 2015 (subject to change under the Affordable Care Act future guidance), the Plan Administrator will issue a HIPAA certificate of Creditable Coverage upon request only. To request a HIPAA certificate of Creditable Coverage, contact: TLC Benefit Solutions, Inc., P.O. Box 947, Valdosta, GA 31603. Phone: (229) 249-0940, Toll-free: (877) 949-0940.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998, is a Federal law that mandates that group health plans which provide medical and surgical benefits shall provide to those who are receiving benefits in connection with the Mastectomy and who elect breast reconstruction in connection with the mastectomy, coverage for:

(1) Reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce asymmetrical appearance and;

(3) Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

This coverage is to be determined in consultation with the attending physician and the patient. Such coverage, if available, is subject to annual deductible and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the Plan.

Newborns' and Mothers' Health Protection Act (NMHPA)

Under Federal law, group health Plans offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

However, the Plan may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, the Plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under Federal law, require that a physician or other health care provider obtain Prior Authorization for prescribing a length of stay of up to 48 hours (or 96 hours as applicable). The Plan may impose a Prior Authorization requirement for hospital stays beyond this period.

For information on services that require Prior Authorization, please see *Section 8: Utilization Management Program*, or contact the Plan Administrator.

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans to ensure that financial requirements (such as copays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. MHPAEA does not mandate that a plan provide MH/SUD benefits.

The Plan is in compliance with MHPAEA, and will interpret the Plan's terms governing MH/SUD benefits shall be interpreted in compliance with MHPAEA.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits the Plan from:

- Requesting or requiring individuals or their family members to undergo genetic testing.
- Using genetic information to determine eligibility for coverage or to impose preexisting condition exclusions.
- Collecting genetic information for underwriting purposes or with respect to any individual prior to enrollment or coverage.
- Adjusting group premium or contribution amounts on the basis of genetic information.

The Plan will not discriminate in individual eligibility, benefits or premiums based on any genetic information. The Plan will not require genetic testing of participants or intentionally gather genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes.

What is "genetic information"?

Genetic information means information about an individual's genetic tests, the genetic tests of family members of the individual, family medical history or any request for and receipt of genetic services by an individual or a family member. The term also includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to an individual using assisted reproductive technology, genetic information about the embryo.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

A Covered Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and his/her Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

Plan coverage may be continued under USERRA for up to the lesser of:

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

(2) The day after the date on which the Employee fails to apply for or return to a position of employment, as required by USERRA.

An Employee who elects to continue coverage under USERRA may be required to pay not more than 102 percent of the full premium under the Plan (determined in the same manner as the applicable COBRA premium) associated with such coverage for other Employees. In the case of an Employee who performs service in the uniformed services for less than 31 days, such Employee may not be required to pay more than the Employee's share, if any, for such Plan coverage.

To the extent allowed by law, COBRA coverage and USERRA coverage run concurrently.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible Dependents in Plan coverage immediately upon returning to active employment, even if you and your dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting period.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

20. PLAN ADMINISTRATION

The Plan is administered by TLC Benefit Solutions, Inc. ("Plan Administrator"). The Plan Administrator shall have the full power and discretionary authority to control and manage all aspects of the Plan in accordance with its terms and all applicable laws, including, but not limited to:

- Administer the Plan according to its terms and to interpret Plan policies and procedures;
- Interpret terms of the Plan and determine eligibility for participation and for benefits under the Plan;
- To make factual and legal findings;
- Resolve and clarify inconsistencies, ambiguities and omissions in the Plan document and among and between the Plan document and other related documents;
- Take all actions and make all decisions regarding questions of coverage, eligibility and entitlement to benefits, and benefit amounts; and
- Process and approve or deny all claims for benefits.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to other persons or entities that provide services in regard to the administration of the Plan (e.g. pharmacy benefit manager, the Designated Decision Maker, Utilization Management program vendors)

Any determination made by the Plan Administrator shall be given deference in the event the determination is subject to judicial review and shall be overturned by a court of law only if it is arbitrary and capricious.

Prescription Drug Benefits

Envision Pharmaceutical Services, Inc. ("Envision") is the claims fiduciary with respect to prescription drug benefit claims administration. Please see *Section 12: Prescription Drug Benefits* for more information.

Designated Decision Maker (DDM)

The Plan Administrator has delegated fiduciary responsibility and discretionary authority to ELAP, Inc. ("Designated Decision Maker" or "DDM") with respect to:

- the review and audit of certain claims in accordance with the applicable Plan provisions of *Section 13: Claim Review and Audit Program*.

Duties of the Designated Decision Maker.

The DDM shall have the following duties with respect to the Claim Review and Audit Program:

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

(2) To determine all questions of eligibility, benefits, status and coverage under the Plan;

(3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;

(4) To make factual and legal findings;

(5) To decide disputes which may arise relative to a Covered Person's rights;

(6) To perform the duties in conjunction with the provisions of the Claim Review and Audit Program; and

(7) To keep and maintain records pertaining to the Claim Review and Audit Program.

The duties of the DDM shall be limited to those set forth above. The DDM shall have no authority, responsibility or liability other than with respect to its duties under the Claim Review and Audit Program.

Utilization Management Program

The Plan Administrator has delegated fiduciary responsibility and discretionary authority to administer the Plan's Utilization Management (UM) program to Doctors Direct Healthcare. Such duties include:

- Processing notifications and requests for Prior Authorization pursuant to the Plan's requirements;
- Determining appeals from non-authorizations submitted by healthcare providers

The Plan Administrator determines appeals from Covered Persons and their representatives. Please see *Section 8: Utilization Management Program* for additional details.

Transplant Program

The Langdale Company Employee Benefit Plan (the "Plan") includes a special carve-out program for human organ and tissue transplant benefits, which are fully-insured and administered by National Union Fire Insurance Co. of Pittsburgh, PA (the "Transplant Policy"). Claims and appeals for benefits under the Transplant Policy are governed by the terms of the Transplant Policy plan documents, and administered by National Union Fire Insurance Co. of Pittsburgh, PA. Please see *Section 7: Transplant Program* for details.

21. GENERAL PLAN INFORMATION

PLAN NAME: The Langdale Company Employee Benefit Plan.

PLAN NUMBER: 572

PLAN SPONSOR'S TAX ID NUMBER: 58-0542427

PLAN TYPE: Welfare Benefits Plan (Group Health Plan)

PLAN YEAR: January 1 – December 31

PLAN ADMINISTRATION:
Self-funded (with the exception of organ and tissue transplant benefits)
Fully-Insured (organ and tissue transplant benefits)

SOURCE OF BENEFITS: General assets of Participating Employers

SOURCE OF CONTRIBUTIONS: Employee and Participating Employers

PLAN EFFECTIVE DATE: November 5, 1990

PLAN SPONSOR INFORMATION:

The Langdale Company
1202 Madison Highway
Valdosta, Georgia 31601
Phone: (229) 333-2500

PLAN ADMINISTRATOR:

TLC Benefit Solutions, Inc.
P. O. Box 947
Valdosta, Georgia 31603
Phone: (229) 249-0940
Toll Free: (877) 949-0940

AGENT FOR SERVICE OF LEGAL PROCESS:

Vice President of Human Resources
The Langdale Company
1202 Madison Highway
Valdosta, Georgia 31601

Service of legal process may also be made on the Plan Administrator TLC Benefits Solutions, Inc.

PARTICIPATING EMPLOYERS WHOSE EMPLOYEES MAY BE COVERED:

CBC Capital, Inc. d.b.a. Fussell Tire & Service
Industrial Cutting Tools, Inc.
Kinderlou Forest Development, LLC
Kinderlou Forest Golf Club, LLC
LANCO Trucking, Inc.
Langboard, Inc.
Langdale Chevrolet, Inc.
The Langdale Company
Langdale Farms LLC
Langdale Ford Company
Langdale Forest Products Co.
Langdale Fuel Co.
Langdale Industries, Inc.
Langdale International Trading Corp.
Langdale Timber Company
Langdale Woodlands, LLC
Lowndes Bancshares, Inc., d.b.a. Commercial Banking Company
Naval Stores Suppliers, Inc., d.b.a. Southern Builders Supply Co.
Southland Forest Products, Inc.
TLC Benefit Solutions, Inc.
TLC Building Components, Inc.
TLC Mouldings, Inc.
TLC Wood Additives
The Val d'Aosta Company, d.b.a. Clarion Inn Conference Center

Amendment or Termination of the Plan

The Plan Sponsor reserves the right, at any time, to amend, suspend or terminate the Plan, in whole or in part, for any reason. Only the Plan Sponsor has the authority to amend or terminate the Plan. Such authority of the Plan Sponsor may be exercised by the Vice President of Human Resources after consultation with the President and upon approval of the President. All amendments will be made via a written instrument signed by the Plan Sponsor. The Vice President of Human Resources may sign such amendment.

Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Rescission of Coverage for Misrepresentation or Fraud

Rescission is the cancellation or discontinuance of coverage under the Plan that has retroactive effect.

The Plan will rescind Plan coverage if a Covered Person commits fraud or makes an intentional misrepresentation of a material fact in connection with eligibility for coverage, a claim for benefits, enrollment information, or any other matter affecting a Covered Person's receipt of Plan coverage or benefits.

With respect to eligibility, when you enroll a Spouse or Child in the Plan, you represent the following—

- The Spouse or Child is eligible under the terms of the plan; and
- You will provide evidence of eligibility on request;

Further, you understand that—

- The plan is relying on your representation of eligibility in accepting the enrollment of your Spouse and Children;
- Your failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and
- Your failure to provide evidence of eligibility will result in disenrollment of the Spouse and/or Child, which may be retroactive to the date as of which the Spouse and/or Child became ineligible for plan coverage, as determined by the Plan Administrator.

Conformity To Law

This Plan shall be interpreted to comply with the requirements, to the extent required, of any applicable law or regulation to which it is subject, including but not limited to, the Employment Retirement Income Security Act (ERISA), the Internal Revenue Code (IRC), and the Patient Protection and Affordable Care Act (PPACA).

Clerical Error

Any clerical error by a Participating Employer, the Plan Administrator, or an agent of either, in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered. The Plan reserves the right to recover any overpayments, as described in the Recovery of Payments section of this SPD.

22. STATEMENT OF ERISA RIGHTS

As a participant in The Langdale Company Employee Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan And Benefits

Examine, without charge, at your Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts, if any, and a copy of the latest annual report (Form 5500 Series), if a report is required, that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

Upon written request to the Plan Administrator, obtain copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, if any, and copies of the latest annual report (Form 5500 Series), if a report is required, and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue group health plan coverage for yourself, Spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents must pay for such coverage. Please refer to *Section 18: COBRA Continuation Options* and the documents governing the Plan's rules governing your COBRA continuation coverage rights.

You should be provided a certificate of Creditable Coverage, free of charge, from the Plan Administrator when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Plan. These persons are referred to as "fiduciaries." The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents (without charge) relating to the decision, and to appeal any denial, all within certain time schedules. Please see *Section 14: Claims and Appeals* for more details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case the court may require the Plan Administrator to provide the materials and to pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims and appeal procedures that are available to you under the Plan, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money (if the Plan is considered to have money), or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous. However, no legal action may be commenced or maintained against the Plan prior to your exhaustion of the Plan's claims procedures described in *Section 14: Claims and Appeals*.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA).